I have been asked by Professor Dorries to speak for up to an hour about a day of death investigation.
His request was unconditional.
I interpreted it to mean that I can speak for an hour or so on the subject of a day of death investigation with some repetition, the occasional deviation but, hopefully, without hesitation.

A day of death investigation begins here.
Meet our French Briards Freddie and Lily.
Every morning whatever the weather they insist that I join them for a walk through the beautiful Hawthorn Dene.
I can enjoy this quiet time to gather my thoughts.

At 8 am on every working day the Team meets in person or joins remotely to discuss the day ahead and what it looks like:

- How many referrals have come in overnight
- How they will be allocated
- What my diary looks like
- What the court diary looks like
- Any matters of interest including whose birthday it is so that they don't forget to buy the cakes

We began those team meetings as the pandemic struck and have continued with them. They provide a focus and foster a genuine team spirit for a day of death investigation.

Context is everything, so let me explain where Coroners fit in with a day of death investigation.
It is not all about Court.
In England and Wales in 2021 there were 586,213 deaths registered.
2/3 were signed off as natural deaths by a doctor, many with scrutiny from our Medical Examiner and Medical Examiner's Officer colleagues.

195,180 of the deaths were referred to Coroners because they were:

- Unnatural
- Violent
- In state detention
- Or the cause of death was not known

As you all know a day of death investigation is governed by section 1 of the Coroners and Justice Act 2009, and the Regulations and Rules to go with it, including the Notification of Deaths Regulations 2019.

All of our referrals are made via our portal 24/7.
Early decisions in a day of death investigation will include:

- Some preliminary inquiries to drill down into the referral to see, if it is really one for me.

- The referral could be from a GP who lacks confidence in signing the Medical Certificate as to the Cause of Death and just needs some reassurance about the wording of a natural cause of death.

- How many times in a day of death investigation do I hear from my Coroner's Officer, that the doctor says that they cannot be sure about the cause of death? The reality is, that they don't have to be, as the Standard of proof is 'to the best of knowledge and belief' - a lower standard than the balance of probabilities 'more likely than not'.
  In a day of death investigation I do have some sympathy with a cautious doctor.

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In the case of Sood in 1998 the Court of Appeal upheld the conviction of a doctor for making a false declaration contrary to the Perjury Act 1911 and endorsed the remarks of the Crown Court sentencing Judge:
"The declaration that you make so far as someone's death is concerned is very important indeed…. Let us hope it is going to become clear that if other doctors think that it is merely a fact of form or technicality, they will learn now that it is not so and that is a matter of grave substance"
The doctor in Sood had deliberately completed the MCCD in the knowledge that it contained false details as to when the doctor had last seen the patient.
Motive or active intention to deceive were irrelevant.

- Many referrals are because the doctor has not seen their patient in the previous 28 days. That time was increased from 14 days during the pandemic.
  I was tempted to do an anonymous straw poll about how many of you have seen your doctor in the previous 28-day period. If you have not, and you had the misfortune to die, then the Coroner in your Area will take an interest. Many lament the passing of the Covid easements and the rise of the uncertified death.

- It is very tempting to think that the doctor is being difficult and that if you were in their shoes then of course you would sign the MCCD or seek clearance from the Coroner to do so with a form 100a to the Registrars of deaths saying that you know about the death, but it's not one that you are going to stuck into.
  Forms 100a are the most underestimated and dangerous form known to the world of death certification and investigation. I suggest that in a day of death investigation they require the utmost care.
  Coroners don't know what they don't know, hence the need for sufficient, proportionate and proper inquiry.

- With every referral, and I mean EVERY referral, the family are spoken with by the Coroner's Officer allocated to the case. They are at the heart of the process because it is their loss (but not to the detriment of others).
  The point of contact within the family, if there is one, can signpost the Coroner's Officer to matters they may be concerned about, so that they can be drawn to my attention. Some have no concerns and sing the praises of the medical team. The background is all important to my decisions in a day of death investigation.

