THE UNIVERSITY OF HULL

Accounting for Sudden Death:
A Sociological Study of the Coroner System

being a Thesis submitted for the Degree of

Doctor of Philosophy

in the University of Hull

by

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July 1984

Social Administration

UNIVERSITY OF HULL

Summary of Thesis submitted for Ph.D degree

by John Fenwick

on

Accounting for Sudden Death: A Sociological Study of the Coroner System.

July 1984

The study examines the work of the coroner. The thesis is sociological in orientation and method, drawing where necessary from other disciplines, e.g. law, philosophy. The study concentrates upon the nature of coroners' categorisations and the production of the socially recognised 'facts of sudden death'. While detailed consideration is given to the inquest and inquest verdicts, the whole range of coroners' work is examined. Differing but complementary research methods are employed to yield essentially qualitative material. Existing sociological studies, e.g. of 'official statistics' and of suicide, are evaluated. Coroners' methods of ascribing meaning to sudden death are examined. An important aim is to render processes of construction 'visible' for sociological study.

Part One (Chapters One and Two) opens with a review of theoretical issues in sociology. The methodology of the study is 'located' within sociological theory. Part One continues with an historical discussion of the office of coroner, and an outline of legislation and formal medico-legal procedure.

Part Two (Chapters Three, Four and Five) forms the largest section of the study, consisting of material collected by field research, i.e., interviews with the coroners of five

counties, systematic observation of inquests, and unpublished/ published statistics. Provisional conclusions are discussed as the study progresses, covering topics which include, inter alia: discretionary authority; the inquest as court of law; the differing perceptions of individual coroners; the relevance of historical factors; the Press; methods of constructing the verdict; the roles of doctors, pathologists and police; social control; official statistics; and historica and geographical statistical variations.

Part Three (Chapters Six and Seven) draws overall conclusions about coroners' accounts of sudden death. It places coroners' work within bureaucratic and ideological contexts. The work of the coroner is situated in terms of the ways society conceives of and deals with death as a whole.

Two short appendices add further statistics and further methodological details.

ACCOUNTING FOR SUDDEN DEATH: A SOCIOLOGICAL STUDY OF THE CORONER SYSTEM

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ACKNOWLEDGEMENTS

I wish to express my thanks to H.M. Coroners of the 'five counties', the Department of Social Administration of the University of Hull, the former S.S.R.C., the Home Office, Dr. Keith Bottomley, Terry Donnelly and Denise Fenwick.

INTRODUCTION

Anyway, I don't envy your writing your thesis at this time. It must be like writing a thesis on the Government of France at the time of the Revolution.*

The late 1970s and early 1980s witnessed considerable public debate, together with proposed and actual procedural change, in the hitherto fairly placid world of the coroner and the inquest. Toward the end of the fieldwork period upon which the present study is based, and during the subsequent assembly of the thesis, coroners' work became (or was said to have become) controversial.

Whilst no academic piece of work can ever be wholly removed from the society and the State in which it is produced, the first substantive point of this introduction must be to emphasise that both the original impetus for this study and its continuing dominant concerns are unrelated to any current debates about what coroners (to put the matter crudely) should and should not be doing. Rather, the starting point is a sociological perspective upon the work of an officer who has attracted the attention of some historians and some writers of (now rather out-of-date) legal textbooks, but has not attracted any sociological attention other than that of sociologists who wish to make points about suicide or the suicide rate.

The present discussion is not a study in the sociology of suicide. It is a sociological study of the work of the

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* Correspondence from one of the coroners participating in the interview programme.

coroner as a whole. Coroner 'system' is referred to for a number of reasons: firstly, because coroners' work constitutes an interactive social system; secondly, because the inquest in particular can be seen as a formal system; and, thirdly, because coroners' work (generally, and individually) has a systematic nature. 'Accounting' is similarly referred to on a number of grounds: firstly, because coroners routinely produce accounts of sudden deaths in the form of verdicts, verbal statements and statistical records; secondly, because the study is concerned inter alia with the accounts of their work offered by individual coroners during interview; and, thirdly, because the study itself aims to achieve a sociological account of coroners' accounts. 'Sudden death' is used as a shorthand term for those deaths which are dealt with by coroners.

The information upon which the study is based is drawn from interviews with the coroners of five counties; from observation at a coroner's court; and from analysis of statistical records held in a coroner's office supplemented by other statistical material. Part One of the study aims to situate the research in terms of sociological theory and methodology and the historical development of coroners' work. Part Two draws in detail from the elements of field research specified above, and most of the thesis is devoted to this discussion of empirical material. Part Three elaborates some overall conclusions, locates coroners' work in a wider context, and reconsiders some of the issues introduced at the beginning of the study. Provisional conclusions are drawn chapter-by-chapter throughout the study. In addition to the principal fieldwork elements of interview, observation and statistical search, published and unpublished documentary sources were consulted

and these, together with those casual observations and discussions which necessarily (and sometimes surprisingly usefully) accompany the formal fieldwork programme, complete the stock of relevant material.

The study aims to offer a coherent and comprehensive account of coroners' work; to inform description by an examination of the historical development of the office of coroner; to consider significant changes in the work of the coroner and the use and meaning of verdicts; to examine the perceptions of individual coroners; to compare the formal procedural model of what-coroners-do with informal processes of reasoning and construction; to approach the topic by more than one empirical route and to render explicit the theoretical and methodological options; to move to more general considerations of the sociology of death and of how a significant proportion of deaths are organisationally processed within the coroner system; to examine the inquest as a court of law; and to draw conclusions about the organisational characteristics of a bureaucratic system for dealing with unformed, disorganised, events.

