

# **“How we got here: Law Commission Report 62 and the Coroners Act 2006”**

## **Coroners Orientation Programme**

**18 June 2007, Wellington**

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### **Perspective**

Parliament has enacted:

No-one shall be deprived of life except on such grounds as are established by law and are consistent with fundamental justice.

(New Zealand Bill of Rights Act 1990 s 8)

New Zealand has acceded to treaties which do not form part of domestic law:

Everyone has the right to life...

(Universal Declaration of Human Rights art 3)

Every human being has the inherent right to life. The right shall be protected by law. No one shall be arbitrarily deprived of life

(International Covenant on Civil and Political Rights art 6)

Citizens of the European Community enjoy the protection of art 2(1) of the European Convention on Human Rights Art 2(1)):

Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction for a crime for which this penalty is provided by law.

New Zealand law is presumed to conform with our international obligations: *Tavita v Minister of Immigration* [1994] 2 NZLR 257 (CA).

### **Synopsis**

Yours is a noble role. You are members of the independent judiciary with two vital functions. One is to give to the living the comfort that comes from closure; to know

how and why a loved one has suddenly died. The other is to preserve life: by learning from the sudden death then speaking truth to power, however unpalatable that truth may be, so that disaster is turned to good.

## **Introduction**

In the Law Commission Report we paid tribute to some exemplary work of past coroners. That compliment must not permit distraction from the bitter facts that they were under-resourced, lacked both leadership and proper systems, and were insufficiently valued within the community. The new regime that comes into effect on 1 July allows all that to be changed. I have been invited to attempt something of an overview of a field in which you are expert and I am an outsider.

I begin with the perspective of two French thinkers:

One should always have one's boots on, and be ready to leave.<sup>2</sup>

Death never takes the wise man by surprise; he is always ready to go.<sup>3</sup>

Sudden death was as familiar to Montaigne in the 16<sup>th</sup> century as to La Fontaine in the 17<sup>th</sup> when he borrowed and improved on his compatriot's idea. When we undertook the Coroners Report I was intrigued to discover that whereas to me death was something that just did not happen, that is, until it took place, the Maori and Jewish communities had formulated similar philosophies to the French.

My kind of blinkered approach has long affected the Western view of death and may underlie the way we have, until now, treated our coroners. It will certainly have contributed to what one writer has termed "chronocentricity": focusing simply on the present we commit systemic failure to learn from the lessons of the past. For example, following the Air Canada crash at Dryden, Ontario, the UN's International Civil Aviation Organisation issued a Circular.<sup>4</sup> It analysed the consequences of failure to learn the lessons of the Erebus Royal Commission Report on the aviation disaster in Antarctica. It stated:

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<sup>1</sup> High Court, Auckland. As President of the Law Commission signed the Report on 25 July 2000.

<sup>2</sup> <<Il faut être toujours botté et prêt à partir>> (1580) Essais de Montaigne Livre 1 chap XX p 189 ed A Armaingaud (1926).

<sup>3</sup> <<La mort ne surprend point le sage. Il est toujours prêt à partir>> (1678-9) Fables Livre 8.

<sup>4</sup> Human Factors Digest No 10, ICAO Circular 247-AN/148.

The Erebus Report was, probably, ten years ahead of its time<sup>5</sup>. After all, Chernobyl, Clapham Junction, Kings Cross and other major high technology systems catastrophes had yet to happen. They need not have happened. In retrospect, if the Aviation Community – and the safety community at large – had grasped the message from Antarctica and applied its safety lessons, Chernobyl, Clapham Junction, Kings Cross and certainly the Dryden Report would not have existed.<sup>6</sup>

We now have the opportunity to strip off our blinkers and ensure, contrary to past experience, that by learning and expounding effectively the true lessons of disasters the future is properly protected from repetition.

I must emphasise that the foregoing is not rhetorical but of direct relevance to the interpretation and application of the 2006 Act. To understand the Coroners Act it is not enough simply to examine the text. Section 5 of the Interpretation Act 1999 requires that we also consider its purpose. But in the case of any public institution that requires work. According to a recent formulation:

...the insight of Lord Wilberforce in *Prenn v Simmonds* [1971] 1 WLR 1381 (HL), that the Court must examine the factual matrix before presuming to construe a contract, applies and with stronger force to the construction of a statute. Similarly with the legal matrix. As Bennion *Statutory Interpretation* (4<sup>th</sup> ed) states at 505:

...an Act is a legal instrument. It forms part of the body of law... [there is need for] particular knowledge as to the enactment which is the unit of enquiry, for example concerning the relevant factual outline. At the end of it all it is the legal meaning that the interpreter must seek.

The statement applies with stronger force to one that has existed since the 12<sup>th</sup> century.<sup>7</sup> The 2006 Act must be seen in its historical and social context.

## **Background**

The history of coroners has described an upside down Bell curve. They began as high officers of the Crown with wide-ranging duties. They included protecting the Crown's pecuniary rights arising from some deaths. An object which caused death was forfeited to the Crown as a deodand. If death was suicide or the deceased was

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<sup>5</sup> The allusion is to the fact that its lessons did not enter public consciousness for a decade.

<sup>6</sup> The sense is that its implications lay unrecognised for that period.

convicted of felony the deceased's chattels were forfeit. To protect the Crown's economic interests the coroner would impanel a jury and hold a Court of record. Holdsworth wrote:

[The coroner] must hold inquests [in relation to sources of claim including] unexplained death, because in all these matters the Crown was pecuniarily interested.<sup>8</sup>

By the sixteenth century the importance of the coroners had diminished considerably and their "chief duty had already... become that of holding inquests in case of unexplained death".<sup>9</sup> Over time the purpose of inquests into such deaths shifted from ascertaining the Crown's pecuniary rights to determining the cause of the death. Holdsworth remarked that this:

is a curious illustration of how a procedure, invented for one purpose, has come, in a changed order of society, to be used for another.<sup>10</sup>

By the time we reported in July 2000, as many of you know well, coroners were no longer universally valued as high officers of state; the institutional recognition of the coronial role had reached a low level. We wrote:

13... it became clear that coroners are attempting to fulfil a critical role in preventing future unnecessary deaths, meet the individual needs of families, obtain the confidence of the public, and manage an increasing workload, without the necessary systems and facilities in place to support their role. The fact that the coronial system is able to function at all is a testament to the dedication of coroners and other individuals who work diligently in the coronial system. In the words of Warwick Holmes, former Chairperson of the Coroners' Council:

Ours is a call for help which we know is unselfish given the role coroners are endeavouring to fulfil in the business of making our country safer and incidentally saving lives.

