


## **Lecture Notes**

### **Death Investigation: Procurator Fiscal & Coroner**

 [Medicolegal Systems of Death Investigation](#)

[Scottish Legal System & the Procurator Fiscal](#)

[English Legal System and the Coroner](#)

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## **MEDICO-LEGAL SYSTEMS OF DEATH INVESTIGATION**

In the British Isles there are four different legal systems with considerable variations in the way death is investigated.

1. England and Wales
2. Scotland
3. Northern Ireland
4. The Republic of Ireland

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### **PURPOSE OF MEDICO-LEGAL INVESTIGATION OF DEATH**

1. Detection of crime.
2. Statistics.
3. Investigation of medical aspects of certain deaths.
4. Citizens rights.
5. Audit.

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### **PRINCIPLES OF INVESTIGATION**

1. Expeditious investigation.
2. Thorough examination.
3. Impartial investigation.
4. Public rights respected.

The practical aspects of death investigation are dealt with in the lecture notes on the [Medico-Legal Autopsy](#)

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### **TYPES OF MEDICO-LEGAL SYSTEM**

1. Medical and scientific examination in private without judicial enquiry.  
e.g.:- the Medical Examiner system in the USA.

2. Medical and scientific investigation combined with judicial enquiry in open court.  
e.g.:- the Coroner system of England and Wales.
  3. Law enforcement agency enquiry sometimes combined with medical and scientific investigations and judicial investigations in private.  
e.g.:- the Procurator Fiscal system of Scotland.
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## SCOTTISH LEGAL SYSTEM

Due to strong mediaeval ties with the Continent, the Scottish Legal System owes more to Roman principles than Anglo-Saxon. The development of Scots Law was independent of England until the 1707 Act of Union. This act made provision for retention of a separate legal system. The office of the Procurator Fiscal was formally recognised as one of service to the Crown in 1746 and became financially independent a century later. Much state emanating from Westminster has brought Scottish and English Law closer together. Great administrative differences remain, particularly the need for corroboration, such that no person may be convicted on the testimony of a single witness.

As in many European Countries, criminal law in Scotland is administered by a Public Prosecutor. The prime holder of this office is the Lord Advocate, who with the Solicitor General and Advocates Depute (collectively known as Crown council), prosecutes on behalf of the Crown for the High Court of the Judiciary. These officials preside at Edinburgh but sit on a regular Circuit of the major Scottish towns. In each Sheriffdom the Lord Advocate appoints a Procurator Fiscal.

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## THE PROCURATOR FISCAL

The Procurator Fiscal is appointed by the Lord Advocate and is always a Lawyer. One is appointed for each Sheriff Court District. The Procurator Fiscal prosecutes in the Sheriff Courts and District Courts. The Procurator Fiscal is in many ways comparable to the Public Prosecutor in many Continental Legal Systems. The Procurator Fiscal is a lawyer and has wide powers in the investigation of criminal matters. Amongst his roles is the investigation of sudden, unexplained or suspicious deaths. His main interest is in excluding criminality. He requests either an external examination or autopsy to be performed by a forensic pathologist. There is a provision for two doctors to attest to the findings in serious cases. The function of the Fiscal is to receive reports from the Police on all crimes committed in his District and to direct the Police in their task. In addition the Fiscal conducts the prosecution in the Sheriff Court and prepares the Crown case in criminal trials committed to the High Court.

**It is the duty of the Procurator Fiscal to enquire into certain categories of death in order to:**

- Minimise the risk of undetected homicide or other crime
- In pursuance of the public interest to eradicate dangers to health and life
- Allay public anxiety
- Ensure that full and accurate statistics are compiled
- Secure and preserve evidence relevant to the rights of interested parties

In death investigation it is the primary concern of the Fiscal to establish whether or not there has been any criminality or possible negligence involved in a death. This function in death investigation is similar to that of the English Coroner. However, the PF is not obliged to establish the precise cause of death in the medical sense, once the possibility of criminal proceedings have been ruled out. This is gain in parallel with the Continental system. By contrast the Coroner must establish the precise cause of death . In England and Wales, 25% of

all deaths are referred to the Coroner; almost all require autopsy. In Scotland about 13% of deaths are referred to the Procurator Fiscal and about 70% of these require an autopsy. The overall autopsy rate in England and Wales is nearly 25% and that in Scotland nearer 9%.