A particular feature of the research process has been to make "visible" the theoretical and methodological bases of the study: to open up for inspection aims and theories in terms of the required internal consistency. The study adopts a particular theoretical orientation, deriving broadly from phenomenological sociology. It does not claim a position of ascendancy or even opposition in respect of other theoretical options. It has simply been made transparent for examination within its own terms and the overall aims of the research.

The overall aims are to examine how coroners (located by legal structure on one hand, and by their individual attitudes

on the other) come to ascribe meaning to hitherto meaning-less phenomena: how the process of constructing the facts-of-the-matter takes place. In short, the study addresses itself to the issue of how what might be called "true stories" are produced, from the point of referral to a coroner through to formal statistical disposal.

PART ONE

CHAPTER ONE: INTRODUCTORY COMMENTS - SOCIOLOGICAL THEORY AND RESEARCH METHODOLOGY

1(1) Prefatory Remarks and the Scope of the Study

Sociologists habitually present research methodology as a technical preface or appendix to a description of their substantive research. Methodology, as an atheoretical guide to how-it-happened, is taken to denote the framework within which the study occurred, the implication being that readers who 'know about the methodology' can 'judge the results'. Recitals of technical methodology, however, can leave out rather more than they include. There is always the possibility that the sociologist started to think seriously about methodology only after the research was completed, but before it was written-up, and that the research framework finally appears as rather more systematic than it was during the research. The journalistic bonhomie of attempts to 'come clean' about research methodology, such as Bell and Newby's collection (1977), may add only another gloss (that of 'disarming frankness') to the traditional glosses.

It is argued in the present chapter, and throughout the study to follow, that any informative presentation of specific methods adopted, or of research methodology in general, must transcend a purely technical review of research design. It is accepted, following Cicourel, that methodologies necessarily embody implicit theories about sociology and about society: that the measurements used by sociologists "..... always have their theoretical and substantive counterparts" .(Cicourel 1964, 1).

The present introductory discussion aims explicitly to situate research methodology, and research subject-matter, within

the theoretical options constitutive of sociology. This requires an extensive review of sociological theories and their philosophical underpinnings. The discussion will then be related to the tasks of the study as a whole. Particular concerns are to make visible the theoretical premises of the study, to clarify the link between these and the particular research methods adopted, and to relate all of this to some continuing problems in sociology. Theory and method, in short, are taken to be quite inseparable. It will be argued that, in terms of the aims and interests of the present study, phenomenological sociology, in the broadest sense, provides the most useful basis on which to proceed. This broadly phenomenological orientation will become clear in succeeding chapters.

The study is a sociological analysis of the work of the coroner. The coroner 'accounts' for sudden deaths: his accounts are both 'explanation' and statistical record. The coroner 'system' is taken to consist of the (systematic) activities of coroners themselves, interacting with coroners' officers, doctors, police personnel, pathologists and others within the framework of both legal and informal rules. The processing of sudden deaths is a central concern, and sudden deaths may, for now, be defined as all those deaths dealt with by coroners. It is a major assumption of the study that the generally available 'facts of sudden death' are <u>produced</u> or, as it were, 'constituted' (made real) by <u>coroners' activities</u>. The research is concerned with identifying, describing and analysing the ways in which coroners transform disorganised events, clues and pieces of evidence into coherent accounts, and then record such accounts as the statistical facts. One might refer to such organisationally-produced 'facts' as 'true stories' as, in practice, coroners'

categorisations amount to the 'true stories' of 'what-really-happened'.

Reference is made below to existing sociological work referring to coroners, but it will become clear that such work has tended to address questions rather disimilar from the questions underlying the present study. Aside from differences of theoretical orientation, the work of Douglas (1967), Atkinson (1978),Bradshaw (1973), Sacks (1966), Watson (1975), Henson (1978) and Taylor (1982) has focussed largely upon suicide. While suicide is certainly given more than passing attention in the present study, it is not of central interest. The study aims to describe coroners' work rather than one particular inquest verdict.

Although there are difficulties in drawing conclusions from national statistics (as will later be seen) Table 1(1)1 suggests that suicide is indeed a minor part of coroners' day-to-day activities:

TABLE 1(1)1: CORONERS' WORK 1975*

TOTAL DEATHS ENGLAND & WALES	TOTAL DEATHS REPORTED TO CORONERS	TOTAL CORONERS' INQUESTS	TOTAL INQUEST VERDICTS OF SUICIDE
582,700	153,366	23,455	3,717

*Source: Unpublished Home Office statistics derived from coroners' annual returns.

In 1975, only 2.4% of deaths reported to coroners culminated in an inquest verdict of suicide. Such cases do, of course, take up more than 2.4% of coroners' time, given that coroners may deal with some of their cases by a single telephone call. However, suicide cannot be regarded as a central part of the

everyday work of coroners.

Insofar as suicide is a topic of relevance in the research presented herein, it is a relevance arising from the importance of the 'sociology of suicide' as an established body of knowledge and from the criticisms of this body of knowledge which can be made. Further, suicide is amongst the most publicly-available aspects of coroners' work and this too is a matter which will be discussed.

The research, then, has not been concerned exclusively, nor mainly, with suicide. Nor has it been concerned solely with the minority of coroners' cases dealt with by public inquest. However, the inquest is afforded more detailed attention than it might 'deserve' (purely in terms of the frequency of its use) on the grounds that it is, historically, of particular significance and also, by virtue of its public nature, because it renders the processes of categorisation visible.