14 The lack of adequate systems and services to support the role of coroner has far-reaching consequences for society. In particular, it impacts on the ability of coroners to meet the objectives of the Coroners Act 1988 and develop a consistent approach when making findings. It has led to unacceptable backlogs of cases in many areas. These factors in turn affect the ability of other agencies to collect, record and comment on information from coroners' reports.

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<sup>7</sup> The first reliable evidence of the existence of the office of coroner is the Articles of Eyre of 1194. Coroners found a mention in Magna Carta. Clause 17 of Magna Carta 25 Edw 1 (1297) provided "no sheriff constable, escheator, coroner, nor any of our bailiffs shall hold pleas of our Crown".

<sup>8</sup> Holdsworth *A History of English Law* Volume 1 85.

<sup>9</sup> Holdsworth 122.

<sup>10</sup> Holdsworth 86.

What was the significance of allowing the status of the coroner to plummet?  
It is necessary to pause to consider the nature of the coroner's role.

### **The character of the office**

Section 4 states:

#### **4 Coroner's role**

- (1) A coroner's role in relation to a death is—
  - (a) to receive a report of the death from the New Zealand Police; and
  - (b) to decide whether to direct a post-mortem and, if one is directed, to determine whether to authorise certain people (other than the pathologist) to attend; and
  - (c) to authorise the release of the body (including determining, if a post-mortem has been directed, whether the pathologist wishes and is permitted, on the release of the body, to retain body parts or bodily samples); and
  - (d) to decide whether to open an inquiry (and, if one is to be conducted, whether an inquest should be held); and
  - (e) if an inquiry is to be opened and conducted,—
    - (i) To open and conduct it for the 3 purposes stated in subsection (2) (and in section 57), and not to determine civil, criminal, or disciplinary liability; and
    - (ii) to determine related matters such as whether to prohibit the making public of evidence and whether to authorise the making public of certain particulars of deaths suspected or found to be self-inflicted deaths; and
    - (iii) on completing it, to complete and sign a certificate of findings in relation to the death; and
  - (f) to give members and representatives of the immediate family of the person who is, or of a person who is suspected to be, the dead person concerned, and certain others, notice of significant matters in the carrying out of the duties and processes required by law to be performed or followed in relation to the death.
- (2) The 3 purposes referred to in subsection (1)(e)(i) are—
  - (a) to establish, so far as possible,—
    - (i) that a person has died; and
    - (ii) the person's identity; and
    - (iii) when and where the person died; and
    - (iv) the causes of the death; and
    - (v) the circumstances of the death; and

(b) to make specified recommendations or comments (as defined in section 9) that, in the coroner's opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred; and

(c) to determine whether the public interest would be served by the death being investigated by other investigating authorities in the performance or exercise of their functions, powers, or duties, and to refer the death to them if satisfied that the public interest would be served by their investigating it in the performance or exercise of their functions, powers, or duties.

(3) This section is only a general guide to a coroner's role.

### **The purposes of inquiries**

The 2006 Act states:

#### **57 Purposes of inquiries**

(1) A coroner opens and conducts an inquiry (including any related inquest) for the 3 purposes stated in this section, and not to determine civil, criminal, or disciplinary liability.

(2) The first purpose is to establish, so far as possible,—

- (a) that a person has died; and
- (b) the person's identity; and
- (c) when and where the person died; and
- (d) the causes of the death; and
- (e) the circumstances of the death.

(3) The second purpose is to make specified recommendations or comments (as defined in section 9) that, in the coroner's opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

(4) The third purpose is to determine whether the public interest would be served by the death being investigated by other investigating authorities in the performance or exercise of their functions, powers, or duties, and to refer the death to them if satisfied that the public interest would be served by their investigating it in the performance or exercise of their functions, powers, or duties.

A coroner is an judicial officer not subject to control by central or local government.<sup>11</sup>

The authorities cited by *Jervis on Coroners* for the proposition that coroners are officers of the Crown<sup>12</sup> apply with stronger force in New Zealand.

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<sup>11</sup> Matthews 536; Jervis 1-13.

<sup>12</sup> (12<sup>th</sup> ed) 1-05 and 1-06, despite the fact that English coroners are appointed and paid by a local authority.

Matthews notes that:<sup>13</sup>

The coroner is unusual in the English legal system, as a judicial officer who conducts an inquiry (the coroner's "inquest") rather than presides over legislation.

As appears from s 57, their task is not to adjudicate on disputes but to find facts. That is an important topic, to which I will return. The Irish Supreme Court has held that, because a coroner's court does not decide but rather inquires, in holding an inquest the coroner's court is not exercising the judicial power of the state: *Morris v Dublin City Coroner* [2000] 3 IR 602, para 11. *Jervis* argues that the better view is that the coroner's court exercises the judicial power of the state for the purposes of legislation other than the Coroner's Act.<sup>14</sup> *Jervis* also states that the role of the coroner includes executive as well as judicial functions.<sup>15</sup> That may be because of the recommendatory role (s 3(1)(b); s 4(1)(e)(i) and (2)(b) and s 57(3)).

But in New Zealand a coroner no more exercises executive functions than do Law Commissioners, who commonly include High Court judges as the Law Commission Act 1985 expressly contemplates.<sup>16</sup> In terms of the New Zealand Bill of Rights Act 1990 coroners are squarely within "the... judicial branch... of the government of New Zealand" (s 3(a)).

But in truth coroners, like Law Commissioners and Ombudsmen, resist labels. They are sui generis, contributing to what in the Preface to the Report we called the primary function of the State: protecting the lives of its citizens.

### **The coroners' court**

The coroners' court is in law an inferior court of record.<sup>17</sup> It has implied inherent powers, sometimes called "inherent" powers in the sense that they inhere in the statutory role, as *Jervis* explains at 11-01A:

A court endowed with a particular jurisdiction inherently has powers "which are necessary to enable it to act effectively within such jurisdiction" (*Connelly v*

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<sup>13</sup> Matthews "What is the Coroner for?" (1994) 110 LQR 536.

<sup>14</sup> *Jervis* 11-22 and 11-29.

<sup>15</sup> *Jervis* (12<sup>th</sup> ed 1-06).

<sup>16</sup> Section 10.

<sup>17</sup> *Jervis* 11-01.

*DPP* [1964] AC 1264 at 1301 per Lord Morris). This notion of inherent jurisdiction applies to inferior courts, such as the county court (*Langley v North West Water Authority* [1991] 1 WLR 697, CA), so there is no reason for it not to apply to the coroner's court.

