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Medico-Legal Death Investigation Systems – England & Wales

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ABSTRACT

Suspicious unexpected death is one of the worst events that a family will experience. To allow closure there is the need to identify any underlying medical causes of death. This requires thorough investigation to exclude unnatural causes of death. Death investigations within England and Wales are conducted at local authority level, with the medico-legal systems being a combination of Coroner and Medical Examiner. Post-mortem examinations were carried out on 39% of all deaths reported to the coroner in 2020, with the medico-legal dissection rate for England and Wales being around 13%. Death investigation in England and Wales remained relatively unchanged for decades, but the system has experienced comprehensive revisions allowing a system that is less fragmented with clear supervisory and leadership responsibilities. This paper will outline the death investigation systems, including the legislative framework, key players and their symbiosis.

Keywords: Coroner; death investigation; forensic pathologist; inquest; medical examiner.

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INTRODUCTION

Historical background to medico-legal investigation

The first historical record of medico-legal investigation originate from China as recorded in Tz'u Sung's textbook 'Hsi yüan chi lu' (The Washing Away of Wrongs) in 1247 CE. It served as an instruction manual for medico-legal death investigations. The first reported autopsy or post-mortem is that of Julius Caesar in 44 BCE[1].

Although research and learning into medico-legal death investigations have evolved since then, only recently has this been recognised as an independent discipline within medicine[2].

Medico-legal death investigations in England underwent progression and development independently from its European counterparts. The Coronial system in England was officially established in 1194 with knights mainly taking up the role of a coroner, originally as a form of tax gatherer[2]. Coroners are independent judicial officials who are in charge of examining the causes of fatalities. In early days, coroners were elected by freeholders and the role was said to be carried out for life. Along with conducting inquests or death investigations, coroners were also tasked with administrative duties and generating revenue for the Crown. It was common for coroners and sheriffs (executive arm of judiciary) to work together at the time. However, coroners had more powers (even above sheriffs) and this power imbalance made working together quite difficult for these two professions. Eventually, the job of a coroner became restricted to death investigations and dead bodies.

The Local Government Act of 1888 replaced general election of coroners with appointment by local authorities. Further legislative reforms in 1926 made it mandatory for an individual to have at least 5 years of experience working as a medical practitioner or a lawyer in order to become a coroner[1].

There are a total of approximately 98 coroners covering 109 areas in England and Wales. This roughly follows the borders created by local authority districts. Officers are hired by coroners to help them conduct their investigations[3].

Today, homicide investigations are led by a Senior Investigating Officer (SIO), who ensures appointment of relevant staff for the investigation process and formulate appropriate search strategies. The investigative team also consists of three Detective Inspectors, out of which two will lead core teams and

the third will head the intelligence unit/Major Incident Rooms (MIR).

A Crime Scene Manager (CSM) will be present to oversee crime scene examination process. They may also be required to give evidence in court. The Police Search Advisor (POLSA) team works under both SIO and CSM. The primary role of POLSA is to undertake scene search operations. Any forensic evidence present is recovered by Scenes of Crime Officers (SOCO) who are well trained in collection and recovery process and is up to date with latest crime scene processing protocols.

UK AND LAWS RELATED TO DEATH INVESTIGATION

The United Kingdom consists of England, Wales, Scotland and Northern Ireland. The population of UK as estimated by mid-2020 was 67.1 million with 669,000 deaths recorded and being the most in a mid-year reference period since 1986[4].

The countries were initially governed by the Parliament of United Kingdom and Northern Ireland. However, devolution acts from 1998, followed by the Government of Wales Act (2006) split the governance and legislative systems into 3 – England and Wales, Scotland and Northern Ireland. In 1935, the first Metropolitan Police Laboratory came into existence. In 1996, it was renamed as the Forensic Science Service (FSS) that covered England and Wales. The FSS ran into serious financial difficulty causing its closure in 2012 and its role was taken up by private forensic science service providers.

