GUERNSEY LAW AND PRACTICE: INQUESTS

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This article considers the origins of Guernsey's inquest practice and procedure and suggests that a review of Guernsey's coronial law is necessary in order to bring both the role of coroner, inquest procedures and the system of death certification in the Bailiwick up to date with modern practice and expectations.

Introduction

1 The current edition of *Jervis*[1] contains a helpful and absorbing summary of comparative death inquiry law in various jurisdictions but, as might be expected, has little to observe as regards Guernsey. Instead, it is noted that "Guernsey has no specific inquest legislation" and that while "A few local laws make reference to inquests, so acknowledging their existence and role", such laws "contribute nothing to the substance of inquest law in Guernsey."

2 Whilst it is true that Guernsey has little in the way of statutory law to set out the detailed investigations and proceedings required of the coroner, this is largely because the nature of and proceedings for inquests are founded in the customary law of Guernsey and little has been written about their evolution into the modern-day inquest procedure which is practised today.

3 The term "coroner" is generally well understood in the English sense, being an independent officer holder, who investigates all deaths where the cause of death is unknown,[2] where there is reason to think that the deceased died a violent or unnatural death, or the deceased died while in custody or otherwise in state detention.

4 However, in Guernsey, although the same term "coroner" is used to describe the functions of the office holders who investigate sudden deaths and deaths from unnatural or suspicious cases, and who direct and hear inquests, the functions which would generally be exercised by a UK coroner are in practice split between the Law Officers of the Crown and judges of the Magistrate's Court. In essence, the two Law Officers undertake the investigative coronial work, including liaising

[1] Matthews, *Jervis on Coroners* (14th ed, 2020).
[2] The duties to investigate are set out in the Coroners and Justice Act 2009.

with families, funeral directors, medical professionals and advising upon appropriate death certification requirements as well as authorising *post mortem* examinations, directing the holding of any inquest and determining relevant evidence including documents and witnesses. The Magistrate's Court holds the inquests into deaths and the magistrates may reach a verdict (there are no jury inquests, unlike in England and Wales).

5 This split of judicial functions is unique amongst the Crown Dependencies and, in terms of the United Kingdom and Ireland, a similar split of judicial functions arises only in Scotland. However, other jurisdictions associated with Britain and British colonial history do split the functions and provide for magistrates to sit as coroners and for the police (or others) to investigate and present the evidence to the magistrate.[3] In general terms, Guernsey's system is largely based upon the English coroner system prior to the significant reforms of the last 35 years. This presents some novel challenges for those (few) advocates currently practising inquest law in Guernsey.

6 This article seeks to explore some of the origins of the role of coroner, with particular reference to the English system (which is set out in some detail given that English rules are followed by Guernsey in practice) and to demystify current procedure. It also suggests that future reforms are needed in order both to modernise the current system and to take advantage of the learnings from recent UK reforms to the coronial process and from the effects of the COVID-19 pandemic.

Coroners in England and Wales—background

7 The origins of what, in England and Wales, is known as the office of coroner are relatively opaque, although it is thought that it may have been established around the 11th century[4] and to have been founded in the role of the "keepers of the pleas of the Crown".[5] It is considered one of the oldest offices known to English law and the primary motivation for its creation was thought to be the need for an official to protect the financial interest of the Crown in criminal proceedings.[6] In 1276, the Statute of Coroners sought, for the first time, to detail the coroners'

[3] Matthews, *Jervis on Coroners* (14th ed, 2020), see for example Malta, para 22–54.
[4] *Ibid.*, at p 4.
[5] *Ibid.*, at p 4.
[6] *Report of the Committee on Death Certification and Coroners* (1971 HMSO Cmnd. 4810), Part III, Ch 10, at p107.

duties as regards carefully examining the body of a deceased[7] and by around the 13th and 14th centuries in England, coroners were considered to be the "principal agents of the Crown in bringing criminals to justice".[8]

8 However, coroners' inquiries were not just initiated following homicides and deaths by misadventure, but also when death was sudden or unexpected, or where the cause of death was unknown. It is of note that anyone who found the body of a person whose death was considered sudden or unnatural was obliged to summon the coroner, who would be expected to attend the scene as soon as possible and to view the body.[9]

9 In those times the coroner also had other powers. For example, he (for it would always have been a "he" given that women generally did not hold public office in mediaeval times) could effectively bind over and "attach" those who witnessed or were otherwise thought to be connected to the deceased, on pain of being "amerced" for non-attendance. He also had certain powers of arrest, *e.g.* for anyone indicted for homicide. Coroners would usually sit with juries who would appraise whatever object or even animal might have caused the death and also the value of any land and chattels of persons who had committed homicide or suicide, some of which might be forfeited to the Crown.

10 After an inquest, the coroner was required to make a record of his proceedings[10] and thus, importantly, to record formally the death.

11 As the centuries progressed, the legal system evolved and so did the office of coroner. Escheators were appointed to value land and chattels of deceased persons and the original role of keeper of the peace was extended into matters of criminal justice including the coroners' powers of arrest, which powers became more centralised in the King's courts. Gradually, the role of coroner in relation to criminal justice became pitted against those of the justices, save in relation to inquests, and the important status once held by coroners diminished.

12 Following a series of petitions from coroners in the late 1740s, an Act was passed in 1751 which established a uniform fee system to help improve their status, but did nothing to help clarify their roles. On the

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[7] https://www.parliament.uk/about/living-heritage/transformingsociety/private-lives/death-dying/dying-and-death/investigatingdeath/

[8] Matthews, *Jervis on Coroners* (14th ed, 2020) at p 5.