But, like the District Courts and indeed the Court of Appeal and the Supreme Court, they do not have the inherent power of the High Court to go beyond the limits of statutory authority in order to do justice.

Like the wardship jurisdiction, that of the coroner's court is inquisitorial rather than accusatorial.<sup>18</sup> The inquisitorial nature of the coroner's court affects both procedure and evidence. It is the coroner, not the parties, who decides which witnesses will be called.<sup>19</sup> Coroners are not bound by the rules of evidence.<sup>20</sup> *Jervis* gives the reason:

In theory at least, the coroner's inquest, being an *inquisitorial* proceeding, designed for the coroner... to start with no preconceptions and to elicit the true facts regarding the incident in question, had no need for [common law restrictions on evidence]. The aim was to find out that objective truth in the public interest and not the limited "truth" as between and for the purposes of two or more parties.

The result is that the coroner's court is not bound by the strict laws of evidence. In particular, this means that "hearsay" evidence, even of a documentary nature, can be admitted.

Coroner's courts may be the scene or source of acrimonious conflicts, such as the *Berryman* litigation<sup>21</sup> and the Princess Diana inquest.<sup>22</sup> Because of the grave consequences of adverse findings natural justice must be complied with.<sup>23</sup> The power to confer party status and permit cross-examination may be used for that purpose.<sup>24</sup>

Nowadays the coroner's court, like the courts of general jurisdiction, must be sophisticated, able to respond to the ever-increasing demands of a complex society. Ian Freckleton argues that in Australia the abolition of coroner's juries has occasioned a significant change in the role that coroners now play, in terms of the complexity of evidence that can be dealt with by coroners who possess an expertise in grappling

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<sup>18</sup> *Jervis* 12-99.

<sup>19</sup> *Jervis* 10-14.

<sup>20</sup> Section 26(5).

<sup>21</sup> See *Solicitor-General v Miss Alice* HCWN CIV 2005-485-1026 14 February 2007 (to be reported in NZLR).

<sup>22</sup> *R (Paul) v Coroner of the Queen's Household* [2007] 2 All ER 509.

<sup>23</sup> *Re Erebus* [1981] 1 NZLR 618 (CA), [1983] NZLR 662 (PC).

<sup>24</sup> Section 26(4).

with technical issues not shared by lay jurors.<sup>25</sup> The need for a change from the often simplistic approaches of the past is discussed later. The new full-time New Zealand coroners are well equipped to set new standards.

The standard of proof required varies between jurisdictions. In England the standard is beyond reasonable doubt, whereas in New Zealand, as in Canada and Australia, the standard is the balance of probabilities of *Blyth v Blyth* [1966] AC 643 (in Australia *Briginshaw v Briginshaw* (1938) 60 CLR 336).<sup>26</sup>

A coroner's verdict is not binding on anyone wishing to contest its findings of causation of death in subsequent litigation.

### **The Law Commission report**

Having identified major failings in the institutional arrangements for coroners we saw vital need for proper systems. These included:

- (1) need for leadership and co-ordination, hence the appointment of a Chief Coroner;
- (2) need for high professionalism, hence:
  - reduction of the number of coronial districts and the appointment, in the same manner as other judicial officers and according to similar criteria, of a smaller number of full-time coroners
  - proper remuneration fixed in the manner appropriate for the rest of the judiciary by what is now the Remuneration Authority
  - the security of tenure which is essential to judicial independence
  - appropriate training;
- (3) the creation of a national coronial information database (a recommendation that has received emphasis from Dame Janet Smith's reports in the Shipman Inquiry as to the 215 killings of patients)<sup>27</sup>;

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<sup>25</sup> Ian Freckleton *Causation in Coronial Law* (1997) 4 Journal of Law and Medicine 335.

<sup>26</sup> Freckleton (ed) *Causation in Law and Medicine* (2002 Burlington Ashgate/Dartmouth) 351-352 citing *Briginshaw v Briginshaw* (1938) 60 CLR 336.

- (4) clarification and co-ordination of relations between coroners and administrative and government agencies.

As to what the coroner should do we reported:

8... the inquiries of the coroner should not be limited to matters of mere formality, but should be of social and statistical significance in a modern community.

9 Recent research into the investigation and analysis of accidents and death has revealed the crucial importance of not focusing exclusively on what seems to be the immediate cause of a fatality: the primary causes can and frequently do lie much deeper. In this context, it has progressively become evident that the fundamental causes of fatalities, and therefore the measures needed to avoid recurrence, can require a much broader perspective than the one currently adopted by coroners.

10 With certain notable exceptions... deaths tend to be considered in isolation. There is no system for appraisal of the background factors contributing to the death to determine whether it is an isolated episode or an example of a deep-seated problem. The Commission considers it imperative that an investigation into the possibility of fundamental causes be a regular exercise of the coroner's function. A true appraisal of apparently insignificant incidents can reveal, and then remove or reduce, the risk of disaster. This is made difficult at present, however, because there is no system for the collation and appraisal of one coroner's finding in relation to others.<sup>6</sup>

...

As to how to do it we said:

#### (1) THE NEED FOR A CHIEF CORONER

71 In the preliminary paper we noted that during consultation, many people expressed concerns in relation to the supervision of coroners. It was noted that in New Zealand there is currently no person or office responsible for the administration of the Act and for overseeing how coroners exercise their powers or carry out their duties. We observed that this causes a number of problems in practice:

- There is currently no point of contact for coroners or members of the public concerned about the operation of the Coroners Act 1988. Coroners have expressed concerns about their isolation from each other. Individuals and groups have also expressed concern that there is no one person they can approach in relation to coronial matters.
- There is a perceived lack of uniformity in practice between coroners. It was noted that many coroners will investigate very few deaths during their time as coroner. Other coroners will investigate many deaths. This often means that coroners have different amounts of experience and often adopt different procedures.

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<sup>27</sup> <https://www.the-shipman-inquiry.org.uk/thirdreport.asp>

- There is no guidance as to how coroners should exercise their discretionary powers under the Act.

72 We noted that a Chief Coroner is appointed in most territories in both Australia and Canada. We proposed that a Chief Coroner be appointed in New Zealand. The Chief Coroner’s functions would include: engaging in research and planning to ensure coroners are equipped to perform their functions systematically and properly;

- ensuring that coroners are properly trained;
- liaising with the government in relation to the appointment and disposition of coroners throughout New Zealand;
- liaising with the public and other coroners; u ensuring that reports from coroners are properly appraised and that they are publicly available;
- maintaining an overview of patterns of sudden deaths and their fundamental causes and considering whether additional inquiries are required; and
- reporting regularly to the Ministers of Justice and Health with particular emphasis on patterns of circumstances leading to death or risk of death and the steps needed for their prevention or reduction.