The Fiscal investigation of sudden death also differs from the Coroner system in that there is no routine Public Inquest, although a Public Inquiry may be held in certain circumstances. The Fiscal may precognosce lay and medical witnesses. Precognition is an informal statement, not made on oath, which could form the basis of oral testimony in any subsequent trial. Precognition is taken in person, by the Fiscal or his Depute, at a private sitting with the witness.

It should be remembered that in Scotland any doctor can certify death if he feels competent to do so. In England only the doctor who was in attendance during the last illness can do so.

As in England and Wales, the only person with a statutory obligation to report death to the Fiscal (or Coroner) is the Registrar of Births and Deaths. In practice, however, most cases are reported to the Fiscal directly by doctors and the police, who are aware of the types of cases requiring reporting. The Registrar is obliged to notify the Fiscal of all deaths which fall into any one of nineteen categories. This list was drawn up in 1966 and provisions are currently under review. Some of the current provisions are therefore outdated.

It is the duty of the appropriate procurator fiscal to enquire into all sudden, suspicious, accidental, unexpected and unexplained deaths and in particular all deaths resulting from an accident in the course of employment or occupation, deaths while in legal custody and deaths giving rise to serious public concern.

Deaths are reported by the police, hospital doctors, general practitioners, Registrars (of Births, Deaths & Marriages) or relatives of the deceased.

A 1998 Crown Office booklet [Death and the Procurator Fiscal](#) is available to all GPs and hospital doctors.

The categories of death requiring to be reported to the procurator Fiscal are:

1. any death due to violent, suspicious or unexplained cause.
2. any death involving fault or neglect on the part of another person.
3. possible or suspected suicide
4. any death resulting from an accident.
5. any death arising out of the use of a vehicle including an aircraft, a ship or a train.
6. any death by drowning.
7. any death by burning or scalding or as a result of a fire or explosion.
8. Certain deaths of children - any death of a newborn child whose body is found, any death from apparent sudden infant death syndrome (cot death), any death of a child from suffocation including overlying, any death of a foster child.
9. any death at work, whether or not as a result of an accident.
10. any death related to occupation, e.g. industrial disease or poisoning
11. any death following an abortion or attempted abortion.
12. any death as a result of a medical mishap, and any death where a complaint is received which suggests that medical treatment or the absence of treatment may have contributed to the death. (\* See below).
13. any death due to poisoning or suspected poisoning, including prescription or non-prescription drugs, other substances, gas or solvent fumes.
14. any death due to notifiable infectious disease, or food poisoning.
15. any death in legal custody.
16. any death of a person of residence unknown, who died other than in a house.
17. any death where a doctor has been unable to certify a cause

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With regard to number 12, (**deaths under medical care/medical mishap**) "Medical Care" includes surgical, anaesthetic, nursing or any other kind of medical care. Such deaths may result from diagnostic or therapeutic procedures or be linked to defects in medicinal products or faulty medical equipment.

There is no time constraint such as a "24 hour rule".

It is the duty of the procurator fiscal to inquire into deaths which all into a number of categories:

- Deaths which occur unexpectedly having regard to the clinical condition of the deceased prior to their receiving medical care.
- Deaths which are clinically unexplained.
- Deaths seemingly attributable to a therapeutic or diagnostic hazard.
- Deaths which are apparently associated with lack of medical care.
- Deaths which occur during the actual administration of a general or local anaesthetic.
- Deaths which may be due to an [anaesthetic](#).
- Deaths caused by the withdrawal of life sustaining treatment to patients in a persistent vegetative state

Most of these deaths are the unfortunate outcome where every reasonable care has been taken, but some may result from negligent acts on the part of medical or paramedical staff (by commission or omission) or may be associated with criminality.

Form F89, which gives details of the medical care and death, should be completed. Supplies of form F89 should be available on the wards or from Medical Administration. On receipt of form F89 the procurator fiscal will decide what further enquiries will be needed. The police may or may not be involved.

The aspects that the procurator fiscal will be particularly interested in include:

- whether the patient was properly and sufficiently examined by the doctors.
- whether all due precautions were observed in the performance of any procedures and medical care and in the selection and administration of any anaesthetic or medication.
- whether there were any factors present which could or should have been discovered indicating that the procedure or medical care would be attended with a special risk to life.

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When appraised of a death, the Fiscal may order further enquiries via the Police, his only investigative officers. The C.I.D. may need to be involved. The police are unlikely to become involved in most hospital deaths.