Medico-legal death investigation in England and Wales usually follow one of the three pathways listed below:

- Death (anticipated) that occurs as a result of poor health and the doctor is able to issue a Medical Certificate of Cause of Death (MCCD)
- Death where the doctor is unable to issue MCCD either because they did not treat the deceased recently or because the death was unexpected. The case will then be forwarded to the coroner. The scene of death may be attended by police along with an officer from the coroner's office and initial investigation may be conducted. If initial investigations suggest no third-party involvement and the absence of any suspicion surrounding the death, then the coroner may continue with the investigation. At this stage, the coroner may enlist the help of police officers and may also appoint a histopathologist (non-forensic) to carry out an autopsy to determine the cause of death.
- If the outcome of the initial investigations suggests suspicion surrounding the death, the police then take on the lead role in the investigation. The coroner, in discussion with the police appoints a forensic pathologist (Home office registered) to conduct a post-mortem examination.

Forensic and non-forensic post-mortem examinations are quite different. This means that any error during the initial investigation leading to a 'non-suspicious death' conclusion will result in a non-forensic autopsy, which may lead to missing or overlooking a potential homicide.

THE DIFFERENT JURISDICTIONS AND TERRITORIES AND THEIR SUBTLE DIFFERENCES

The United Kingdom has around 48 police forces - 43 territorial police forces in England and Wales (39- England, 4- Wales), national polices forces for both Scotland and Northern Ireland and three specialist forces – Civil Nuclear Constabulary, British Transport Police and the Ministry of Defence Police[5]. Police forces in the UK work under a governmental department called the 'Home Office' that coordinates and operates a range of centralised departments, one of which is the National Crime Agency (NCA). The NCA acts as a list holder of experts in various fields which may help in crime investigation. But the police forces present in the United Kingdom may have their own preferred experts who may be contacted based on the advice of the Scientific Support Manager (SSM) in the force.

LEGISLATION AND MEDICO-LEGAL SYSTEM IN ENGLAND AND WALES

The coroner system in England and Wales is headed by a Chief Coroner and guided by the Coroners and Justice Act 2009. According to Section 5 of the act, coroner investigations are undertaken to ascertain the identity of the deceased, the circumstances surrounding the individual's death (how, when and where) and to gather any relevant details required to register a death certificate[3].

In England and Wales, the Crime Scene Manager is required to notify the Coroner's Office when there is a deceased individual found in their respective jurisdiction. According to the Coroners (Investigations) Regulations 2013, a Coroner will also have the option to conduct coronial inquiries outside of their jurisdiction if required[3].

REPORTING A DEATH

All deaths in England and Wales must be registered. However, the coroner only has a duty to investigate certain deaths. The coroner's duty to investigate arises only when the coroner has reason to believe that the death is violent, unnatural, the cause of death is unknown or occurs in custody or in state detention.

Where a death is from natural causes (for example, from a naturally occurring disease) in most cases that death will not need to be reported to the coroner. The coroner is informed of a death in the following circumstances[6,7]:

- where the deceased was not treated by a doctor during their last illness
- where the deceased was not treated by a doctor for the illness he died from within the last 14 days leading up to death
- of children and young people under 18, even if due to natural causes.
- within 24 hours of admission to hospital
- that may be linked to medical treatment, surgery or anaesthetic
- that may be linked to an accident, however long ago it happened
- that may be linked to drugs or medications, whether prescribed or illicit
- where there is a possibility that the person took his own life
- where there are suspicious circumstances or history of violence
- that may be linked to the person's occupation, for example if they have been exposed to asbestos
- of people in custody or detained under the Mental Health Act, even if due to natural causes
- due to some unusual illnesses including hepatitis and tuberculosis.

The coroner has the authority to permit any action around the removal and examination process of the body found and is usually present during the post-mortem examination. The coroner needs to be informed about the exhibits taken during the process, and provided a list of names and contact details of those who attend the examination. They may also nominate the mortuary and the pathologist for the post-mortem examination. The Coroner also has a duty to liaise (through Coroners Liaisons Officers) with the next of kin and law enforcement officials regarding the release of the body and any delays to this process if further post-mortem examination is required.

INQUEST

An inquest can be defined as a legal inquiry conducted to identify the cause and circumstances around a death[3]. Inquests may be held in the presence of a jury or otherwise. According to Rule 8 of the Coroners (Inquest) Rules 2013, inquests should be completed within six months of a Coroner first being made aware of a death or as soon as practically possible.