We also said:

(2) THE NEED FOR PROPER SYSTEMS OF INFORMATION AND ANALYSIS

89 The Law Commission has consulted with and had the benefit of a comprehensive submission and additional materials from Professor John Langley of the Injury Prevention Research Unit (IPRU) in Dunedin. Professor Langley has been actively involved in promoting the need for a National Coronial Surveillance System in New Zealand. He expressed concern that there is a lack of understanding about what is required for an effective surveillance system: Contrary to some perspectives it involves more than the loading of existing information onto a database. While this would be an advance we wish to emphasise that this information is variable in quality. He explains that: Epidemiologic surveillance is the ongoing systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event... This information is used in planning, implementing, and evaluating interventions and programs which impact on the health of the public. Surveillance data are used both to determine the need for public health action and to assess the effectiveness of the programs.

90 Professor Langley advises that much more thought is needed with regards to the future analysis, interpretation, and dissemination of the data generated by a national database. He states that resources need to be allocated for these purposes as there exists already much health-related data that is “untouched by human thought”.

The major recommendations were accepted. It is pleasing to see that the 2006 Act has after many years restored the coroner to a proper status. Section 3 of the Act states its purpose:

...to help to prevent deaths and to promote justice through –

- (a) investigations, and the identification of the causes and circumstances, of sudden and unexpected deaths, or deaths in special circumstances; and
- (b) the making of specified recommendations or comments (as defined in section 9) that, if drawn to public attention, may reduce the occurrence of other deaths in circumstances similar to those in which those deaths occurred.

And s 9 defines “specified recommendations or comments” as recommendations or comments by the coroner on:

- (a) the avoidance of circumstances similar to those in which the death occurred:
- (b) the way in which people should act in circumstances of that kind.

The previous Act of 1988 had contained subclause (b) expressed in other language (s 15(1)(b)). But there had been no emphasis on the need for a systematic approach to preventing deaths and promoting justice. As will appear, to achieve that goal will require not only the qualities of diligence, sound judgment and independence for which you were appointed, but an ability to capture the imagination and secure the confidence of the people of New Zealand that your work matters and warrants their support.

### **Causation**

Just how far coroners are able to go under the Act towards our goal:

that an investigation into the possibility of fundamental causes be a regular exercise of the coroner’s function. A true appraisal of apparently insignificant incidents can reveal, and then remove or reduce, the risk of disaster.

remains to be seen.

The precise nature of the coroner’s responsibility to determine the cause of death is a matter of acute difficulty and importance. That is brought out sharply by the English experience. A coroner’s inquest in England must determine “how... the deceased

came by his death”.<sup>28</sup> The latest authority *R (Hurst) v London Northern District Coroner* [2007] 2 WLR 726 (HL) states that:

[3]... It is not disputed that, in accordance with the decision of the [English] Court of Appeal in *R v North Humberside Coroner, ex parte Jamieson* [1995] QB 1, under domestic English law an inquest is to determine “by what means”, as opposed to “in what broad circumstances”. The deceased came by his death.

As will be seen, a much more expansive approach has been taken in New Zealand, in Australia, and by force of the European Human Rights Convention, in English cases under the Human Rights Act 1998.

In New Zealand the equivalent subsection is s 57(2)(d) and (e) of the 2006 Act, which provides that one of the purposes of a coroner’s inquiry is to determine “the causes of the death” and “the circumstances of the death”, which might be regarded as a somewhat broader expression.

Section 11 of the English Act provides for proceedings at an inquest, covering subjects such as evidence, the inquisition, and death certificates. Section 11(5) states:

- 11.—  
...  
(5) An inquisition—  
    (a) shall be in writing under the hand of the coroner ...;  
    (b) shall set out, so far as such particulars have been proved—  
        (i) who the deceased was; and  
        (ii) how, when and where the deceased came by his death; and  
    (c) shall be in such form as the Lord Chancellor may by rules made by statutory instrument from time to time prescribe.  
...

Section 57 of the Coroners Act 2006, by contrast, which it is convenient to repeat, is purposive rather than procedural in focus. It provides:

**57 Purposes of inquiries**

- (1) A coroner opens and conducts an inquiry (including any related inquest) for the 3 purposes stated in this section, and not to determine civil, criminal, or disciplinary liability.  
(2) The first purpose is to establish, so far as possible,—  
    (a) that a person has died; and

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<sup>28</sup> s 11(5)(b)(ii) Coroners Act 1988. Section 12 of the 1988 New Zealand Act required the coroner to find “how the death occurred”.

- (b) the person's identity; and
- (c) when and where the person died; and
- (d) the causes of the death; and
- (e) the circumstances of the death.

(3) The second purpose is to make specified recommendations or comments (as defined in section 9) that, in the coroner's opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

(4) The third purpose is to determine whether the public interest would be served by the death being investigated by other investigating authorities in the performance or exercise of their functions, powers, or duties, and to refer the death to them if satisfied that the public interest would be served by their investigating it in the performance or exercise of their functions, powers, or duties.

The difference in language and orientation between the English and New Zealand provisions suggest a rather different approach to the scope of the enquiry into causation.

In *R v North Humberside Coroner, ex parte Jamieson* the Court of Appeal took a narrow approach to the ambit of inquests. Sir Thomas Bingham MR held at 24:

“how” is to be understood as meaning “by what means”. It is noteworthy that the task is not to ascertain how the deceased died, which might raise general and far-reaching issues, but “how ... the deceased came by his death,” a more limited question directed to the means by which the deceased came by his death.

Freckleton contends that in *Jamieson* “the court read down in important ways the scope of inquests”.<sup>29</sup>

A similar approach was taken in Australia in *Kahn v West and Keown* [1999] VSC 530. The court took the approach that the scope of coroner’s duty to find “how” the deceased died is narrow – the issue being pulling the trigger, not whether shooting was legitimate.