[9] See *Report of the Committee on Death Certification and Coroners* (1971, HMSO, Cmnd 4810) Part III Ch 10 at pp 108–9.

[10] *Ibid*, at p 110.

one hand, the justices contended that the coroners only had jurisdiction if there was evidence of violent death; on the other, the coroners considered their jurisdiction included all sudden and unexplained deaths.

13 These disputes took place amongst a background of growing pressures on the coronial system, no doubt partly due to an increasing population and the development of more sophisticated medical investigation techniques. In recognition of this, in 1836, the UK Parliament passed the Births and Deaths Registration Act which provided for registration of deaths and placed certain duties on coroners. In particular, it empowered coroners to summon medical witnesses to an inquest and, if necessary, to carry out a *post mortem.* In tandem, the Attendance and Remuneration of Medical Witnesses at Coroners Inquests Act 1836 enabled the coroner to require a medical practitioner to perform an autopsy if he was not satisfied as to cause of death.

14 Although these Acts were significant in recognising the public importance of the role of coroners, they were still not enough to ensure that the role was fulfilled appropriately. In 1860, the UK Parliament passed the County Coroners Act, which acknowledged the need to improve the status of coroners in line with other public professionals and highlighted the importance of inquest procedure. Notably, for the first time coroners were to receive a suitable salary rather than a fee.

15 In that same year, a UK parliamentary report recommended that the coroner's jurisdiction should include every case of violent or sudden death or where the cause of death was unknown or there was suspicion of criminality. This report led to the Coroners Act of 1887, which largely consolidated the law relating to coroners, confirming their fundamental duties to inquire into all deaths of unknown cause. The Local Government Act 1888 provided for appointment of coroners by the relevant county or district, rather than by election.

16 The role continued to evolve against the global pandemic of Spanish influenza and the conflicts of World War, both rather macabrely highlighting the importance of the coronial role, particularly as regards certification of medical cause of death. The Coroners (Amendment) Act 1926 provided for coroners to be qualified as a solicitor or barrister, or otherwise as a medical practitioner of not less than 5 years' standing and for inquests to be adjourned (in the case of murder, manslaughter or infanticide) pending the outcome of criminal proceedings. Despite later parliamentary inquiries into the practice of

coroners (notably the *Report of a Departmental Committee*[11] of 1935, which recommended statutory rules of procedure be created), no further coronial legislation was enacted for many years, and no rules of procedure were enacted until 1953. Further debates over the practice of death certification and role of the coroner continued until the appointment in 1965 of the Committee chaired by Mr Norman Brodrick, QC whose committee published a substantial and key report in 1971.[12] Not least that committee identified the following grounds of public interest for a coroner's inquiry being—

- to determine medical cause of death,
- to allay rumours or suspicion,
- to draw attention to the existence of circumstances which, if unremedied, might lead to further deaths,
- to advance medical knowledge, and
- to preserve the legal interests of the deceased's family, heirs or other interested parties

17 These principles remain at the heart of the inquest process today. The committee Brodrick chaired, which reported in 1971, also made significant recommendations to change the coroner system. Although some changes were made to legislation (notably the repeal of power to commit an accused for trial, under the Criminal Law Act 1977, the reform of the coroner's jurisdiction under the Coroner's Act 1980 and the Coroners Rules 1984, consolidating the 1953 Rules), not all the 114 recommendations were implemented.

18 As the population increased, and numbers of deaths similarly rose, the cost of the inquest service increasingly attracted political focus. There were disagreements over whether the responsibility for the role should be at local, rather than national level. Further reviews of the coroners' service were undertaken,[13] leading, ultimately, to the next significant piece of legislation in the form of the Coroners Act of 1988. This was followed by the Shipman Inquiry (2001–2003),[14] chaired by Dame Janet Smith, and the Fundamental Review of Death Certification

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[11] The eponymous Wright Committee, chaired by the Rt Hon Lord Wright.

[12] https://discovery.nationalarchives.gov.uk/details/r/C9239

[13] See for example a report chaired by Evan Stone QC published by Justice (1986) at https://files.justice.org.uk/wp-content/uploads/2015/01/06172027/CoronersCourt.pdf

[14] The Shipman Inquiry, Third Report (2003) CM5854 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/273227/5854.pdf

and Investigation, chaired by Mr Tom Luce (2003),[15] which identified further vulnerabilities in the coronial system which, not least included concerns over lack of quality controls, independent safeguards, and training.

19 The subsequent 2004 Home Office paper "Reforming the Coroner and Death Certification Service"[16] recommended further reforms intended to improve the involvement of bereaved families with the coroner, for all new appointees to have a legal qualification, and for coroners' officers to continue to be employed by either the police or local authority responsible for appointment. It also suggested there should be more powers given to coroners to obtain information and for the appointment of a Chief Medical Adviser to support the Chief Coroner in relation to medical issues related to coroners' investigations.

20 These proposals led to the Coroner and Justice Act 2009, which created the office of the Chief Coroner of England and Wales and enacted major structural reform to the coroner service. It also made some significant changes. Not least, it introduced the new concept of "investigations" into deaths, as well as making new provisions relating to coroner areas, creating new titles for coroners, and removing barriers to where investigations could be held. The Act also provided for a new system of death certification (medical examiners), intended to be implemented later. Much of the legislation did not come into effect until 2013, being in the form of secondary legislation comprising the Coroners (Investigations) Regulations 2013 ("the Investigations Regulations"); The Coroners (Inquests) Rules 2013 ("the Inquests Rules"); and the Coroners Allowances, Fees and Expenses Regulations 2013 ("the Allowances, Fees and Expenses Regulations").