- Those decisions include whether there is to be a Post-Mortem Examination to determine the cause of death.
  In 2021 there were 84,599 such examinations. Many disclosed a natural cause of death after all, so those Investigations were discontinued leaving the 83 Coroner Areas with 32,762 Inquests.

- Coroners can now discontinue investigations without a Post-Mortem Examination if the natural cause of death has become clear by other means.

- As you can now appreciate the system of scrutiny and investigation performs a dynamic triage system, so that only those deaths which are unnatural, violent or in State Detention go through to a public Inquest hearing.

- If only we could get all those Inquests listed within 6 months, so that the families can have the final death certificate. But circumstances sometimes conspire against Coroners in doing so.

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- Valiant efforts are being made to deal with the pandemic backlog, but Coroners often wait for the outcome of concurrent Investigations, such as: -
  - hospital SI - Serious Incident reports - soon to be replaced by a catchy acronym PSIRF- Patient Safety Incident Response Framework.
  - Coroners also wait for reports from
    - ✓ the Police
    - ✓ the Health & Safety Executive
    - ✓ the Independent Office for Police Conduct
    - ✓ The investigation branches whether air, rail, health care and, in the future, from the road safety investigation branch.
    - ✓ Then there are decisions awaited from the Crown Prosecution Service and eventually an outcome from a Crown Court trial. Even then as part of a day of death investigation decisions about the resumption of an Inquest need to be considered.
    - ✓ Decisions to adjourn are not taken lightly, and the expectations of the family must be carefully handled.
    - ✓ The same is true whenever a post-mortem examination is required. The decision to do so is mine and I must consider the type of examination.

    We have suffered ongoing problems with pathology for years, and without anyone getting to grips with it we have followed the example of other Coroner Areas by setting up a regional scanning facility at the Royal Victoria Infirmary in Newcastle upon Tyne. That was quite a journey working with multiple Local Authorities and having to navigate the perilous waters of procurement during a day of death investigation.

Regarding post-mortem examinations, I sense that the number of requests for what was known as a "defence PM" is on the decline. If requested, the Coroner must decide and give reasons for that decision.

Everyone needs to know not just what the Coroner has decided but why, and that goes for every judicial decision.

This is an inquisitorial system. There are no parties. No case to put. No address on the facts at the end of the hearing.

It is fact finding led by the Coroner. That means that the Coroner directs the team and the direction of the Investigation.

If the Investigation needs an Inquest, then the Coroner asks the questions first, and the interested persons may then ask any other relevant questions.

But as we know, not all referrals to Coroners lead to an Inquest.

The heavy lifting, the back-office work or the "muck and rubble", as Professor Pollard referred to it, is often underestimated in a day of death investigation.
It takes 3 forms:

1. Coroner engagement
2. Investigative work
3. Preparation for Inquest

I will take each in turn.

1. Coroner engagement

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In a day of death investigation Coroners need to create and maintain the infrastructure required to fulfil their statutory duty. This also requires Coroners to educate others in what we do (and cannot do) and the importance of the Rule of Law and Judicial Independence.
I agree with the Chief Coroner's observations at his recent Conference for Local Authorities, when he said "If you were designing a coronial system – even a locally resourced one – from scratch, you would probably not come up with the somewhat complicated set of relationships that currently exist in many coroner areas".
Coroners must do what they can within the system to make it all work, so here is a non-exhaustive list of those individuals and organisations I must deal with in a day of death investigation:

- Local Authority - Chief Executive, managers, finance, Elected Members, IT department.
- MPs
- Faith Groups
- GPs
- Hospitals
- Ambulance Service
- Funeral directors
- Registrars
- Pathologists
- IT software provider
- Other Coroners
- Police
- Regulators GMC, NMC, BSB, SRA, HTA, CQC
- Crown Courts
- Family Courts
- Emergency Planners
- Mental Health
- Alcohol and drug teams
- Safeguarding Children and Adults
- Suicide prevention
- Organ donation
- Schools
- Universities
- The Coroners' Court Support Service
- Bereavement Nurses
- Archivist
- Families

I am sure that there are dialogues with many others in a day of death investigation.