In *Ex parte Minister of Justice; Re Malcolm* [1965] NSW 1598 McClemens J had held that the function of the coroner was to face the “real cause” of death squarely, rather than focusing on the mode of dying. To do so he adopted from *Jervis* both the distinction between the terminal cause of death (such as infection) and a “definable event” (such as a wound) and the approach that where the terminal cause of death is a

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<sup>29</sup> Freckleton 1997, 341.

direct consequence of the definable event the death should be regarded as being caused by the definable event. In *Malcolm* the coroner had focused on the pneumonia suffered by the deceased in his last days of hospitalisation. This was simply the terminal cause of death. The pneumonia was caused by a number of factors: the deceased was operated on while inert, vegetative, incontinent of urine and faeces, and suffering from a bed sore, a secondary infection from the bed sore, a bladder infection.

*Malcolm* was followed in *Re Hendrie; Louw v McLean* HCCH CP 445/87 12 January 1988. Hardie Boys J approved of the need to find not only the terminal cause of death but also the real cause of death, an analysis which McClemens J drew from *Jervis*. Hardie Boys J concluded “for an inquest to have a useful social function it must I think be able to go beyond the mere medical cause of death”: 11. Hardie Boys J noted similarity between the New Zealand, New South Wales and English statutes with regard to this causation jurisdiction.

Freckleton characterises the decision of the Court of Appeal in *R v Poplar Coroner, Ex parte Thomas* [1993] QB 610 as “savour[ing] more of the malice of a legal academic, setting an impossible problem for his or her students, than of real life”.<sup>30</sup> The medical cause of death was a prolonged asthma attack. The issue was whether the late provision of an ambulance was a cause of the death. The ambulance had arrived 33 minutes after the first “999” call was made.

The coroner had decided that the death was a natural one and declined to order an inquest. In the Divisional Court of the Queen’s Bench Division the deceased’s mother successfully argued that a death caused by a naturally occurring disease could be an unnatural death where it should and could have been prevented by the performance of a duty owed to the deceased by a person or authority.

The Court of Appeal reversed that decision. Two judges adopted the “common sense” test of *Alphacell Ltd v Woodward* [1972] AC 824. Dillon LJ formulated a number of scenarios in which an ambulance might arrive too late to save a patient and concluded (at 628):

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<sup>30</sup> Freckleton 2002, 349-350.

...in each of these scenarios common sense indicates that what caused the patient's death was, on Lord Salmon's test in *Alphacell Ltd v Woodward* [1972] AC 824, 847, the asthmatic attack, not the congestion of the traffic, the bursting of the water main, the malfunction of the computer or the inefficiency of the ambulance service.

His judgment sternly concluded "it is not the function of a coroner's inquest to provide a forum for attempts to gather evidence for pending or future criminal or civil proceedings": 629.

Simon Brown LJ (now Lord Brown) took a different approach. His judgment included a critique of the diminished ambit of the inquisition. He reasoned (at 631):

...the scope of what a coroner's inquisition may achieve by way of a formal result has gradually been whittled down over the years. All indeed that remains, bar the verdict, is the coroner's limited power under rule 43:

"A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is that he is reporting the matter in writing to the person or authority who may have the power to take such action and he may report the matter accordingly."

Merely, however, because the coroner's inquest may nowadays be thought lacking any very clear or cogent role is no sufficient reason for adopting too narrow an approach to section 8 [which provides the circumstances in which an inquest is warranted, including unnatural death].

Taking a case mid-way between asthma "with its considerable mortality rate" and an ectopic pregnancy "which clearly ought never to result in death", Simon Brown LJ postulated that a death from such an intermediate condition in the event of a clear failure of the emergency services would be an unnatural one: 631. He went on to say (at 631):

Indeed, I for my part would so regard this very case if the late arrival of the ambulance had constituted a more extreme failure of the service than I believe it did. If death from Legionnaire's disease is accepted to be unnatural only because it is extremely rare, why not these sorts of cases too?

The New Zealand statutory scheme, under the 2006 Act, is more consonant with the approach suggested by Simon Brown LJ. The role of New Zealand coroners includes bringing public safety issues to light and thus assisting in the prevention of similar deaths in future, within the limits of s 57(3). The Accident Compensation scheme in New Zealand, with its bar on proceedings in negligence for personal injury, the

absence of juries, and now the enhanced status of coroners may be seen as public interest pointers to why coroners here should assume greater scope to extrapolate from the cases before them and make findings on dangers to public safety.

Freckleton argues in favour of the approach in *Malcolm* and the recognition in the New Zealand statute of the importance of prevention and thus analysis of the wider context of the death. It is worth quoting him at length:<sup>31</sup>

It assists the community little to identify by formal coronial findings only the proximate or terminal events around deaths. Frequently, it is as to the environment within which acts and omissions which resulted in a death, as well as in relation to the potentiating and exacerbating nature of factors leading to the death, that analysis needs to be undertaken if the incidence of avoidable death is to be reduced. Often it is intangible factors such as workplace culture, longstanding practices of neglect or insensitivity, lack of awareness of options different from those adopted that need to be identified if important changes are to be made which will reduce unsafe practices. It is coroners who are best positioned as a result of the formal hearing process of inquests to discern such issues, to make findings about them and to make recommendations about how they can be changed. A range of public policy reasons, distinct and separate from those operating in the civil and criminal contexts, suggest that the notion of causation needs to be construed more broadly in the coronial context than in most others within the contemporary legal system.

Freckleton observes that:<sup>32</sup>

The obligation to determine causation, especially in relation to deaths, has proved, as a matter of law and fact, and extremely problematic exercise going to the very heart of the coronial function.

The chief difficulty is that findings of causation are bound up with findings of fault. *Halsbury Australia* says at 20.10[68]:

Determinations of culpability are an inevitable corollary to the process in which findings of causation are made. The reality is that many coronial inquests are broad in their scope and a finding that a person caused another's death is likely to be a precursor, and stimulant to, civil action, disciplinary action, media ignominy and potentially criminal prosecution. While the inquest is technically and inquisitorial proceeding, there are often a number of "parties" with fundamentally and adversarially opposed objectives.

Freckleton criticises the judicial notion that causation can be a matter of common sense. He argues:<sup>33</sup>

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<sup>31</sup> Freckleton 1997 353-354.

<sup>32</sup> Freckleton 2002, 331.

<sup>33</sup> Freckleton 1997 298.

As often where platitudinous, non-specific descriptors are employed, they hide a range of unarticulated or generally assumed policy assumptions. This is particularly the case with causation in ordinary adversarial hearings.

His argument is supported by the judicial recognition that judgments as to causation include major elements of policy. See *Environment Agency (formerly National Rivers Authority) v Empress Car Co (Abertillery) Ltd* [1999] 2 AC 22, 30G-32A per Lord Hoffmann:

one cannot give a common-sense answer to a question of causation for the purpose of attributing responsibility under some rule without knowing the purpose and scope of the rule...