An interim death certificate should be obtained during the inquest so that the registrar of death can be notified. The final death certificate may be obtained once the inquest is over.

Inquest conclusions

Once the inquest is complete, the following verdicts or conclusions are usually reached (please note that this list is not exhaustive)[3]:

- Natural cause
- Accident
- Industrial disease
- Abortion (attempted or self-induced)
- Drug dependency/drug abuse
- Lawful or unlawful killing
- Suicide
- Open verdict (insufficient evidence to reach any other verdict)

In 2020, 30,936 inquest conclusions were recorded. Twenty four percent of inquests recorded an outcome of death by accident / misadventure, 12% by natural causes, 14% suicide and 10% unclassified conclusions[8].

KEY PLAYERS & THE SYMBIOSIS

Apart from the coroner, other professionals also play an important role in the death investigation process:

The Medical examiner

In April 2019 a non-statutory medical examiner system was introduced, and in 2021 the statutory footing was in the form of a white paper which included provisions for medical examiners. The medical examiner offices are now established in NHS trusts namely East of England, London, Midlands, North East and Yorkshire, North West, South East, South West and Wales. During 2021/22, the role of these offices was extended to include all non-coronial deaths[9].

The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.

The Forensic Pathologist

The Forensic pathologists (Home Office registered) play a vital role in forming forensic examination strategies. The pathologist may advise the Senior Investigating

Officer on a number of matters including (but not limited to)[10]:

- Providing advice on the transport of the body to the mortuary
- Assisting in victim identification
- Assessing previous health of the victim
- Determining the circumstances surrounding the death of the victim
- Estimating time of death
- Assisting in the decision-making process, where required

A post-mortem examination usually takes place within 2-3 days after death, although sometimes, this may be less than 24 hours. The role of the forensic pathologist, however, does not end with the post-mortem examination. The forensic pathologist may be required to liaise with the investigation team and the Crown Prosecution Service (CPS) throughout the investigation process.

The Police

Primary roles of the police force in a medico-legal death investigation include:

- Crime investigation and
- Case referral to the CPS

Once the police have been informed of a sudden, unexpected or unexplained death and necessary details have been collected (location of the body, details of the caller etc), the next step is the deployment of personnel to the scene, preserving life and securing the scene. Death should not be assumed unless clear evidence (that can be interpreted by a non-medical person) is present.

If the death is thought to be suspicious, further tasks are undertaken such as collection of evidence, intelligence checks, evaluation of third-party involvement, witness identification etc. If death is not considered to be suspicious, then a doctor (who attended to the deceased within the last 14 days of death) may provide an MCCD and police investigation will no longer be required.

Crown Prosecution Service (CPS)

The Crown Prosecution Service is a governmental body that deals with the prosecution of criminal cases in England and Wales that have been investigated by the police and other related organizations.

Duties of CPS in death investigations include:

- Determining which cases need to be taken to court
- Assessing charges in complex cases and advising police, particularly during the early stages of the investigation process
- Preparing and presenting cases
- Providing victims and witnesses with advice, information and support

The prosecutors must be independent and fair and follow the Code of Crown for Prosecutors. According to this code, prosecutors must have sufficient evidence to try the individual(s) and the prosecution should be in the interest of the public[11].

Others

Where necessary, the SIO should seek the expertise of other specialists such as[10]:

- Toxicologists
- Anthropologists
- Entomologists
- Odontologists
- Ballistics experts
- Other pathological disciplines (neuropathologists or paediatricians)

CONCLUDING REMARKS

In 2020 in England and Wales, there were 607,922 deaths of which 205,438 were referred to the coroner. Of those, 79,357 resulted in post-mortem examinations, 31,991 in inquests and 239 with a jury[7]. While medico-legal dissection is an important tool in modern death investigation, England and Wales can learn from other judications in the UK with considerably lower post-mortem examination rates[12]. The death investigation and certification process in England and Wales remained relatively unchanged for over 50 years, but the system has experienced comprehensive revisions allowing a system that is less fragmented with clearer supervisory and leadership responsibilities. This allowed for the creation of the coroner post that leads the jurisdiction and for local medical examiners to help with the death certification scheme.

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