When all the information necessary is to hand, **the Fiscal will decide on the need for an autopsy**. An autopsy will not always be necessary. Scotland has a much lower autopsy rate than England as the main aim of the Fiscal is merely the exclusion of criminality and negligence. If the Procurator Fiscal is satisfied that death is due to natural causes and that there is no element of criminality or negligence, he will invite the GP or hospital doctor to issue a death certificate. In deciding on the need for an autopsy, potential hazard, such as risk of infection, is considered.

In deaths outside the deceased's residence, where the G.P. or hospital doctor is unlikely to be involved, the Fiscal may seek the help of a preliminary external examination of the body by a Police Surgeon. This serves to confirm the occurrence of death and the Police Surgeon himself may be able to allay suspicions. Further, having seen the body and police report, the Police Surgeon may rarely certify the death himself.

If the Fiscal considers that an autopsy is necessary on any one of the following four grounds, he must apply to the Sheriff for authority to perform the autopsy. This is rarely refused. The possible grounds are:

1. That the Fiscal's enquiries cannot be completed unless the cause of death is fully established.
2. That there are circumstances of suspicion.
3. That there are allegations of criminal conduct.
4. That the death is associated with anaesthesia in connection with a surgical operation and the fact that all reasonable precautions were taken must be fully established.

**The fiscal may request:-**

- (a) a two doctor autopsy: where there are suspicious circumstances or where criminal proceedings may follow.
- (b) a one doctor autopsy in cases of probable suicide, accident and non-suspicious natural death.
- (c) a one doctor autopsy or external examination (view and grant) at the discretion of the pathologist. In cases where a history of potentially fatal medical condition is obtained from the G.P. and there are no worrying injuries on the body and no suspicious circumstances then certification may follow external examination (view the body and grant the death certificate).
- (d) a view and grant preferred: rarely requested. The usual reason is a strong objection to autopsy by the relatives. A strong reason for autopsy would usually override the family's objection.

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## **THE FISCAL'S FURTHER OPTIONS**

The Fiscal may precognosce material witnesses. This is a private interrogation aimed at amplifying the witnesses preliminary statements. This may form the basis of the Fiscal's final report to Crown Council. It is Crown Council who make the final decision as to what proceedings, if any, will follow upon a death. Not every death reported to a Fiscal requires to be reported by him in turn to Crown Office. Sudden deaths that in the opinion of the Fiscal, are free from suspicion and other difficulties may be cleared up by him upon his own responsibility. There are certain categories of death which require to be reported by the Fiscal to Crown Office.

## **DEATHS REPORTABLE AFTER INVESTIGATION BY THE FISCAL TO THE CROWN OFFICE**

0. Where there are any suspicious circumstances.
1. Where there is a possibility that criminal proceedings may be instituted
2. Where the circumstances point to suicide.
3. Where death occurred in circumstances, the continuation of which or the possible recurrence of which is likely to be prejudicial to the health and safety of the public.
4. Where death is due to a medical mishap
5. Where there has been a request by a person having an interest that a Public Inquiry should be held into the circumstances of the death
6. Where a Public Inquiry has been held under the 1976 Act.
7. Any death of a member of the Armed Forces or a policeman resulting from an accident while on duty
8. fire or explosion

9. Any death resulting from abuse of volatile substances
10. Any death as a result of an accident in the course of voluntary or charitable work
11. Any death in which the circumstances are such that in the opinion of the Procurator Fiscal the death should be brought to the notice of Crown Counsel

A Public Inquiry into the circumstances of a death should be held when any desire has been expressed by an appropriate interested party (usually relatives), or where the Fiscal is of the opinion that a Public Inquiry should be held under the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976. The Fiscal for the district most closely associated with the death must apply to the Sheriff for the holding of a Public Inquiry under the act when -

a (1) It appears that the death has resulted from an accident occurring in Scotland while the person who has died, being an employee, was in the course of his employment or, being an employer or self-employed was engaged in his occupation as such; or

a(2) The person who has died was, at the time of his death, in legal custody, or

b. It appears to the Lord Advocate to be expedient in the public interest that an Inquiry under the Act should be held into the circumstances of the death on the grounds that it was sudden, suspicious or unexplained, or has occurred in circumstances such as to give rise to serious public concern. Serious public concern may arise out of alleged hospital negligence or public transport accidents. Public Inquiries are mandatory in respect of deaths under Section 1 (1) (paragraph a), but at the discretion of the Lord Advocate under paragraph b.