Before answering questions about causation, it is therefore first necessary to identify the scope of the relevant rule.

Clearly remoteness is a key consideration. An extreme example of an attempt to have remote causes considered can be found in *Eastern Health Board v Dublin City Coroner* [2002] IESC 82 (Irish SC). The deceased was mentally handicapped and was 22 when he died. The Supreme Court of Ireland considered that the words “how... the death occurred” in the Coroners Act 1962 did not include inquiry into the effect on the deceased of being given the “3-in-1” vaccine when he was a baby.

### **Causation and human rights**

In *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 the House of Lords created an exception to the general rule of English law. It held that the approach in *Jamieson* is not sufficient to discharge the United Kingdom’s obligation under international law to hold an investigation which will encompass the possibility that failures of public authorities contributed to the death. *Middleton* held that in an investigation required by article 2 of the European Convention (right to life) “how” the deceased died means “by what means and in what circumstances”. This was consistent with the decision of the European Court of Human Rights in *McCann v United Kingdom* (1995) 21 EHHR 97 which held that article 2 requires that when a person has been killed by the use of force by state agents there is an effective official investigation. This is the procedural element of the state’s obligation under article 2.

The House of Lords has recently held that *Middleton* applies only to inquests about deaths involving potential state responsibility occurring after 2 October 2000: *R (Hurst) v London Northern District Coroner* at [72].

Neither *Jamieson* nor *Middleton* has been cited in New Zealand judgments. Section 8 of the New Zealand Bill of Rights Act 1990 provides for the right not to be deprived of life. Therefore if New Zealand generally took a narrow approach to causation, *Middleton* might suggest a more expansive approach in cases where s 8 applied. However, the terms of the 1988 and 2006 New Zealand statutes, with recognition of the public interest in preventing death, do not support the adoption in New Zealand of the narrow approach in *Jamieson*.

In *Ding v Minister of Immigration* (2006) 25 FRNZ 568I I cited the decision of Sir Edward Coke CJ four centuries ago in *Calvin's Case* (1609) 7 Co Rep 1a, followed throughout the Crown's evolution from sovereign monarch to government of the democratic state, that the citizen's duty of allegiance to the Crown has as a reciprocal a Crown obligation of protection. I also referred to some difference in approach between *Tavita* and other appellate judgments to the significance of international conventions. An appeal from that decision has been argued and we may expect that there will soon be definitive authority on those point.

My own preference is for *Tavita* to receive effect so that New Zealanders enjoy via the International Covenant on Civil and Political Rights the same level of protection, which may be delivered by coroners, as is available to Europeans under the European Convention. In a forthcoming paper I have expressed the view, which has received some academic support, that the common law created by judges of other generations can and should evolve so as to give no less protection than modern bills of rights.<sup>34</sup>

### **Cultural concerns**

On the sensitive question of dealing with body parts the Final Report of Lord Justice Clarke in the Thames Safety Inquiry<sup>35</sup> makes harrowing reading. I append note by my clerk Megan Crocket which, after outlining some points from Australia and Canada,

in describing the Law Commission's work discusses this topic. Its importance topic continues to grow with the number and range of cultures within our community.

### **Communication**

Speaking truth to power can be uncomfortable. It includes not only those holding authority in the state but the media and others in positions of influence. The lesson of recent disasters has been that common factors can lie behind apparently unrelated events.<sup>36</sup> So Lord Phillips' vCJD (Mad Cow disease) report,<sup>37</sup> referring to a "strategy of sedation" at all levels from Cabinet to the farm, has been echoed by the account by Charpak, Garwin and Journé of responses to the Chernobyl disaster<sup>38</sup> recounting a later <<arrogance et complaisance>> of engineers at another atomic power station.

Those factors included failure of planning, organisation and management at a number of levels, extending from governmental through senior administration to lower levels of management and executive conduct; and in a variety of spheres of operation which had not been properly co-ordinated.

Tackling such institutional failures will require the coroners to explain to the community the nature and importance of their task as servants of that community. As has proved the experience elsewhere in the judicial process, to earn public confidence requires competence, diligence, sustained effort, integrity and courage.

I see this programme, together with the reform that takes effect in 12 days time, as a turning point in the affairs of New Zealanders. I do not doubt that under the leadership of the Chief Coroner you will bring its importance home to the community and receive the support that this bold venture warrants.

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<sup>34</sup> Address to Conference to mark the 20<sup>th</sup> anniversary of the *Maori Council Case* University of Otago 29 June 2007.

<sup>35</sup> Cm 4558 January 2000.

<sup>36</sup> Research by the Oxford Internet Institute is displaying similar patterns (ex rel. the Master of Balliol).

<sup>37</sup> October 2000.

<sup>38</sup> "De Tchernobyl en Tchernobyls" Odile Jacob Paris September 2005 p 490.

**Acknowledgements**

I record with thanks the education provided by my fellow Commissioner, Denese Henare, who led the coroners project and contributed to it both her personal wisdom and the Maori experience.

I also acknowledge with thanks the substantial contribution by Megan Crocket to this paper.

## APPENDIX

### Australia

Legislation regulating coroners varies widely among jurisdictions. In a number of jurisdictions coroners have power to investigate fires as well as deaths.<sup>39</sup> Nearly all states now have a “State Coroner” (or Chief Coroner) system. In such a system local coroners are supervised and co-ordinated by a senior coroner.

The extent of the power to order post-mortem examinations varies from jurisdiction to jurisdiction.<sup>40</sup> Coroners in Australian Capital Territory must take cultural and religious beliefs into account before making post-mortem orders.<sup>41</sup> Relatives may object to an order for post-mortem examination in Victoria and Western Australia, and in New South Wales relatives may apply for judicial review of the coroner’s decision to conduct a post-mortem.<sup>42</sup>

*Halsbury’s Laws of Australia* says at 20.10[31] that:

The increasing focus upon the role of the coroner as a vehicle for preventing injury and death has become a characteristic of the evolution of coronial law in Australia, particularly since the mid 1980s.

The range of verdicts possible in Australia is fixed by practice and is not codified.<sup>43</sup> The verdicts are: unlawful homicide, lawful homicide, suicide, misadventure, accident, natural causes, and an open finding. In Tasmania and Victoria a coroner is to find, if possible, the identity of any person who contributed to the deceased’s cause of death.<sup>44</sup> Australian coroners now have specific powers to and duties to report to government about public safety and health and the administration of justice:

*Halsbury’s Australia* 20.10[78]. *Halsbury Australia* comments at 20.10 [80] that:

Coronial comments, recommendations or riders can be of profound importance to manufacturers, distributors, industrial entities, health institutions, government instrumentalities and many others. They are frequently publicised extensively by the media and can inure to the considerable embarrassment and financial disadvantage of those subject to them.