The discussion of sociological theory and research methodology in this opening chapter also serves to define the scope and objectives of the research as a whole. In the second chapter, an historical account of the coroner system is offered, together with a summary of the legal and procedural elements of the contemporary coroner's duties, thus providing a foundation and framework for the presentation of the original research material.

Chapter Three presents the results of semi-structured interviews with the coroners of five counties in the North of England: fifteen coroners in all. Further informal interviews were subsequently held in some cases and material obtained from these, together with notes made in conversation with personnel other than coroners (coroners' officers or doctors, for instance) are also used. The purpose of the interviews was to collect

coroners' own accounts of their work: their perceptions, opinions, processes of reasoning and theorising used, and so on: and to compare these accounts with the formal model of coroners' work presented in Chapter Two, and to the material gathered in other parts of the fieldwork. Similarities and differences in what coroners do, and say, is also of interest.

Observational information, drawn from systematic observation of fifty inquests in one coroner's court and supplemented, like the interviews, by additional informal observation, forms the basis of Chapter Four. The approach is ethnographic, and a sociological account of how the coroner constructs the 'true-story' of the death is sought. It is at the inquest that the muddled details of a sudden death are reconstituted to form the particular 'fact' of a suicide, an accident, or some other verdict. Comparisons will also be made between the coroner's inquest and other courts of law.

Chapter Five presents a statistical profile of coroners' inquest decisions. National statistics for the period 1926-75 are presented and discussed, using published and unpublished sources. Additionally, an analysis of records over the same fifty year period, drawn from the files of a full-time coroner's office is made, and related to the pattern of national statistics. Statistical material is used, like interview and observational data, as a qualitative resource. The status of the statistics of coroners' work as 'the facts of sudden death' will be evaluated, and the well-established sociological arguments about 'official statistics' (discussed at some length in the present chapter) will be re-introduced in the light of the research material. Such statistics will be regarded as reliable records of coroners' decisions and activities: not as reliable/

unreliable records of 'types of death occurring'. It will be argued that the status of the statistics as the 'facts of death' is constituted by the activities of coroners.

Chapter Six discusses the problem of suicide as traditionally conceived in sociology, together with some central definitional problems. Brief consideration is given to philosophical views of suicide, followed by an analysis of the views of sudden death and suicide produced by quite a different vehicle: the Press. The chapter concludes with observations upon the sociology, ideology and routinisation of death, sudden death and suicide: and an appraisal of how far coroners' categorisations can be located in a wider cultural and social context.

The final chapter attempts to draw together the research in the form of concluding comments and assimilation of the variety of material presented. The central issue is coroners' production of the 'facts' of sudden death.

The chapters are arranged to form three parts: Part One, broadly introductory and providing a basis for presenting the bulk of the research material; Part Two, presenting, discussing and evaluating the data collected from the three chief elements of the research fieldwork; and Part Three, broadly concerned with extending the scope of discussion beyond particular coroners' decisions, suggesting some wider context for understanding coroners' work, and drawing conclusions.

Appendices include further details on research design and organisation of the study.

The task of the present study is to describe, investigate, analyse, and provide the means for understanding the processes whereby coroners, in their normal occupational activities, process sudden death and produce the publicly-available facts of

the matter. This is a study of decision-making but, more fundamentally it is a study of reality construction in a setting uniquely interesting: for the coroner retrospectively constructs a reality of the past, with his key informant necessarily unavailable.

The initial task is to examine the theoretical and methodological bases of the research, and to introduce some of the issues of central concern.

1(2) Theories and Options in Sociology

Historically, the dominant theoretical and methodological strain of sociology has been positivism, with early positivist sociology arising as a conceptual, and practical, solution to the problems of social order posed by political change in the late eighteenth and early nineteenth centuries. The term 'positivism' is, of course, often used in an extremely vague, and polemical, sense (Giddens 1974, 2). Therefore it is useful to outline the meaning of the term as used in the present discussion.

The first assumption of positivism is that sociology can adopt the methods of natural science and can scientifically investigate the world-out-there. Its second assumption is that sociology can produce results akin to those of natural science, in the form of laws or invariant generalisation. Thirdly, positivist sociology defines itself as a technical, neutral, enterprise, discarding values and presuppositions (Giddens 1974, 3-4).

Another definition of positivism:

> ..... a doctrine centering on the proposition that only empirically and scientifically useful know-

> ledge deserves the title "knowledge" at all and that all competing types of cognition or inquiry belong to more primitive stages of civilization. (Dallmayr and McCarthy 1977, 2).

The ideological assumptions of positivism have been criticised by a variety of sociologists although most particularly by Marxists (e.g. Swingewood 1970). What concerns us here is that consciousness, subjectivity, reality and, most important, meaning, are excluded from the positivist programme almost completely.

Durkheim puts the positivist position well:

> ..... real laws are discoverable which demonstrate the possibility of sociology better than any dialectical argument. (Durkheim 1970, 37).
>
> Sociological method as we practise it rests wholly on the basic principle that social facts must be studied as things, that is, as realities external to the individual. (Durkheim 1970, 37-38)
>
> When ..... the explanation of a social phenomenon is undertaken, we must seek separately the efficient cause which produces it and the function it fulfils. (Durkheim 1938, 95).

That the social world might be explained is still a widely-held notion in sociology, but by no means self-evident. The distinction between explanation and understanding is a crucial one. Causation is another sociologically problematic notion. Positivists have seen their task as a technical matter of distinguishing causes from non-causal correlations (e.g. Isajiw 1968). Yet the notion of causality in the social world remains speculative: a metaphor. Used as a metaphor, talk of causality may have some heuristic use, but it is used quite literally, and not only amongst positivists.