21 However, the reforms have not ended there. Whilst this article does not permit an extensive review of all relevant reports or of the reports and post-implementation reviews post the 2009 Act, suffice it to say that, in the wake of the Covid-19 pandemic, which placed additional pressures upon the coronial service, further reports and government responses have been published to consider the effectiveness and capacity of the coroner service to date. These led to proposals for the Judicial Review and Courts Act 2022,[17] which

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[15] *Reforming the Coroner and Death Certification Service* CM 6159 (2004) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/251078/6159.pdf

[16] *Reforming the Coroner and Death Certification Service* Cm 6159 (2004).

[17] *Reforms to the coroner service in England and Wales* by Catherine Fairbairn and Georgina Sturge, 23 September 2021 https://researchbriefings.files.parliament.uk/documents/CBP-9328/CBP-9328.pdf

received Royal Assent on 28 April 2022, having been introduced in the House of Commons on 21 July 2021. Key changes in respect of coroners include—

- widening the circumstances in which a coroner might discontinue an investigation,
- enabling a coroner to hold an inquest in writing in certain circumstances,
- enabling remote participation in pre inquest reviews and inquests,
- enabling inquests to be held without a jury where a death is suspected to have been caused by Covid-19.[18]

22 In relation to the important 2009 Act recommendation for the introduction of a system of medical examiners the Health and Care Act also received Royal Assent on 28 April 2022. Under that Act, the Coroners and Justice Act 2009 is further amended to introduce a statutory medical examiner system within the NHS (rather than local authorities in England), for the purpose of scrutinising all deaths not involving a coroner. It also requires the Secretary of State to ensure that funds and resources are made available to medical examiners to enable them to carry out their functions.

Coronial functions in Guernsey

23 Little is known about Guernsey's legal system between the early 11th and 13th centuries during which time both England and France were frequently at war and the situation in the Channel Islands has been described as unsettled at best.[19] It is therefore perhaps of little surprise that in Guernsey, the origins of the exercise of coronial functions (what is known, in England, as the functions of the coroner), are not clear, but, it is suggested, likely derive from the exercise of Crown functions and not least the Crown's important role in relation to criminal justice.

24 It is apposite to consider, albeit briefly, the development of the roles of what today are termed the "Law Officers of the Crown", namely the offices of HM Procureur (Attorney General) and HM Comptroller (Solicitor General). It is considered likely that these offices derived from the position of pleader for the King around the 14th century. There would thus appear to be some synergy in terms of dates, with the origins

[18] Judicial Review and Courts Act 2022, ch 4 although similar provisions had initially been implemented as emergency provisions made under the Coronavirus Act 2020.
[19] Ogier, *The Government and Law of Guernsey* (2012), at p 140.

of the English coroner as "keeper of the pleas of the Crown". Certainly the office of HM Procureur is noted in the *Precépte D'Assise* (1441),[20] albeit the first recorded appointment to the office of HM Comptroller appears to be in 1554.[21] As pleader for the King, the holders of the offices of HM Procureur and HM Comptroller had a key role in investigating homicide and sudden unexplained deaths on behalf of the Crown and under the customary law, they, together with officers of the Royal Court, were expected to view corpses *in situ* (a practice which, happily for the present incumbents of those offices, is no longer followed).

25 It is well established that Guernsey's customary law originated from the unwritten customs of the Duchy of Normandy, including unofficial compilations of such customs.[22] In the *Grand Coutumier de Normandie*, one such unofficial compilation, being a translation of the Latin *Summa de Legibus in Curia Laicali*[23] reference is made to the diverse types of law made by record and which includes "*veue de corps langoureux*"[24] (or the Latin "*visionis corporis*"), which effectively translates as the viewing of a body.

26 The Norman writer Guillaume Terrien describes the "*veue de corps*" in further detail in Book 12 of his work covering crime and criminal procedure. His commentary makes it clear that the viewing of a body was, as might be expected, part of the then criminal justice process governed by customary law.[25] As is well known, his work was later commented upon and approved by the Privy Council in 1583 in the context of its application to the laws, customs and usages of Guernsey, such approval and commentary sometimes termed as the "statement of Guernsey Law known as the *Approbation des Loix*",[26] which was registered by the Royal Court in 1584. The *Approbation des Loix* confirms that "*le bailiff et jurés avec les officiers de Sa Majesté ont la vue des corps et aussi y appellent tels chirugiens qui pensent être*

[20] *Ibid*, p 124.
[21] *Ibid*, p 125, see also fn 36.
[22] *A v R* [2018] UKPC 4, at para 27.
[23] Ogier, *The Government and Law of Guernsey* (Guernsey, 2012, 2nd ed), at p 148.
[24] Everard, *Le Grand Coutumier de Normandie* (St Helier, 2009, Jersey and Guernsey Law Review).
[25] Terrien *Commentaires du Droit Civil,* Livre XII, p 502, ch 8.
[26] Ogier, *op cit*, at p 166.

convenable".[27] In other words, the various functions of the Royal Court, Jurats and Law Officers included viewing the body of the deceased.