Any person with an interest in the case may make representations to the Lord Advocate that an Inquiry should be held. The Lord Advocate's decision in this regard is final.

Whereas in England and Wales an inquest (public inquiry) is heard into most unnatural deaths, including accidents and suicides, Scottish Fatal Accident Inquiries are more focused on deaths likely to cause public concern.

At the Fatal Accident Inquiry the Sheriff sits without a Jury. He determines when and where the accident and death(s) took place, their cause(s), the reasonable precautions that might have prevented the accident, any defects in the system of working that contributed to the accident, and any other relevant facts. No witness can be compelled to answer any question indicating that he is guilty of any crime or offence.

## **CROWN COUNCIL'S OPTIONS**

Crown Office may order further enquiries to be made if they are not satisfied with the conclusiveness of the Procurator Fiscal's investigation. The Lord Advocate may decide that no further action is necessary or may initiate criminal proceedings against a third party, or may order a Fatal Accident Inquiry to be made public. Privacy is maintained until the definitive Court Hearing.

The Sheriff conducting the Fatal Accident Inquiry does not have choice of verdicts as does the Coroner, but simply makes a determination. The determination of the Sheriff at Fatal Accident Inquiry is not admissible in evidence in any Judicial proceedings, of whatever nature, which arise out of an accidental death.

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## ENGLAND AND WALES (THE CORONER)

The Office of Coroner dates at least since the Twelfth Century. The name "Coroner" is derived from the original Latin title of the office, "Custos Placitorum Coronas".

[Coroners are appointed](#) under the Local Government Act 1972. There are approximately one hundred and fifty Coroners in England and Wales. Most are Solicitors by profession and most hold the post of Coroner as a part-time office. Each Coroner presides over a certain geographical area. In large Cities the Coroners are generally appointed on a full-time basis and many are doubly qualified. The Office of Coroner is an independent one. Only the High Court can issue instructions to Coroners.

Link to Professor Pounder's Editorial in the BMJ ["The Coroner Service; a relic in need of reform"](#)

The role of the Coroner is to investigate sudden deaths and to hold inquests where appropriate. There is a duty in common law for every person "about a body" to notify the Coroner of circumstances likely to require the holding of an inquest. Wilfully failing to notify a coroner of such a death is an offence "obstructing the Coroner in the course of his duties". The duty of reporting a death to the Coroner is legally binding only upon the Registrar of Births and Deaths and governors of institutions, such as prisons, borstals and detention centres.

Cases reported to the Coroner by the Registrar of Births and Deaths come into a number of categories:

1. Where the deceased was not attended during his last illness by a Medical Practitioner.
2. Where the Registrar has been unable to obtain a duly completed certificate of cause of death.
3. Where the deceased was seen by the Medical Practitioner neither after death nor within fourteen days before death.
4. Where the cause of death is unknown.
5. Where the Registrar has reason to believe the cause of death to have been unnatural, caused by violence or neglect, or by abortion, or to have been attended by suspicious circumstances.
6. Which appears to have occurred during an operation or before recovery from the effect of an anaesthetic
7. Which appears to have been due to industrial disease or industrial poisoning.

The Registrar should not register any death which he has reported to the Coroner or which he believes has been reported to the Coroner by others, until he has received a Coroner's certificate or a notification that the Coroner does not intend to hold an inquest.

There is no statutory duty upon a doctor to notify any death to the Coroner. The law is satisfied if he issues a certificate and leaves it to the Registrar to inform the Coroner on receipt of the death certificate. In practice many deaths are referred directly to the Coroner by the doctor involved in the case. As there is no statutory duty for the doctor to notify the death to the Coroner, there is no official list to guide the doctor when deciding whether or not to refer a case to the Coroner. However there are a number of cases where a doctor would be well advised to inform the Coroner or Coroner's Officer. These include:-

1. Where the identity of the body is unknown.
2. Deaths due to violence, whether it be accidental, suicidal or homicidal. There is no time limit for referral of such deaths.