Careful control of a diary to avoid it becoming congested in a day of death investigation is essential.
Coroners need preparation and thinking time away from court.
Coroners must be properly resourced.

2. Investigative work
The list of available short form conclusions provides a broad range of the types of case that will be referred in a day of death investigation:

- Suicide
- Unlawful killing
- Accident
- Misadventure
- Alcohol related
- Drug related

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- Industrial disease
- Lawful Killing
- Natural causes
- Open
- Road traffic collision
- Stillborn
- Narrative (e.g. complications of a necessary surgical procedure)

I have not forgotten Riders of Neglect or the mental gymnastics in trying to decide if a death was unnatural. A natural death is not defined by the Coroners & Justice Act 2009.

Coroners are Judges, and Coroner's Officers are their investigators. A good Coroner's Officer will be in tune with how their Coroner is likely to approach an Investigation, but that requires time, training and experience of people and society.

Let me give you some examples of the sort of things I must be thinking about in a day of death investigation.

- Do we have a proper and accurate identification? How many times might the mortuary telephone and say that the family have been in and it's not their relative so Is this Derek Winter, if not who is it and where is Derek Winter?
- What are the full circumstances surrounding the death?
- Is there any prospect of foul play?
- Is the police inquiry sufficient?
- Who is the appropriate family member to deal with?
- Concerns in writing from the Family?
- Regular contact with Interested Persons
- Do we need a Post-Mortem Examination?
- If so, what type? Who by? When?
- Are the extended pathology tests needed? (e.g. toxicology)
- What is the relevant medical history?
- A detailed written medical background from GP and hospital? Or a summary?
- Ambulance logs/transcripts
- Is there a mental health background?
- Statements required concerning circumstances of the death
- Do we need an independent review or an expert witness?
- Notes
- Records
- Telephones
- Computers
- Clothing
- Photos
- Medical Equipment
- Medication
- Protocols and Procedures. If they exist, have they been followed, trained on and audited?

Of course, a Coroner's Officer in a day of death investigation know their caseload by name, but can a Coroner really know all of the cases in an office by name? I doubt it. That is why when an Officer comes to see me or telephones and says it about the Joe Blogg's case, I must gently ask for some signposts to jog my memory or go into the electronic file.

3. Preparation for Inquest

Top tip - READ THE FILE.

Gather your thoughts about a case as part of your day of death investigation

- Identify Interested Persons

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- Set the scope of the Inquest
- Deadlines for statements but avoid sequencing
- Is Article 2 engaged?
- Is a Jury required?
- Are there any other matters for further investigation?
- Provisional list of witnesses in person? Or to be read under Rule 23?
- Any further disclosure?
- Who will prepare the Bundles?
- Fix a date of Opening or a PIR hearing.
- Decide a duration of Inquest
- Fix a date of Inquest
- Venue for hearings
- Anonymity of witnesses
- Special measures for witnesses
- Public interest immunity
- Legal representation
- Interpreters
- Intermediaries
- A body worn camera and CCTV evidence
- Remote participation and/or observation
- Other matters of relevance

Then there's the Inquest.
This could be a lengthy Jury hearing with multiple Interested Persons and lawyers, or a short hearing perhaps with just a family member present with all evidence admitted under Rule 23.
It could even be an Inquest in Writing without having to go into Court.
Whatever form it takes the family deserve the best from you despite what may be otherwise happening in your day of death investigation.

Always rise from court and take time with your rulings.

In a day of death investigation, including Inquest hearings, be prepared for your Coroner's Officers to be waiting for you at lunchtime and after Court to talk cases through with you.

Don't forget to write that Prevent Future Death Report, you had said you were going to do, while it is fresh in your mind.