27 Terrien's *Commentaires* remain a source of authority in construing the customary laws of Guernsey and in confirming the involvement of the Law Officers in relation to deaths at around the same time as the role of Coroner was evolving in England and Wales. Whilst, post the *Approbation*, customary law authorities included other influences such as Norman law and also the law of Jersey, the evolution of the role of the Royal Court and the offices of the Law Officers in relation to the investigation of sudden deaths, was not dissimilar to the evolving role of Coroner in England and Wales. Not least, the Law Officers, in their coronial capacity were expected to view the body, together with other relevant officials, but also the inquest court, such as it was, was a court of record, whose function was to inquire into the cause of death.

28 Indeed, if one figuratively presses a "fast forward" button to 1848 and the publication of the Royal Commissioners' Second Report into Criminal Law, confirmation of this point is well made during the examination of Lieutenant Bailiff Hilary Olivier Carré. During the examination, the Lieutenant Bailiff is asked by the Commissioners to confirm whether the Royal Court exercises the jurisdiction of Coroner and whether the Crown Officers are present, and he confirms the same. He is also asked how the court is put in motion in presiding as Coroner and he states that "The constable, or any other person, reports the death to the Crown Officers and to the Bailiff, by whom the matter is brought before the Court". The evidence further records that "The constables of their own authority, or on being required by the Crown officers, collect all the evidence which they can discover and bring the witnesses before the Court". Further, he confirms that witnesses are examined on oath and that the inquiry goes to the investigation of the cause of death, "as completely as it is possible to discover from the evidence". Also of note is that "the conclusions of the Crown officers" are heard and that the process by which the matter came to the attention of the court was termed the "*Levée de Corps*", which was clearly considered to be a distinct proceeding[28] and one which seems to have naturally evolved from the *veue de corps.*

29 Lieutenant Bailiff Carré also described the form in which the *Levée de Corps* came before the court as "*Les officiers de la Reine*

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[27] *Approbation des Lois, Coutumes et Usages de L'Ile de Guernesey, Livre Douzième, Chapitre Vingt-Huitième* (1897 ed).

[28] *Second Report of the Commissioners appointed to inquire into the State of the Criminal Law in the Channel Islands—Guernsey* (London, 1848, HMSO) pp 155–156, at paras 4332–4368.

actionnent les témoins d'enquête pour découvrir comment un tel trouvé mort est parvenu à sa fin." He also described formal modes of stating the verdict including by natural and violent death.[29]

30 In summary, the 1848 Commissioner's report into the criminal law demonstrates the practice that had evolved over the centuries whereby the Law Officers traditionally summoned witnesses to inquests and makes it plain that they had a clear and established role in relation to the inquest process as a matter of customary law.

Statutes post 18th century

31 Neither statute nor rules of procedure have, to date, sought to clarify the customary law functions of the Law Officers in relation to deaths. However, However, art 1 of what is known as the Magistrate's Court Law (1925),[30] which established the office of Magistrate, provided that the Magistrate would have the same function regarding inquests into cause of death as a Judge of the Royal Court and art 12 of the same Law was careful to preserve the role of the Law Officers in relation to inquests.

32 Prior to the creation of the office of Magistrate, and subsequently the Magistrate's Court, all criminal trials and civil matters as well as inquests would have been dealt with by the Royal Court. Although one can only speculate, almost one hundred years on it is very likely that the draftsman of the 1925 law did not consider it necessary to prescribe the nature and form of inquest proceedings in that Law, as these were well established in the customary law and both the Law Officers and Royal Court in Guernsey were by this time, well versed in dealings with deaths of unknown cause.

Further reforms

33 At the beginning of the 19th century, the population of England and Wales was around 8 million, but was only just over 20,000 in Guernsey. Over the next 100 years those figures effectively quadrupled for England and Wales and doubled for Guernsey.[31] This meant that the workload in Guernsey was considerably smaller in relation to death

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[29] *Ibid*, p 156, at para 4368.

[30] *Loi ayant rapport à l'Institution d'un Magistrat en Police Correctionnelle et pour le Recouvrement de Menues Dettes* (1925) Ordres en Conseil vol VII.

[31] Office for National Statistics 1921 Census https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/censusunearthedpopulationwidowsandorphansin1921/2022-04-12; and, as regards Guernsey—http://www.islandlife.org/population_gsy.htm

certification and, as regards inquests, would have meant no more than a handful taking place each year. This perhaps explains why, unlike the decades of policy change and reform of the coronial role which has taken place in England and Wales over the last one hundred or so years, in Guernsey, the pace of change has been significantly slower.

34 The 1925 Law was subsequently amended but the policy driver for change was principally in relation to creation of a Magistrate's Court and extension of the court's jurisdiction and powers (but not affecting its jurisdiction to hold inquests.) In particular, the Magistrate's Court (Guernsey) Law 1954, created the Magistrate's Court and provided that it should be constituted by a Magistrate. It also provided that the court should have jurisdiction to hold inquests into the cause of death and confirmed (in Part V) that nothing in the Law was to derogate from the right of the Law Officers of the Crown, or either of them, to require the holding of or to appear at inquests.

35 In subsequent years, the work of the Magistrate's Court increased significantly together with various administrative changes in criminal justice, including, for example, responding to modern human rights considerations. A general review of the constitution and jurisdiction of Guernsey's courts culminated in reform of the Magistrate's Court and its criminal and civil jurisdictions, as well as various other miscellaneous changes under the auspices of the Magistrate's Court (Guernsey) Law 2008 "the 2008 Law". Importantly, whilst this Law retained the jurisdiction of the Magistrate's court to hold inquests it also added some further clarification by providing in s 21 that "The Magistrate's Court has jurisdiction to hold inquests into the cause of death, wherever occurring" and also providing in s 22 for Ordinances to be passed in relation to the holding of inquests and to enable transfer of jurisdiction from the Magistrate's court to the Royal Court.