Functionalism is perhaps the purest form of positivist sociology and is, of course, a determinist sociology (Parsons 1960; 1966, 6). It presupposes the objective status of the

world-out-there, and proceeds to investigate this world with the atheoretical tools of a methodology borrowed from natural science. Mills' criticisms of "abstracted empiricism" might be recalled here: the criticisms of a method which generates details in great number, the rationale being that quantity at some point becomes transformed into sociology: and explanation. It is a method without any obvious theoretical foundation (Mills 1970, 65).

As for symbolic interactionism, elements of this potentially radical school have been vulgarised and assimilated into mainstream positivism, while its original philosophical base in G.H. Mead's work has largely been neglected or misinterpreted. In essence, Mead's interpretation of self and society is not compatible with the static and determinist model of society inherent in positivism (Strauss 1964: XII - XIII).

Mead conceptualised the self as follows:

> ..... an individual who affects himself as he affects another; who takes the attitude of the other insofar as he affects the other, insofar as he is using what we term "intelligible speech"; who knows what he himself is saying, insofar as he is directing his indications by these significant symbols to others with the recognition that they have the same meaning for them as for him; such an individual is, of course, a phase in the development of the social form (Strauss 1964, 40).

The emphasis here on 'taking the attitude of the other', on meaning, on language and, implicitly, on intersubjectivity*, suggests that Mead's thought may have more in common with the phenomenological position than with the conventional image of interactionism. For Mead, self was constituted (made real)

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* The term intersubjective is used to describe some aspects of our mutual interrelatedness ...; intersubjectivity points to the inherent sociality of consciousness and to the experience of the world by self and others as a world in common. (Phillipson, 1972, 125).

socially: and not only was human communication seen as symbolic (which is obvious enough) but social life and the social world 'itself' were seen as symbolic processes of interaction. Natanson, in examining the philosophical bases of Mead's thought, finds a parallel between Mead, Husserl and Schutz: and explicitly rejects the view of Mead as a "social behaviourist" (Natanson 1973, 3-4).

Mead, social psychologist and philosopher, gave an impetus to the pure sociological work at Chicago by his emphasis on the construction of self by social processes. Following Mead, it can be said that meanings in the world are constructed, not pre-existent, nor irrelevant. Men share meanings, using symbols as convenient shorthand: language is central here. The self is socially constructed, yet renders itself, for practical purposes, 'objective' and acts to define social life: in terms of shared meanings and symbols.

There may not, of course, be agreement about supposedly 'shared' meanings. Interactionists within the sociology of deviance emphasised that 'self' may effectively, and perhaps coercively, be defined by others (Becker 1973; Scheff 1974). Also, the act of interpretation, of making sense and generating order from pre-existing disorganisation, necessarily involves the individual in the process of giving meaning to others' actions. That the self can 'itself' be the object of individual action makes interpretation of others' action practically possible. Methodologically, the task for the interactionist is to 'catch' the process of interpretation as it happens: to 'take the role' of the other (Blumer 1962, 188). Role-taking has parallels with both Weber's verstehen, and the phenomenological method of description, though it is synonomous with neither.

Phenomenology is neither a theory nor a mode of explanation. It is, in sociology, a method of describing and understanding the processes whereby individuals constitute the social world. There is no reality-out-there to be measured or explained: social reality is a configuration of meanings, made (for practical purposes) 'real' only by these meanings and by human activity. This reality - which we might call a practical facticity - is an achievement of members of society. Their methods of achieving this reality are objects of sociological inquiry: in the present study, coroners' methods of creating the practical reality of sudden death are the focus of attention.

Berger and Luckmann's re-formulation of the sociology of knowledge revealed some of the elements of a broadly phenomenological sociology (1967). In the task of describing reality-construction, a central problem is to first describe how subjective meanings are transformed into 'objective' facticities. Signs, and in particular language, are key elements. Language allows logic to be imposed on the "objectivated social world" (Berger and Luckmann 1967, 82).

The social world, then, is available for experience as an objective 'thing': which is not, of course, to say (with the positivists) that it is'in fact' an objective thing. The experienced reality of the social world derives from the sense of its objectivity.

Filmer accepts the phenomenological framework, yet believes it provides few clues as to how the social construction of the world might be investigated (Filmer 1972, 203-205). He sees ethnomethodology as an operationalisation of the phenomenological perspective and, it seems, is not alone in this view. For instance, Wiles and Wiles (in a guide to criminological literature)

write:

> Garfinkel has added to the terminological confusion by introducing the word 'ethnomethodology', but all he means by it is the methodology necessary for a phenomenological sociology
> (Wiles and Wiles 1974, 35).

This is a rather shaky position to adopt, as phenomenology is itself a method: not a theory in search of a method. Moreover, it is increasingly the case that ethnomethodology is something rather different from phenomenology. This is most clear in the work of the conversation analysts in ethnomethodology (e.g. Atkinson and Drew 1979). It is much less the case in early ethnomethodological work.

Society, then, acquires its apparently objective status because members continually define it as real (Walsh 1972, 19). The phenomenologist suspends belief in this apparent objectivity in order to study as closely as possible the phenomenon at hand. The positivist accepts the objectivity of what appears to be.