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<sup>39</sup> *Halsbury Australia* 20.10[35].

<sup>40</sup> *Halsbury Australia*, 20.10[65].

<sup>41</sup> Coroners Act 1997 (ACT) s 28.

<sup>42</sup> *Halsbury Australia* 20.10[67].

<sup>43</sup> *Halsbury Australia* 20.10 [70].

<sup>44</sup> Coroners Act 1995 (Tas) s 28(1)(f) and Coroners Act 1985 (Vic) s 19(1)(e).

## **Canada**

Most Canadian jurisdictions have coroners, including Quebec, a civil law system. Some provinces which have coroners retain juries. Ontario has a Chief Coroner, whose motto is 'We Speak for the Dead to Protect the Living'. Alberta, Manitoba, Prince Edward Island and Nova Scotia have medical examiners, a model like that in many American states. Newfoundland's death investigation system is that of judicial inquiry, which *Jervis* describes as being a little like Scotland's system.<sup>45</sup>

In *People First of Ontario v Niagara (Regional Coroner)* (1991) 85 DLR (4<sup>th</sup>) 174, 183-184 the Ontario Court held that:

The social and preventative function of the inquest which focuses on the public interest has become, in some cases, just as important as the distinctively separate function of investigation the individual facts of individual deaths and the personal roles of individuals involved in the death.

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<sup>45</sup> *Jervis* 22-13.

## **FURTHER COMMENTS ON THE 2006 ACT**

The Report focused chiefly on cultural concerns and a systematic co-ordination of coroners and of the implementation of their recommendations. Some further points warrant mention.

### ***Chief Coroner***

The office of Chief Coroner is a significant innovation in the new Act. Recommendation 11 was that a Chief Coroner be appointed with functions as set out in the Report.

Section 7 lists the functions of the Chief Coroner. A number of the functions proposed in the Report are found in the Act. Notably, the Chief Coroner is charged with issuing practice notes by s 7(h), reflecting the proposal in para 75 of the Report. The Chief Coroner is to help make arrangements for the training and education of coroners (s 7(b), liaise with the public (s 7(m)), and maintain a register of summaries of coroners' findings (s 7(j)), all of which arise from recommendations in para 72 of the Report.

The Report suggested that the Chief Coroner issue guidelines or protocols and gave a number of possible topics. Under the Act the Chief Coroner is to issue practice notes: s 7(h). Section 132 gives greater detail of the power to issue practice notes. Coroners are directed to have regard to all relevant practice notes: s 6.

Some themes of the Report were not taken up in the Act. These include key elements of the role of coroners in promoting the prevention of death. For example the Report recommended that the Chief Coroner maintain an overview of patterns of sudden deaths and their fundamental causes, and report regularly to the Ministers of Justice and Health with particular emphasis on patterns of relevant circumstances and prevention of death (para 72). The recommendation that a coronial database be set up and maintained by the Chief Coroner is not found in the Act.

The functions of the Chief Coroner in the Act have, in general, a more administrative, supervisory flavour than the functions in the Report. Section 7(a) gives the Chief Coroner the role of oversight and facilitation of support services and advice to coroners, and s 7(k) requires the provision to coroners of advice and planning relating

to emergencies. Section 7(c) allows the Chief Coroner to designate certain coroners to certain types of death. The Chief Coroner is to maintain a list of pathologists who will perform post-mortems: s 7(d). The Chief Coroner is to perform the role of Head of Bench in relation to the exercise of coroners' judicial discretion: s 7(j). The Chief Coroner is to liaise with other investigative bodies to avoid duplication of effort and to ensure the timely investigation of deaths: 7(l).

### ***Cultural concerns***

The right to life is the key right in most inquests and coronial disputes. Other rights which are likely to be raised with some frequency include: the right to a fair hearing, the right to respect for private and family life (under the ECHR), the right to freedom of religion, the right to freedom of expression, and the prohibition on discrimination.<sup>46</sup>

### ***Freedom of religion***

The right to freedom of religion often arises in the context of post-mortem examinations. Many religions impose obligations of conduct around deaths which conflict with coronial practice. Some religious groups are opposed to post-mortems, for example. Jervis observes:<sup>47</sup>

A claim to total exemption from the law authorising invasive post-mortem examination of the dead would ... fail. An invasive post-mortem will be justified even against religious belief where it contributes to the inquest's purpose in promoting and protecting public safety, public health and the rights and freedom [sic] of others, and is not disproportionate in effects.

However, new technology, such as MRI machines, thoracoscopy, laparoscopy, radiology, and needle biopsy with histology, may in some cases obviate the need for invasive autopsies, or may provide the option of minimally-invasive autopsies, allaying concerns based on religious or cultural belief.<sup>48</sup> *R (Kasperowicz) v Plymouth Coroner* [2005] EWCA Civ 44 involved an objection to an autopsy on 88-year-old Polish Roman Catholic woman. Sedley LJ said at 15:

If, in this case or indeed in any case, a limited post-mortem can properly be relied upon to answer the statutory question, and if to do more would wound the feelings of the surviving family, I can for my part see no legal inhibition on limiting the post-mortem examination accordingly.... It is simply that a post-mortem examination is not so defined in the statute as to require it in every

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<sup>46</sup> Jervis, 21-04.

<sup>47</sup> Jervis 21-20.

<sup>48</sup> See Jervis (supp) 6-55.

case to be an invasive procedure. The choice, it seems to me, is a matter of common decency and good practice. It is not a matter of law.

***Right to custody of the body***

Recommendation 15 was that coroners should be given temporary *possession* of the deceased's body and body parts. Section 19 of the new Act gives the coroner the exclusive right to *custody* of the deceased's body.

***Retention of tissue or body parts***

The Law Commission recommended that a pathologist authorised by a coroner may retain any body part or tissue he or she considers necessary in order to determine any of the matters in s 15 of the 1988 Act: recommendation 17. Retention of tissue or body parts for other purposes would require the consent of the family.

Retention is permitted in three situations by s 48 of the 2006 Act. First, where the part or sample is minute: s 48(2)(a). Second, where the pathologist believes that retention is necessary for the purposes of the post-mortem and gives the coroner written reasons: ss 48(2)(b) and 49. Third, where the pathologist has explained the reasons for retention to the family and there are no objections: s 48(2)(c).