Extraterritorial scope of inquests in England and Guernsey

36 The addition of the words "wherever occurring" in s 21 of the 2008 Law are important insofar as this makes it clear, in case of any doubt, that the Magistrate's Court has power to hear an inquest into deaths occurring outside Guernsey. It is of interest that this contrasts with the position in England, notwithstanding previous more ancient similarities and it is apposite to consider the English position here.

37 Usually, in England, the jurisdiction of a coroner arises in the first instance only where the coroner is "made aware that the body of a deceased person is within that coroner's area"[32]: although guidance

[32] Section 1(1), Coroners and Justice Act 2009.

issued by the Chief Coroner in England has, as further noted below, since clarified that in certain circumstances the coroner may have jurisdiction if the body is "near" his area, thus there still needs to be a sufficient (and land based) nexus with the relevant coroner's area (bodies can also be transferred between coronial jurisdictions in England under the Coroners and Justice Act 2009). The reason for adding the words "wherever occurring" in the 2008 Law is not clear from the policy letter and informal discussions with the relevant drafter have not revealed any recollection of a reason for their inclusion save to make it clear that the jurisdiction of the Magistrate's Court was not to be confined to deaths occurring in Guernsey. As, historically and by custom and practice, the Law Officers would have had responsibility across the Bailiwick for investigating deaths of unknown cause, the addition of these words is helpful and logical. Insofar however as this means that an inquest can be (and has been) opened before the Magistrate's Court in order that enquiries into deaths occurring overseas can be made, this marks another difference with practice and procedure in England. It is also of note that the Chief Coroner's Guidance No. 18 states—

> "in some other countries coroner jurisdiction has been extended by statute beyond the confines of territorial land. For example, section 18 of the Coroners Act 2009 No 41 of New South Wales, Australia, provides for jurisdiction where a 'death or suspected death occurred outside the State but the person had a sufficient connection with the State … [including] if the person … was last at some place in the State before the circumstances of his or her death or suspected death arose.'"[33]

Contempt of court

38 A slight anomaly relates perhaps to the magistrates' ability to deal with contempt of court issues which might arise if a witness refused to attend court pursuant to a summons. It is submitted that it is arguable that the Magistrate's Court can compel competent witnesses to give evidence at inquests because art 11 of the 1925 Magistrate's Court Law provided that the Magistrate could exercise all the powers of the former *Cour de Police Correctionelle*, which formerly sat as the Ordinary Division of the Royal Court, but the wording of the Magistrate's Court Law 1925 does not offer any further clarification on this point.

39 The 1848 Royal Commissioners' report into the criminal law also noted that it was traditional for the Law Officers to summon witnesses,

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[33] At para 34 https://www.judiciary.uk/wp-content/uploads/2020/08/guidance-no-18-investigation-without-body.pdf

but similarly did not examine what happens if witnesses refused to appear, the assumption appearing to be that the Constables would be expected to bring the witnesses to court and that the witnesses would comply.

40 It is worth noting that the 2008 Law enables *Ordinances* to be drafted to deal with contempt, although none has been drafted to date. Although in practice less complex inquests are often dealt with "on the papers", witnesses can be summoned to attend the inquest court by the Law Officers and never fail to appear. Indeed, in such a small jurisdiction, there is perhaps more of an expectation that witnesses will attend and give their evidence voluntarily as sudden deaths in the community inevitably attract press coverage.

Other relevant statutory provisions

Registration of deaths

41 As previously noted, in England and Wales, the Births and Deaths Registration Act 1836 introduced a formal system of death registration. However, it was not until 1915 that the Bailiwick of Guernsey sought to do the same as recorded in the Order in Council of 13 June 1925[34]—

> "on the 2nd day of March, 1915 His Excellency the Lieutenant-Governor addressed a letter to the Bailiff and President of the States, asking him to direct that representatives be sent from the Islands of Alderney and Sark to confer with the Law Officers of the Crown in Guernsey with a view to reporting to the Bailiff and President of the States as to the best method of creating a reliable registration of all Births, Deaths and :Marriages in the Bailiwick. Accordingly a Conference was held in Guernsey on the 30th March 1915, when Alderney was represented by His Majesty's Procureur, the Deputy-Greffier and the Vicar. The Island of Sark was not represented, but the Seneschal wrote a letter to His Majesty's Procureur expressing his views on the matter."

42 Although, with the advent of the First World War, the legislation was ultimately delayed, it was finally enacted in 1925. Further reforms seeking to establish registration centrally at the Greffe (rather than in the relevant parish as provided under the 1925 legislation) were made in 1935 with the *Loi relative à l'Enregistrement des Naissances·et Décès dans le Bailliage de l'Ile de Guernesey* or, as per the English translation, the Law Relating to the Registration of Births and Deaths

[34] Ordres en Conseil V 1925.

in the Bailiwick of Guernsey 1935 ("the 1935 legislation").[35] Under art 12 of this Law, a doctor who called to pronounce cause of death who—

> "has reason to believe either that a crime has been committed or that the death was caused or aggravated by negligence or who is unable to state a cause of death, must notify the Island Police, Law Officers of the Crown, Constable or Seneschal of Sark, as the case may be."