Walsh, in his discussion of Durkheim's study of suicide, notes that Durkheim is obliged to introduce his own meanings about suicide into his data, for otherwise no sense could be made of it (Walsh, 1972). The meanings of marriage, education, social isolation, and so on, are necessarily pre-supposed by Durkheim. Where such factors do not correlate in the expected way with the data (e.g. that Jews have a high level of education but a low, not high, suicide rate) Durkheim must assert that education has a different significance, another meaning, for Jews (Walsh 1972, 44). Walsh also notes the problematic nature of official statistics as used by Durkheim, adding that the meanings, intentions and motives imputed in the creation of a category

called suicide vary between societies: as, of course, does the method of record-keeping (Walsh 1972, 46).

To restate the position taken in the present study, suicide rates, and other rates of sudden death, are seen as the products of coroners' activities: as reliable records of what coroners do. To investigate the relation between these rates and 'actual' rates-out-there, in order to test the accuracy of official rates, is, in terms of the theoretical position adopted in the study, an irrelevant enterprise. A study aimed, for instance, at investigating the relative accuracy of English and Scottish suicide rates (Barraclough 1972) is therefore outside the area of our concern.

The essential task of everyday life is to define situations as real, and thus to constitute order, and maintain the social world while managing this task as a routine unproblematic activity. An aim of the research is to describe and understand how coroners carry out this task in relation to sudden death.

1 (3) Situating Research Methodology

The broad theoretical stance of the research having been outlined, it is now of use to situate the research more precisely alongside existing studies of coroners' work. It is also necessary to situate methodology in its wider theoretical context.

Atkinson (1978), in his study of the social organisation of sudden death, moves from positivism, through interactionism, and finally to ethnomethodology. The central research question emerged as: "how do deaths get categorized as suicides?" (Atkinson 1978, 7). Atkinson's own answer is that

> ..... deaths get categorized as suicides in much the same way as anything else gets categorized. (Atkinson 1978, 196).

Hence, nothing particularly useful can be said about coroners' categorisations: the task is to create a sociology without the accepted sub-divisions (sociology of deviance, sociology of the family, and so on) and to investigate members' methods of producing categories.

Nevertheless, Atkinson produces a study of coroners' activities: comparisons between this study, and the seminal work of Douglas (1967) are inevitable. Atkinson suggests that Douglas

> ..... can be faulted first on the grounds that what he does is not so very different from what previous researchers have done, and second that his demonstration is inconsistent with his own programmatics. (Atkinson 1978, 83).

It is possible of course that the second criticism, especially, can be made of Atkinson's own study.

Atkinson produces a description of how some deaths reported to coroners became categorised as suicides. Using interviews and participant observation, Atkinson draws up a list of factors typically sought by coroners and their officers in arriving at a suicide verdict: suicide notes, threats, previous attempts, mode and location of death, personal history of the deceased (Atkinson 1978, 110-140). The factors are not discrete clues: they interconnect within practical theories of suicide (Atkinson 1978, 141).

When coroners categorise a death as suicide, says Atkinson, they not only 'pin a label' upon that death: they explain that death, theorise about it, impute a motive (1978, 143). This process of theorising may be akin to the theorising about suicide traditionally done by sociologists. It may also be akin to theorising by the Press (Atkinson 1978, 156-165). In Atkinson's words, coroners make "order out of chaos" in achieving plausible accounts of how and why death occurred: sense is made out of

disorganisation (1978, 172).

Atkinson's leap into ethnomethodology is a theoretical and methodological 'solution' to the 'problems' that (given his premises) sociological accounts resemble common-sense accounts and that coroners' categorisations resemble members' categorisations. Atkinson's sole recommendation for research and his own, final, programme is a focus on members' methods for repairing indexical expressions.* (1978, 182). He distinguishes this task from Douglas' mere interest in collecting more and more 'indexical particulars' or details. Perhaps Baechler's study (1979) would be seen by Atkinson as yet more 'indexical particulars'.

How categorisations are made (by coroners or anyone) is, then, a matter of 'repairing indexical expressions' i.e. constituting indexical expressions as objective expressions and thus creating a practical and (for members) unproblematic social order. The empirical task is an investigation of how this is done: which Atkinson does not actually do, ending as he does on a programmatic note.

Atkinson's work will be discussed again in more detail. It is sufficient at this point to say that Atkinson's formulation of the problem is interpreted in the present study as follows: how does society, or social phenomena, acquire objective facticity; how are coroners' categorisations about what-really-happened possible, and how are they achieved; how are suicides, or other

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* Despite the obscurity with which it is usually associated, the notion of "indexicality" appears to be fairly straightforward. "Indexical" denotes the particular, the context-bound, the not-yet-ordered potential strands of social life. "Members" (people) render the "indexical" as "objective": they "repair" or "remedy" the "indexical" for the purpose of normal social life. Ethnomethodology concentrates upon this achievement of rendering the "indexical" as "objective". This has some parallel with reification, although perhaps not for ethnomethodologists.

'sorts of death' constituted as practical facts; how are objective context-free statements by coroners about their work made, and what relation do these statements have to the particularities of death?

Douglas (1967) will be discussed below at more than one point. For the moment, it is enough to briefly summarise his approach, particularly in relation to that of Durkheim (1970).