Lord Justice Clark's *Final Report* into the Thames Safety Inquiry discusses the blanket decision to amputate hands in order to identify the deceased. When the Marchioness sank fifty-one people died. Some bodies had been immersed in water for some time before they were found and decomposition had begun. In some cases there were other clear identifiers present yet the hands were nonetheless removed. Lord Justice Clark took the view that for each body all other factors which might lead to a positive identification must be considered before hands are removed for the purpose of fingerprinting: 12:22.

***Reasons for retention***

Recommendation 18 was that prior to retaining any body part the pathologist should be required to give notice to the coroner of the particular body part, the reason for retention, and the length of time it is proposed to retain the body part. Section 49 requires that the pathologist notify the coroner of these same details.

This recommendation also sets out that the family ought to be notified of these matters. Where there is to be retention under s 48(2)(a) or (b) the coroner must notify the family of the proposed retention and must give notice under s 23. The notice must give the detail required by s 50(2). The family must also be informed of the right to request the return of the sample: s 50(3). Where there is to be retention under s 48(2)(c) the family must be informed of the right to request the return of the sample: s 51. Requests for return are made under s 52.

### ***Providing information to the family***

The Report recommends that the family is advised throughout the coronial processes: recommendation 19. Section 23 gives effect to this recommendation. As soon as a death has been reported under s 15(2)(a) or s 16(2)(b) the coroner must give notice of “significant matters” to three classes of people. “Significant matters” include but are not limited to matters enumerated in s 24. The people to receive notice are representatives recognised under s 22 of the deceased’s immediate family, every member of the deceased’s immediate family, and any other person or organisation the coroner considers to have any interest in the death (other than the same interest as the general public).

### ***Returning the body***

Recommendation 20 puts forward the principle that the body be returned to the family as quickly as possible. This is taken up by s 42, which directs the coroner to authorise the release of the body “as soon as he or she is satisfied that it is no longer necessary to withhold it from family members”.

There are two restrictions on s 42. Section 43 requires a coroner who decides not to direct a post-mortem to notify police and wait 24 hours before releasing the body. Section 44 restricts the coroner from releasing the body where he or she knows that the pathologist wishes to retain a body part or sample under s 48(2) until the coroner has determined whether the retention is permitted by s 48(2).

The Report also advocated a system whereby parts retained for testing were either replaced in the body before release or otherwise being dealt with by direction of the family members. This approach is not made explicit in the legislation.

Recommendation 20 further proposes that where the coroner directs that the body be transported “some distance” the state should bear the cost of returning the body. Section 46 puts this cost on the Commissioner of Police.

### ***Microscopic samples***

Recommendation 21 concerned microscopic samples, which pathologists retain as a matter of practice. A definition of “microscopic sample” was to have been inserted. The definition of body parts and tissue was to exclude microscopic samples. Under the Act where the part or sample is “minute” it may be retained by the pathologist: s 48(2)(a).

A form was to have been designed for families to elect return of such samples in non-suspicious deaths, but this is not found in the Act.

### ***Objection to post-mortem***

The Report recommended that families be given the right to object to the coroner’s decision to authorise a post-mortem: recommendation 23. A right of objection “in some cases” is given by s 33. Urgent post-mortem examinations under s 37 are excluded from the objection procedure: s 33(1). If the coroner is satisfied that the death does not appear to have been (and “is unlikely to appear later to have been”) a result of conduct constituting a criminal offence, and is satisfied that the post-mortem does not appear to be required under New Zealand’s laws or international legal obligations, then every member of the deceased’s immediate family may object to the post-mortem. “Immediate family” is given a flexible definition in s 9.

If a coroner decides that the immediate family have a right to object he or she must give the family notice under s 23 of the right: s 34(1)(a). The family must exercise the right as soon as possible, at most within 24 hours of the coroner’s decision: s 34(1)(b). The coroner must respond to the objection as soon as practicable: s 34(2). The coroner must decide whether to direct an inquest or not and must then advise the objectors. The objectors have 48 hours from the coroner’s decision under s 34(2) to lodge an objection under s 34(3) in the High Court.

Objections in the High Court must be allocated a hearing no later than one working day after the objection is filed: s 35(2). The High Court must either uphold the objection or order that the coroner may direct a post-mortem under s 31.

### ***Touching the deceased***

Recommendation 24 proposed that the deceased's family be allowed the option, with the coroner's consent, of viewing and touching the deceased before the post-mortem. Section 24 allows members of the immediate family, representatives of the immediate family (whether or not recognised by s 22), and those chosen by the family to provide religious or spiritual support to view, touch and remain with the body: s 24(2). The coroner must authorise such contact and may impose conditions: s 24(3). The coroner must consider the concerns of the police or the pathologist, risks of contamination of evidence if the death appears to have been (or "may later appear to have been") a result of criminal conduct, risks to the security of the body, supervision of the visitors, and health and safety requirements, among other factors: s 26(3).

One complaint in the Thames Safety Inquiry led by Lord Justice Clarke was that families were refused permission to view the bodies. In his *Final Report* Clarke LJ noted that the coroners and funeral directors were reluctant to allow families to view the bodies because they were putrefied. Clarke LJ said at 12.20:

The whole episode is highly regrettable and there is no doubt that the anguish caused as a result must have been immeasurable.

### ***Representative at post-mortem***

The Report recommended that that provision be made for a doctor, registered nurse, or funeral director be present at the post-mortem to represent the family: recommendation 26. Section 38(d) provides for this, with s 38(2) prohibiting such representative from participating in any other way than observing. Section 38 lists those who are permitted to be present at post-mortem examinations.

### ***Recommendations not taken up by the Act***

Recommendation 16 suggested that once the body has been released, retrieval of the body ought to require the consent of the family. This has not been expressed in the Act.

Recommendation 22 was that persons interested in the matters investigated at inquests, such as defence counsel, ought to have the right to have their own pathologist conduct tests on the body during the post-mortem. Section 38(e) provides for the attendance of a doctor representing a person who may be charged with a criminal offence relating to the death at the post-mortem. However s 38(2) prohibits such a doctor from participating in the post-mortem.

Recommendation 25 was that the family be given the opportunity of having a representative remain with the body while it is under the coroner's control. This is not specifically enacted in the new Act. There is provision for representatives of the immediate family under s 22, but the purpose of this section is to provide a liaison with the coroner. It is unlikely that a coroner would accept that "viewing" the deceased under s 24 stretches to remaining with the deceased while the body is in the coroner's custody.