3. Deaths following abortion.
4. Deaths due to privation and neglect, including self-neglect.
5. Poisoning by drugs or alcohol.
6. Deaths during surgical operations or anaesthetics. There is no time limit, such as the "24-hour rule", and deaths linked in any way to surgical operations or anaesthetics should be referred to the Coroner for his consideration.
7. Industrial diseases.
8. Death of a person in receipt of a disability pension, war pension, etc.
9. Where the cause of death is unknown.
10. Where the death is sudden, or unexpected, or attended by suspicious circumstances.

When the Coroner or his Officer is contacted by a doctor concerning a death, the Coroner will usually decide swiftly whether he considers the death to be within his jurisdiction or not. If he decides that the case is outwith his jurisdiction then the doctor can proceed to certify the death following the usual procedures. If the Coroner considers the case to be within his jurisdiction he has certain options available.

A. He can decide that no further action is called for. In this case he notifies the Registrar to accept a certificate of death granted by a medical practitioner.

B. He can order a post mortem examination.

If he is happy with the result of the autopsy he may certify the cause of death as determined by the post mortem. This Coroner's certificate ("Pink" Form 100, Part B) invalidates any previous medical certificate as to the cause of death.

Following the autopsy he may decide to hold an inquest. Inquests must always be held when death is due to an unnatural event. However, following the Criminal Law Act 1977, inquests must be held with juries only when it is suspected that the death comes into certain categories, as below.

1. Deaths occurring in a prison, or in such circumstances as to require an inquest under any Act other than the Coroner's Act 1887.
2. Deaths due to accident, poisoning or disease that must be notified to any government department or inspector approved under Section 19 of the Health and Safety at Work Act, 1974.
3. Deaths occurring in circumstances, the continuation of which or possible recurrence of which is likely to be prejudicial to the public.
4. Deaths occurring when the deceased was in police custody or resulting from an injury caused by a police officer in the purported execution of his duty.

Coroners may summon juries for inquests into cases of road traffic accidents if they think it necessary. However, there are restrictions in cases of murder, manslaughter, infanticide, death by reckless driving or suicide, in which there may have been abettment. In these cases the Coroner must adjourn the inquest (by acceding to a request from the chief officer of police). Following this the case is referred to the Crown Prosecution Service for investigation and

criminal proceedings. After criminal proceedings have been completed the Coroner does not need to resume the inquest, but if he does so, the findings of the inquest must not be inconsistent with the outcome of the criminal proceedings. Coroners' verdicts may not be framed in such a way as to suggest criminal or civil liability on the part of a named person, and should such evidence come to light unexpectedly during the course of an inquest, it must immediately be adjourned and referred to the CPS.

Following an inquest the jury and/or Coroner may arrive at one of the conclusions given below:-

- Killed unlawfully.
- Killed himself (whilst the balance of his mind was disturbed).
- Attempted/self-induced abortion.
- Accident/misadventure.
- Execution of sentence of death.
- Killed lawfully.
- Natural causes.
- Industrial disease.
- Want of attention at birth.
- Dependence on drugs/non-dependant abuse of drugs.
- Open verdict.

In the case of the conclusion being *natural causes, industrial disease, want of attention at birth or dependence on drugs/abuse of drugs*, the Coroner may add the words "*the cause of death was aggravated by lack of care/self-neglect*". Once a conclusion has been reached by the inquest, the Coroner provides the Registrar with a certificate including the circumstantial as well as the medical causes of death.

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## NORTHERN IRELAND

In Northern Ireland there is a Coroner system which differs from that in England in a number of important respects. The Northern Ireland coroners must be practising solicitors. The Coroner in Greater Belfast is a full time appointment. The other six Coroners are part-time appointments.

Section 7 of the Coroner's Act (Northern Ireland) 1959 states:

*"every medical practitioner, registrar of deaths or funeral director and every occupier of a house or mobile dwelling and every person in charge of an institution or premises in which a deceased person was residing, who has reason to believe that the deceased died, either directly or indirectly, as a result of violence or misadventure or by any unfair means, or as a result of negligence or misconduct or malpractice on the part of others, or from any cause other than natural illness or disease for which he has been seen and treated by a registered medical practitioner within 28 days prior to his death, or in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic), shall immediately notify the Coroner within whose district the body of such deceased person is of the facts and circumstances relating to the death."*

This section places a duty on a number of people, including doctors, to report such deaths to the Coroner.

Section 8 of the Act provides for the involvement of the local police in the investigation of circumstances of such deaths. The Government provides a full time forensic pathology service to assist the Coroners in their investigations.