Douglas argues that Durkheim was not engaged in a monolithic positivist exercise: Durkheim's study of suicide was a synthesis of the methods of nineteenth century moral statisticians and the methods of (what Durkheim saw as) science, the result being far from systematic.(Douglas 1967, 15-22). Further, Douglas argues that an emphasis on social meanings is in fact to be found in Durkheim's study:

> ..... Suicide remains the best sociological work on suicide, primarily because of the ideal of scientific investigation of social phenomena which it is built on and because in the final analysis it broke with the positivistic tradition of research on suicide, the tradition which was so antithetical to the treatment of suicide as actions caused by social meanings.
> (Douglas 1967, 76 emphasis in original)

Douglas' reading of Durkheim, as this passage suggests, does seem to be widely misunderstood. Indeed, it is a puzzling reading. Durkheim's break with the "positivist tradition" is by no means self-evident and it is not clear where his explicit interest in social meanings is to be located. Yet Douglas saw shared values, sentiments and morals as "social meanings" in Durkheim's work, and suggested that Durkheim saw these as causes of suicide (Douglas 1967, 41-42). The term 'causes' seems unfortunate. Douglas talks of Durkheim moving toward a theory "in which the social meanings of behaviour are the ultimate determinants of suicide." (Douglas 1967, 42).

To postulate with Douglas (and, according to Douglas, with Durkheim) that social meanings cause or determine suicide is an extremely abstract notion which at most can be expressed as an ultimately trivial statement (that the meaning of suicide defines what suicide is).

Douglas so far seems to be another Durkheimian sociologist of suicide. Yet he is not. Douglas' criticisms of "official statistics" are of course highly important. So too are Douglas' comments on the status of Durkheim's theory:

> Certainly there is the greatest attention to statistical data in Suicide, but this careful consideration of data came after the general ideas about society and suicide and, in his argumentative approach to the data, Durkheim bends the data to fit his preconceived theory.
> (Douglas 1967, 25).

Durkheim took for granted the meaning-of-meanings, and used this assumed knowledge to support generalisations about suicide and society. He

> ..... relied upon his own common-sense knowledge of social action in European societies to provide most of the superficial meanings of the associations.
> (Douglas 1967, 68)

a point consistent with the comments of Walsh (1972).

Moving on from Douglas' comments on Durkheim, it is useful to identify Douglas' prescriptions for empirical sociological work. These, however, are not altogether clear.

Douglas acknowledges a debt to Weber, noting in passing that empathy, interpretative understanding and subjective meaning remain sociologically heretical notions (1967, 235-237). The relation between language and meaning is noted, and the important point made that there is no single social meaning of suicide: the meanings involved in constructing a 'suicidal situation' are numerous. However, Douglas maintains that members involved in

some way with suicide tend to agree on the appropriate meanings, constructing a "structure of meanings" drawn from the wider culture and past interactions (Douglas 1967, 253).

The implication may be that for coroners, police officers, doctors, relatives and sociologists the meaning of suicide is non-problematic. It is <u>obvious</u>, both to the officials concerned, and to the positivist sociologist. Yet for the non-positivist sociologist, meanings are problematic,* and Douglas gives no clear indication as to how they can be investigated, beyond an abstract programme:

> ..... we must work from the clearly observable, concrete phenomena upward to abstractions about meanings in any culture ....., and the abstractions must be the results of comparisons made by sociologists of the concrete meanings of these phenomena defined as <u>similar</u> by the members of the culture (Douglas 1967, 253-4, emphasis in original)

Possibly this vague recommendation has some relation to Atkinson's prescription for research. It has been interpreted and practised in a different way by Baechler (1979), with some success (although with a relevance for <u>sociology</u> as yet undetermined). Indeed, Douglas' programme is open to any number of interpretations.

It is fair to say that neither Atkinson nor Douglas proceed with the sociological work that they prescribe. It is also reasonable to say that their prescriptions are vague. More importantly, the point can be made that their extensive criticisms of positivist research can be turned back to some extent upon their own studies.

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* It is, of course, necessary to distinguish the socially problematic from the sociologically problematic.

In the present study, an attempt is made to adhere to the stated theoretical and methodological framework: internal consistency is seen as an important factor. The sources from which the research material has been derived have already been briefly mentioned, and are listed in more detail in the Appendix. Some preliminary discussion of these sources can usefully be conducted, however, before proceeding with the study.

The sources were:

observation of fifty inquests, with and without juries, at a single coroner's court;

additional observation at other inquests;

semi-structured interviews with the coroners of five Northern counties;

additional informal interviews with certain coroners, police officers, and anyone who had an interesting account to offer;

analysis of records, over a fifty-year period, in a single coroner's office;

analysis of national statistics derived from coroners' returns to the Home Office, obtained from both published and unpublished sources, and with particular attention to the fifty-year period (1926-75) covered in the local statistical search, plus suicide statistics up to 1980;

published research, largely, although not exclusively, in sociology;

the informal observations, conversations and note-taking

which necessarily accompany research fieldwork e.g. observations made before and after inquests, conversations with coroners' officers while studying coroners' records, and so on.

All these sources yielded substantial qualitative material. The positivist might not be happy about the nature of the material: interviews with coroners, for instance, although based on pre-set questions, were allowed to follow the course of natural conversation, rather than being limited by a multiple-choice answer system or a coding framework. Equally, ethnomethodologists would be perhaps unhappy that the interviews were not recorded on tape: they were recorded by personal notes only, in the interest of encouraging a frank expression of views. There was no interest in examining the structure of the language used by coroners in answering a question. The particular research methods adopted were chosen on several grounds. Firstly, they were designed to yield as much material as possible relating to an unresearched area of activity. Secondly, they were designed to be as unobtrusive and unstructured as possible, while still retaining rigour and form. Thirdly, and most important, they were designed to be consistent with the stated tasks of the research and the explicit theoretical orientation. Large-scale survey methods were not used: nor were any methods which might have distorted the object of study.