43 The same Law prescribes the period of time a body is allowed to be kept. Usual practice was for bodies to be kept at the hospital but on occasion (more frequently in later years as the population increased) they may be kept at the undertakers. If the body is not in the custody of the States (*i.e.*, not at the hospital mortuary), the limit of time it may be kept is 6 days, after which the law requires that the Medical Officer of Health must be informed. A body may only be kept for a maximum of 15 days, after which authorisation has to be obtained from the Law Officers and the Constable of the Parish where the body is (and in Sark, from the Constable and Seneschal) for the body to be kept "above ground".

44 Failure to comply with these provisions constitutes a breach of the relevant law and is punishable by way of a fine.

45 Under the later Registration of Births and Deaths (Supplementary Provisions) (Guernsey) Law 1978,[36] the role of the Law Officers is further affirmed in that where a medical practitioner has carried out a *post mortem* examination of the body of a deceased person and a Law Officer of the Crown is satisfied, after scrutiny of the written report of the medical practitioner upon the *post mortem* examination, that the death of that person was due to natural causes, the death may be registered on production of a certificate as set out in the Schedule to that Law and signed both by the medical practitioner and by the Law Officer of the Crown.

46 The 1935 Law essentially affirms the long-established customary practice and involvement of the Law Officers in relation to deaths of unknown cause.

Cremations

47 A further key statute affirming the role of the Law Officers in relation to deaths is the Cremation Ordinance 1972. Under this

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[35] *Ordres en Conseil* vol X.
[36] *Ordres en Conseil* vol XXVI.

Ordinance, the Law Officers in Guernsey must authorise (by signature) all cremations in the Bailiwick.

48 That Ordinance also sets out specific duties of the Law Officers which include the following:

- not to allow any cremation to take place if it appears that the deceased left a written direction to the contrary;
- not to allow any cremation to take place unless they are satisfied that the death of the deceased has been duly registered by the production of a certificate of registry of death on one of the forms provided by the Registrar of Deaths for production in cases of burial (*i.e.* usually a burial permit);
- before allowing the cremation, to examine the application and certificates and ascertain that they meet requirements and that the inquiry made by the persons giving the certificates has been adequate. The Law Officers may make any inquiry with regard to the application and certificates that they may think necessary;
- not to allow the cremation unless they are satisfied that the application is made by an executor or by the nearest surviving relative of the deceased, or if that is not possible, by another proper person to do so;
- if it is intended to hold an inquest on the body then not to allow the cremation to take place until the inquest has been held, or until the Magistrate has given permission to dispose of the body;
- the Law Officers may also decline to allow the cremation without giving reason.

Current practice

Notification of deaths and post mortem examinations

49 As detailed earlier, the Law Officers hold a number of functions and duties in relation to deaths occurring in the Bailiwick.

50 Under art 12 of the 1935 legislation, where doctors are unable to state a cause of death, or otherwise suspect negligence, or that a crime has been committed, they must notify the death to the police and Law Officers (and to the constables and Seneschal in Sark as the case may be). As there is no medical examiner system in Guernsey, this means regular contact both in and outside core business hours between the Law Officers' Chambers and medical practitioners and the Guernsey police. A sudden or unexpected death will not necessarily require a *post mortem* examination. Many "sudden" deaths, whilst unexpected, may

be predicated by a long and well-known history of medical problems. However, if there is no obvious cause and the medical practitioners are not able to sign a death certificate in accordance with legal requirements, a post mortem examination will be directed by the Law Officers. As is general practice in the UK, the types of case this would involve include and are not limited to—

- sudden deaths when the doctor cannot sign the death certificate,
- allegations of medical negligence,
- acute alcohol poisoning/ intoxication,
- death involving drugs or poisons,
- homicide,
- suicide,
- industrial accidents,
- death from industrial disease,
- death in custody,
- road traffic accidents,
- domestic accidents,
- operation related deaths,
- sudden infant death,
- pregnancy related deaths.

Inquests

51 Like Scotland, the investigative and presiding role of the coroner is split. In Guernsey's case this is between the Law Officers, who carry out the investigative functions and the judges who sit in the Magistrate's Court, there being no separate office of coroner in Guernsey. However, although Guernsey mostly follows UK procedures (and not the Scottish system), in Guernsey there is no jury and no Coroners' Rules. The Greffe has a record of the Acts of Court recording the inquest verdicts, but rarely publishes the verdicts or judgments.

52 Some cases have been reported. For instance, in the case of *Collas v Peet*,[37] it was held that the death certificate completed after an inquest, though generally admissible in a civil trial as evidence of death, may be excluded if the cause of death specified is disputed by the parties and the fact of death is otherwise demonstrable.

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[37] 2000–02 GLR *N* [8].

53 Also, despite the lack of provision for appeals against inquests under the various Magistrates Court legislation, the case of *Kirk v Law Officers* has confirmed that the Royal Court did in fact have the power, as part of its general jurisdiction to review the decisions of inferior bodies, to review decisions of the coroner and to set aside his verdict in appropriate circumstances.[38]

54 In 2010, Judge Finch, who was sitting *ex officio* in the Magistrate's Court helpfully confirmed that—

> "In practice the 1984 Rules are followed in Guernsey, subject to necessary modifications.
>
> Two very important Rules are 36 and 42.
>
> As indicated, they are, in essence, followed in Guernsey.
>
> Rule 36 provides:
>
> > '(i) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely—
> >
> > (a) who the deceased was;
> >
> > (b) how, when and where the deceased came by his death;
> >
> > (c) the particulars for the time being required by the Registration Acts to be registered concerning the death.
> >
> > (ii) Neither the Coroner nor the Jury shall express any opinion on any other matters.'
>
> Rule 42 provides:
>
> 'No verdict shall be framed in such a way as to appear to determine any question of—
>
> > (a) criminal liability on the part of a named person; or
> >
> > (b) civil liability.'

