1. Introduction

The coronial system

In 2005 in England and Wales, 513,000 deaths were registered, of which 232,400 (45%) were reported to coroners. This proportion of reported deaths is an increase of 7,000 (3.1%) from the figure reported in 2004[2].

Governance of the coronial system

In England, Wales, Northern Ireland and the offshore islands there are approximately 120 coronial jurisdictions (ongoing amalgamations change the exact number, there were 137 at the time of running this study). The coroners and their deputies, are appointed by local authorities and are answerable to the Lord Chief Justice. They are managed by the Dept of Constitutional Affairs. Thus, coroners, the coronial system, and coronial autopsies are independent of the NHS, even though they are concerned with causes of death in patients who, for the most part, have been managed in the NHS.

The number of autopsy examinations as a proportion of deaths being reported to coroners has declined over recent years, (49% of deaths reported to coroners were autopsied in 2005 compared to 51% in 2003). It should be noted that the 49% of cases reported to them for which coroners request an autopsy is an average. There is enormous variation nationally; among the jurisdictions with over 1000 cases referred to them per year, the range is actually 28-77%[2].

As a proportion of all registered deaths, the autopsy rate through the coronial system is 22% in England and Wales, but notably, in Northern Ireland it is less than half that in England and Wales, at 9%. In Scotland, where the Procurator Fiscal takes the role of the coroner for medicolegal investigations, the rate is about 10%, as it is in other English speaking countries that have taken their legal framework from the UK (e.g. North America, Australia, and New Zealand). Only certain central European countries (Austria, Hungary) have traditionally had a higher autopsy rate than England and Wales. Therefore it is appropriate that a survey of the outcomes of this autopsy process be undertaken.

In England and Wales, the number of inquests into death has remained relatively stable, with approximately one in eight deaths being reported to coroners resulting in inquest. The most common verdicts following inquest have consistently been found to be accident/misadventure (35%), natural causes, (23%) and suicide (12%); the remaining 30% include death from industrial disease, an open verdict, and all other verdicts[2].