Any methodology presupposes and embodies a theoretical base, a world-view, a conception of the task at hand, and a notion of how to achieve it. Objections to any methodology cannot be based on whether its presuppositions match those of the reader, but only on grounds such as whether the theoretical base can be established to be misconceived; whether the methodology is non-coherent or

inconsistent; whether the research objective is unrealistic; whether the methods are unrelated to the aims; or whether there are hidden presuppositions which are never made explicit. In the present study, the research process is made as visible as possible.

Inquests attended, coroners interviewed, and the period of time studied, are taken to be representative. A sociologist, necessarily, does not study the entire social world. Nor does the sociologist study his small part of the social world in order only to draw conclusions about that small part. Sociologists of every theoretical hue necessarily assume, provided that their work is reasonably carefully done (and often even when it isn't), that their conclusions have an application wider than their specific study literally allows. This might be clearly the case in macroscopic positivist or Marxist sociology, but is equally a feature of ethnomethodological studies of the minutae of everyday life. The permissibility of endowing particular research material with general significance must be judged in terms of the internal dynamic of the particular research. In the present study, an attempt is made to form conclusions as part of a visible process open to view.

An underlying methodological problem is the extent to which the practice of research itself constitutes the 'object of study'. The sociologist who rejects the idea of an external objective world to be explained must be aware that his own activities may 'create' what is the object of study.

Blum's comment is highly pertinent:

> ..... it is easy to see that the methodical character of marriage, war, and suicide is only seen, recognized, and made possible through the organized practices of sociology. These regularities do not exist "out there" in

> pristine form to which sociologists functionally respond, but rather they acquire their character as regularities ..... only through the grace of sociological imputation. Thus, it is not an objectively discernible, purely existing external world which accounts for sociology: it is the methods and procedures of sociology which create and sustain that world.
> (Blum 1970b 336).

On one level, Blum has indicated the problem of reification: an avoidable problem. More fundamentally, Blum has posed the question of whether sociologists not only record, but also generate, their data. A reflexive sociology can, by turning its analysis back upon itself, transform the problem of the generation of data into a resource: but a reflexive sociology can also develop into an unproductive sociology-of-sociology where, narcissistically, its only data is itself. This is a difficult issue. It is one, inevitably, to be reintroduced at a later point in the discussion.

So far, the theoretical, and methodological, features of the study have been outlined, and situated in relation to some existing sociological studies and issues. Something can usefully be said at this point about the problem of "official statistics".

1(4) The Problem of Official Statistics

A discussion of official statistics clarifies some general methodological problems. It is also a necessary preliminary to our later detailed discussion of the statistics of coroners' work.

Bradshaw examined the "ongoing social organization" of suicide by considering the links between the structure of the rate-producing agency (the coroner's office) and the data produced by that agency (1973,4). Bradshaw's hypothesis is that

official statistics about suicide are systematically "biased", and therefore of no use in testing sociological theories which posit a relation between suicide and, for instance, social integration or anomie (1973, 32). Bradshaw appears to postulate that the statistics of suicide are "biased" when measured against some real, or true, rate of suicide. Our first observation, of course, must be that this is a speculative assumption. Against which absolute yardstick is bias to be measured? Bradshaw presupposes an agreed concrete definition of suicide, yet surely there are <u>many</u> levels, not one, on which the alleged real rate of suicide is to be discerned: the commonsense level of meaning; the coroner's level of meaning; the reclassifications of deaths in the work of psychiatric researchers like Barraclough (1974); or the level, say, upon which a Catholic clergyman would estimate the prevalence of suicide. Bradshaw adds another reclassification, and thus performs, essentially, the coroner's task. To attempt 'better' coroners' categorisations seems to be a sociologically rather dubious enterprise. In any event, it is not one which concerns us in the present study.

In expressing extreme scepticism about the existence of one real suicide rate (on practical as well as philosophical grounds) it should not of course be suggested that coroners indulge in a process of capricious labelling, or that any guess about suicide rates is as good as any other. For specific practical purposes, some classifications of suicide <u>are</u> 'better than others'. For our purposes, the question is entirely open: suicide exists, as experiential fact, as organisational product, as practical, statistical, fact, but if one, real, suicide rate somewhere exists, it is both in practice and in principle unknowable. Insofar as it exists on a level of 'unknowable truth',it does not interest

us here. In terms of studying what coroners do, suicide can be assumed to be what coroners say it is.

Bradshaw, incidentally, failed to prove his hypothesis in his own terms. He reclassified accidental, natural or undetermined deaths which could ('really') have been suicide (Bradshaw 1973, 155). Further, for Bradshaw social meanings were unproblematic: they were shared and understood in relation to suicide (1973, 189). Thus the researcher, we gather, need not be delayed by even Douglas' moderate critique.

In the present study, bias and error are not regarded as sensible topics of interest. Kitsuse and Cicourel's early statement of the difficulties inherent in using official statistics in sociology (1963) is seen as having continued relevance. For Kitsuse and Cicourel, sociologists' reservations about official statistics have been of a superficial kind:

> That is, the 'unreliability' is viewed as a technical and organizational problem, not a matter of differences concerning the definition of deviant behaviour.
> (Kitsuse & Cicourel 1963, 134: emphasis added)

Kitsuse and Cicourel's objections were more fundamental:

> ..... insofar as the definitions of deviant behaviour incorporated in the official statistics are not "sociologically relevant", such statistics are in principle "inappropriate" for sociological research.
> (Kitsuse and Cicourel 1963, 134: emphasis in original)

Thus, the sociologist can be concerned with the production of rates, or he can continue to be concerned with the aetiology of whatever behaviour he is studying. However, if he is studying the latter, 'rates' cannot be assumed to tell him anything useful about it.