55 He continued—

> "Also worthy of note is that although interested parties are entitled to be legally represented no one is permitted to address the Coroner as to the facts in evidence at an inquest (Rule 40 of the Coroners Rules 1984). Matters of law may be dealt with. These may include submissions on the possible conclusions to be left to the Court and in making such submissions it will usually be necessary to refer to the evidence given. There is also no

[38] 2000–02 GLR *N* [23] and Judgment 5/2003 *Kirk v Law Officers*.

> prohibition on submissions as to areas of factual investigation to which the inquest should address itself … Above all it has to be emphasized that an inquest is not a trial, nor is it adversarial in nature … It is an enquiry or inquisition."[39]

56 In essence, therefore, the inquest in Guernsey will be broadly familiar to those used to practising in England being an inquiry principally held to establish answers to four key questions:

- who the deceased was,
- where the deceased died,
- when the deceased died,
- how the deceased came by his/her death.

57 In practice, when a Law Officer directs an inquest to be opened, again a police officer will act on behalf of the Law Officer in making the necessary arrangements, and investigations, but the Law Officers will arrange for the body to be released for burial or cremation if the Pathology Department and Police are content that no further investigation in this area is required. Usual practice is for the inquest to be opened before the body can be released by Act of Court.

The inquest court and verdicts

58 As noted, the inquest is presided over by a magistrate and is held as soon as is practicable after all enquiries have been completed. It is also held in public and if oral evidence is required, the Magistrate will examine the witnesses under oath, as may those representing interested parties. The Magistrate will return a verdict—a short statement which records the answers to the previous four questions. There are a number of verdicts that can be given, which will be familiar to anyone practising in England and Wales including:

- natural causes,
- industrial disease,
- dependence on drugs/non-dependent abuse of drugs,
- want of attention at birth,
- suicide/killed him or herself [whilst the balance of his or her mind was disturbed],
- accident or misadventure (which are arguably very similar),
- disaster which is the subject of a public inquiry,

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[39] *In re Schofield* (Mag's Ct) 2009–10 GLR 353.

- unlawful killing,
- open verdict,
- return a narrative verdict.

Influence of English coroner's law and Chief Coroner's guidance

59 It is helpful to reference the comments of Judge Finch in the 2010 inquest noted above. He stated—

> "The normal procedure is to list the cause(s) of death as shown at any *post-mortem* and the appropriate finding, such as 'accidental death', 'natural causes' or 'suicide' *etc*. This familiar procedure will still remain the norm in the majority of cases. A recent development in England and Wales, connected with the requirements of the European Convention for the Protection of Human Rights and Fundamental Freedoms, art 2, has introduced the concept of the 'narrative verdict'. The leading case on this is R (Middleton) v HM Coroner (W. Somerset) [2004] AC 182. This decision of the House of Lords is not technically binding on me in Guernsey, but is of the highest persuasive authority, especially as the judges are also members of the Judicial Committee of the Privy Council, our highest appellate court. Guernsey is, of course, also bound by the Convention, and it is applied in Bailiwick Courts."[40]

60 The above is important in that it confirms that, in Guernsey, the magistrates expect to follow recent developments in England and Wales even if they are not bound by them. The requirements of the European Convention for the Protection of Human Rights and Fundamental Freedoms (which has been incorporated into domestic law under the Human Rights (Bailiwick of Guernsey) Law 2000) apply and in terms of the investigative coroner's functions undertaken by the Law Officers, consideration is regularly given as to whether an inquest matter may engage art 2 of that convention, following English law jurisprudence and guidance of the Chief Coroner.[41]

61 In addition, in relation to the verdict of suicide, following the standard of proof changing in England and Wales from the criminal standard of proof to the civil standard, *i.e.* on the balance of probabilities, this is the standard most likely to be followed by the

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[40] *Ibid.*, at para 5.

[41] https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/ (accessed 4 April 2022)

inquest court in Guernsey.[42] The later Supreme Court decision[43] in that case has confirmed that all conclusions in coroner's inquests, whether short-form or narrative are to be determined to the civil standard of proof which would also materially affect another potential short form verdict, that of unlawful killing. To the extent that this might cause future problems for the Guernsey inquest court in that individuals might be associated with a serious offence in the coroner's court which would not pass the relevant criminal test in a criminal court, the Chief Coroner has helpfully published Law Sheet No 1,[44] which would undoubtedly be referred to in the event of a short-form verdict of unlawful killing potentially arising (which is rare). Other guidance of the Chief Coroner has also been referred to in recent inquests (notably Guidance No 17 on short-form and narrative verdicts).

62 Generally, inquests are held on the papers and routinely may be over within 30 minutes However—as a reflection perhaps partly of population growth, partly of developments in medical science, partly of societal changes, with families wanting to become more involved with the inquest process—in recent years the inquest process has become more complex and witnesses and experts are more likely to be called. The author is also aware of several complex inquests reaching narrative verdicts in recent years. Although the inquest verdicts are not routinely published, generally the work they generate is on the increase and they also take up more court time than they would have done, even a decade ago.