Also don't forget the signings or tasks the Coroner's Officers can push through to you electronically.

At least we don't have coloured paper or wet signatures to contend with.

But we do have our out-of-hours responsibilities for those things that cannot wait until the next working day - homicide cases, organ donation, removal Out of England & Wales. A day of death investigation means exactly that. It is A DAY. That is 24 HOURS.

Establishing the who, when where and how in a day of death investigation can be a huge endeavour - not always appreciated by others.

There are other distractions from a day of death investigation including telephone calls from Coroner colleagues on a variety of topics, training, Coroner Society matters and work with the Chief Coroner's Office.
All of this on top of a day of death investigation I hope keeps us grounded and appreciative of those around us and f the importance of being kind and thoughtful in all that we do.

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Let me finish this evening with some history.

1st February 1936 SAFC V Chelsea
James Horatio Thorpe was Sunderland's goalkeeper for this match.
"Thorpe was the centre of arguably the most controversial moment of the match. After claiming a ball in the penalty area, he dived to the ground to protect it from three onrushing Chelsea players who proceeded to repeatedly kick-out at Thorpe's head, neck and upper-body for a prolonged length of time until a swathe of Sunderland defenders arrived and intervened."
Jimmy Thorpe died 5th February 1936
The Jury Inquest was heard 2 days after the death on 7th February 1936.
There were 6 witnesses called but strangely not the referee Mr Warr of BOLTON or any of the Chelsea players.
The pathologist told the hearing "The rough usage I have heard described would, in my opinion, tend to precipitate an attack of a diabetic coma.
In his summing up to the Jury of 7 the coroner said "one witness described the game as a disgrace to first class football and from what I've heard I quite agree with him. We are not however a court of ethics but if it had been I would have been inclined to say that some of the men playing in the game used dubious tactics".
The Jury confirmed the cause of death as diabetes giving their verdict after 16 minutes.
"We are of the opinion that the referee was very lax in his control of the game and as a rider we urge the board of management of the FA to instruct referees that they must exercise stricter control over the players so as to eliminate as far as possible any future accidents".
There was an FA Commission.
The Commission cleared the referee of any blame but then went on to criticise the Jury.
SAFC was also criticised for fielding a player with ill health.
As a consequence, in the modern game goalkeepers now enjoy almost total immunity from physical challenge.

In many Inquests how often do we as Coroners hear a family say that they just don't want the same thing to happen to someone else?
PFDs are a force for good.

Let me continue with our history lesson.
The Victoria Hall Disaster
Victoria Hall was opened in 1872. There was seating on the ground floor, a dress circle on the first floor, and a gallery above. The hall was a popular venue.
On 16 June 1883, about 2000 children aged mostly between 7 and 11years of age, crowded into the hall.
They had been given tickets to see a show by travelling entertainers, The Fays, from Tynemouth.
It was promised to be "the greatest treat for children ever given" with every child offered the chance to win a prize.
As the performance ended, it was announced that prizes would be given to children with certain numbered tickets as they left.
At the same time, prizes began to be handed out to those children on the ground floor. Many of the 1100 children in the gallery began to stream downstairs to claim their prize.
At the foot of the stairs, the exit door had been opened inwards and bolted to create a gap of about 20 inches (50cm) that would allow one child at a time to leave. This was probably done to control the flow of children and make it easier to check their tickets.
Only a few adults were present and with no one organising an orderly queue, the children rushed for the door.