Why a review is needed

63 Whilst, in England, the diverse nature of the different jurisdictions of the coroner led to a fragmented system over the last one hundred or so years, which was arguably variable in both quality and consistency, rather perversely, the fact that the system in Guernsey is a function split between Law Officers and a limited number (in practice usually two or three) of those judges presiding in the Magistrate's Court, has meant that the system is arguably more consistent and less fragmented as regards the Bailiwick. Only the Law Officers may authorise *post*

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[42] See further the decision in the English case of *Maughan* on 26 July 2018 ([2018] EWHC 1955 (Admin)), there is no reported case in Guernsey turning on this issue, but the relevance of this case in reaching a verdict of suicide has been discussed between the Law Officers and Magistrates in preparing relevant papers for inquest resumption.

[43] *R (Maughan) v HM Senior Coroner for Oxfordshire* [2020) UKSC 46.

[44] https://www.judiciary.uk/wp-content/uploads/2021/09/Law-Sheet-1-1-September-2021-Unlawful-Killing.pdf (accessed 4 April 2022).

mortems and direct the opening of inquests, for example. Also, unlike England, where practice can still vary (despite guidance from the Chief Coroner) during investigations and in the inquest court, in Guernsey both Law Officers and Magistrates share their respective duties and generally apply the same principles. However, it cannot be denied that the current arrangements for the investigation and certification of deaths, and for the authorisation of burials and cremation, are based largely upon outdated English legislation. Part of the legislative framework with which the Greffe, police and Law Officers work is archaic, contains outdated terms and lacks clarity in terms of procedure. For example, the requirement in the 1935 legislation for the Law Officers to authorise "above ground" certificates for bodies to be held other than in States custody at the hospital no longer reflects the reality that the States mortuary is small and many bodies can quite simply be better accommodated with an undertaker, where the family can have a more appropriately sensitive space to view the body of the deceased.

64 In addition, although there is nothing to prevent the magistrate presiding over an inquest to issue any public comment on a matter arising, there is no duty to make reports to a person, organisation or other body if the magistrate believes that action should be taken to prevent future deaths. Having the ability to make a report to prevent future deaths and to direct that action should be taken is an important tool to have in any coroner's workbox and there is arguably a strong public interest in such a tool being made available.

65 A review might also helpfully consider whether more resources should be devoted to the coroner's work. While pressures on resources have become more acute across the public sector in recent months, there remains an inevitable backlog of work following the Covid-19 pandemic. There would be benefit from some increased support if timeframes for the resumption of inquests are not to be further delayed. The resources devoted to coroner's matters are also tightly stretched between the other core functions of the Law Officers and, in the absence of a medical examiner system, currently rely heavily upon the expertise of the States pathologist in Guernsey in relation to certain death certification queries and other matters touching upon the death process (the scope of this article does not permit further comment). That pathologist is frequently under pressure to complete *post mortem* examinations promptly as well as other urgent work. She has no assistant. There is also considerable reliance upon the one coroner's officer employed with Guernsey police, to assist the Law Officers with relevant enquires and the taking of statements. These are, in total, very small resources when considering the case management required to keep updated grieving families, take statements, and generally liaise with doctors, medical experts, hospital employees, other members of the public, undertakers and the pathology department. It is also difficult

to attend relevant training and to keep abreast of relevant legislative or judicial reform.

66 By way of further example, in the UK in 2020, over one third of deaths were referred in some way to the coroner[45] and this is analagous to recent Guernsey figures. This is a significant proportion and demonstrates the extent to which doctors contact a coroner when they have a query on certification. It is also a statistic which may be lower than in previous years as it covers the Covid-19 pandemic period. During this period, the Coronavirus Act 2020 introduced temporary relaxation of death management and affected the way in which deaths have been reported to coroners. This figure likely reflects underreporting, at least in the UK—previous years have reflected a higher, rising trend of death reporting. In Guernsey, by contrast, the Covid-19 pandemic appeared to lead to more queries in relation to deaths and the process of death certification. More recent 2021 figures indicate that more queries have been referred to the Law Officers in relation to death certification—164 queries being referred in 2021 with the total of deaths registered in 2021 being 571. There is also a rising trend in relation to the numbers of inquests with, for example, around 12 per year being closed a decade ago, and some 23 being closed in 2021 alone. This has a consequential effect on the Law Officers' wider functions, which have been considerably impacted by Brexit and Covid-19.

67 Undoubtedly any future review would need to be complemented by liaison with the Committee for Health and Social Care, primary care practices, secondary care providers and the Greffe, and is not a matter which could be completed quickly. An initial proposal to consider a review of current legislation and procedure and how best to strengthen the coroner's process is being drafted in the Law Officers' Chambers. Whilst any review will require consultation with others involved, it is hoped that a review will help to ensure that the death certification and coroner's systems in Guernsey are fit for purpose, that they complement the Bailiwick's healthcare and justice system, and, importantly, that the expectations of families, which lie at the heart of the inquest process, can be met.

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[45] https://www.gov.uk/government/statistics/coroners-statistics-2020/coroners-statistics-2020-england-and-wales#:~:text=Deaths%20abroad&text=Of%20the%20205%2C438%20deaths%20reported,slight%20decrease%20compared%20to%202019 (accessed 4 April 2022).

Conclusions

68 A review of the coroner's services in the Bailiwick is long overdue. As law and practice in Guernsey is largely based upon the coroner's system in England and Wales and given recent reforms there, it is timely to consider a review of processes in the Bailiwick. A review would help to focus on the importance of consistent up to date training both in the investigation and in the death certification and investigation process and would help to ensure that the rights and expectations of the bereaved can be dealt with transparently and on a modern legal basis. The importance of properly investigating deaths, of accurately certifying the cause of death and of avoiding unnecessary delay to families wishing to achieve some closure over the death of their loved one, should not be underestimated.

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