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The gap was not large enough to cope with the numbers of children and the narrow stairwell was swiftly blocked. As more and more children surged down the stairs, they were pushed forward by those behind.
The children at the bottom of the stairs were crushed and suffocated by the weight of the crowd above them.
Eventually, the few adults in the hall realised that children were trapped and began to pull them one by one through the narrow gap. More help arrived and within half an hour or so all the children had been removed from the stairwell.
A total of 183 children (114 boys and 69 girls) died in the tragedy.
The first inquest concluded 18 days after the calamity on Wednesday, the 4th of July 1883, with the jury finding:
"That Frederick Mills and others met their death by suffocation on the stairs leading from the gallery in the Victoria Hall on the 16th day of June 1883, from the partial closing of a door on the landing, fixed in its position by a bolt in the floor, but by whom there is not sufficient evidence to show.
That the manager of the entertainment be censured for not providing sufficient caretakers and assistants to preserve order in the hall on that afternoon…
That we consider the mode of entrance into, and of exits from the hall are sufficient, except the door at which the fatality occurred, and we would recommend its removal at once.
We attach no blame to the caretaker but recommend that in future the proprietor of the hall instruct him to show persons who engage the hall all its modes of ingress and egress."
A second Inquest followed 24 days after the calamity and 6 days after the first Inquest, because some of the victims fell under a different Coroner jurisdiction. They returned a similar verdict on the 10th of July. In response to a set of specific questions posed by the Coroner, they found:

- That Fay and Coates had the "legal duty or responsibility of taking proper precautions for the preservation of the lives of the children whilst within and on leaving the Victoria Hall".
- That it was a neglect of duty in not providing enough staff to keep order that led to the loss of life; that the staff provided wouldn't have been sufficient even if the fatal door hadn't been there.
- That the caretaker had neglected his duty by not informing Fay and his assistants of the door, and by failing to bolt it safely in the outward position when he passed it during the performance.
- That the directors were not justified in erecting the door without instructing the caretaker to point it out to those booking the hall.
- That parents and relatives of the children were not justified in letting their charges go alone, without checking that there were adults to take charge.
- That the various school masters through whom Fay had advertised the tickets were not justified in allowing this without arranging for supervision and control of the children at the performance.

Both of the Juries said that the negligence shown was not of a culpable nature.
"The Coroner then read the following presentments made by the Jury: -
"We recommend that school children ought not to be encouraged to attend entertainments, treats, or excursions, except under proper supervision or control.
"We recommend that statutory powers ought to be forthwith applied to proprietors of buildings in which the public assemble, to provide at their own expense, and to the entire satisfaction of the municipal or local authorities:

- sufficient means of exit;
- all doors, both internal or external, to open outwards;
- proprietors' servants to be on duty on the premises from the commencement to the close of entertainments, meetings, or religious services, and be responsible for all means of exit being instantly available at any time during the continuance of such entertainments, meetings, or religious services;

Leeming Lecture 30.03.23 Derek Winter

- municipal or local authorities to have power to compel the attendance of a sufficient number of inspectors who shall be authorised to attend all such entertainments, meetings, and religious services, and ascertain and report whether the foregoing precautions have been taken."

Some lessons from the past:
- Narrative conclusions and questionnaires are not new nor are PFD reports
- There seemed to be a sufficient and proportionate inquiry.
- It would have complied with Article 2 as being prompt, independent, effective, in public and with family participation.
- The verdicts were elicited from the Jury using a questionnaire on the issue of neglect of duty days after the calamity.

Some food for thought.
The recent Court of Appeal decision of Morahan provides us with a reminder that "an Inquest remains an inquisitorial and relatively summary process".
Why then do Inquests take so long nowadays?

Back to our history lesson:
As a direct result of the Victoria Hall Disaster, Parliament issued laws that required all places of public entertainment to have enough exits, and that all exit doors must open outwards and be easy to open.

Robert Alexander Briggs was a trainee architect in Sunderland and thanks to him we have those emergency exits with the push bar to open mechanism and signage
Slide showing safety door

As another day of death investigation ends, I drive home, and with the advantage of lighter evenings Freddie and Lillie insist that we wind down with another walk, and I can try to focus on things other than a day of death investigation.

Finally, I did say at the beginning that there would be repetition, so if any of you would care to put into the chat section how many times, I said a day of death investigation. There is no prize.

Thank you for listening.

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