Of course, within the sociology of deviance, this early

statement of the problem has been influential. Cicourel's own study of juvenile justice in the U.S.A. is an outstanding example of a rate-producing agency in operation (1968). Yet Kitsuse and Cicourel's argument has not been universally accepted. Hindess, for instance, engages in a polemical defence of official statistics, via a critique of ethnomethodology which he takes, puzzlingly, to be represented by Douglas and Cicourel (Hindess 1973).

Hindess' central argument is that ethnomethodology renders official statistics unusable and, moreover, renders the social world absolutely unknowable. The logical necessity for a background account of the sociologist's account, and an account of that account, ad infinitum, makes the ethnomethodological position absurd. The implication is that official statistics may as well be used, as no 'facts' are otherwise available. In short, ethnomethodolgical criticisms:

> ..... may be directed against the objectivity of official statistics but they would dispose of the objectivity of all knowledge.
> (Hindess 1973, 12).

Yet it is not clear that Hindess understands either positivism or ethnomethodology when he asserts that both

> ..... are united in the complicity of a common conception of knowledge as reducible to experience.
> (1973, 10).

Miles and Irvine present a further Marxist critique of official statistics (1979). They point to the "monopoly power" of the State in both the "production and dissemination" of statistical information, this monopoly having the consequences that, firstly, certain sorts of data appear in official statistics, reflecting the needs and justifying the programmes of State

agencies and, secondly, that the concepts and categories embodied in the statistics are ideologically specific.(Miles and Irvine 1979, 113). Miles and Irvine are critical of the view that the only limitations of official statistics are technical ones (1979, 114): a similar point, it seems, to that of Kitsuse and Cicourel (1963), but with rather different implications, i.e.

> We shall argue that official statistics present not a neutral picture of British society, but one developed in support of the system of power and domination that is modern capitalism ..... (Miles and Irvine, 1979, 114-115).

Miles and Irvine comment on the value of the phenomenological critique of official statistics, but imply that a sociological critique, notwithstanding its value in effectively challenging empiricism, does not amount to the necessary socialist critique:

> For while the phenomenologists have demonstrated the social nature of official data, they often allow the flourishes with which they have pronounced their views to be the finale of their analysis. They have tended to replace the empiricist view of official statistics as objective facts by a perspective treating them solely as subjective judgements reflecting the social reality of individual and organisational decisions and definitions. But individual experience is constituted within social structures - structures that themselves make possible and delimit individual and organisational practices. (Miles and Irvine, 1979, 117).

It is difficult to take issue with this. Organisational decisions indeed occur in a structural context. The coroner does not work in a political or social vacuum. Certainly, ideology is of relevance in understanding the production of sudden death.* Yet the coroner is not concerned with social control in the <u>same ways</u> as police, judges or legislators. His concern is with control of a different order. Further, ideologies of medicine

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* See Chapter Six

and death are related to social structure, and the demands of the State, but not in a way which permits the sensible application of a straightforwardly Marxist analysis. Although Miles and Irvine make a plausible case in their analysis of unemployment statistics (1979, 120-121), it is not easy to see how exactly the same analysis might be applied to sudden death statistics - unless the aim was to focus on, say, industrial deaths, or deaths in police or prison custody, in an explicitly macropolitical way. However, when the aim is to analyse the production of sudden death as a whole, the perspective must be wider.

As official statistics have been so thoroughly criticised from a number of different directions, one might wonder why Durkheim appeared to regard them as fairly unproblematic. Douglas suggested six principal reasons: (1967, 165-166):

a) Durkheim held that the stability of suicide rates denoted an underlying social law;

b) The laws governing suicide could be revealed by inter- or intra-national comparisons of suicide rates;

c) The analysis of statistical rates was a necessary element of the macroscopic theory of suicide which sociology offered as an alternative to individualist (psychological/ moral) theories;

d) As suicide is statistically rare, the sociologist interested in a general theory must turn to the records of large numbers of suicides i.e. suicide rates;

e) The use of official statistics in the formative period of sociology became the general example of how to practise sociology;

f) Official statistics are readily available: they remove the need to collect material in the field.

The factors which account for Durkheim's use of the official statistics of suicide are of course quite compatible with the epistemological and practical concerns of a positivist sociology.

Douglas' critique of official statistics in sociology remains important. He notes that the definitions of suicide used by those who compile the rates may have no relation to the definitions and categories which interest the sociologist: the sociologist who uses official statistics to build theories implicitly accepts the definitions used by officials (Douglas 1967, 169). Moreover, even where the sociologist is aware of definitional problems, the background assumption might still be retained that suicide is a 'thing', more-or-less easily recognisable as being 'a suicide', and that the statistics form a more-or-less reliable source of information about this feature of the world called suicide (Douglas 1967, 170).

The crux of Douglas' argument is that "systematic variations in the meanings of suicide" exist, that these undermine any conception of the suicide-rate as an indicator of how-many-suicides-happen, and that the sociology of suicide, traditionally conceived, has neglected these problems (1967, 178). Suicide is not a phenomenon with one discoverable meaning, it is a term applied to a range of phenomena and meanings. Douglas is worth quoting at length here:

> ..... the meaning of suicide changed throughout the nineteenth century among the psychiatrists..... it went from being a form of insanity to being a form of irrational behaviour and, to some, even a form of rational behaviour. It went from being an act that could not possibly be intended .... to being one that was intended. It went from being an act of whose consequences the victim could not

possibly have knowledge to an act that involved a clear idea of the consequences involved ..... If the formal definitions of suicide among the intellectuals were so complex, so varied, so inconsistent, so changing, what were the meanings of suicide among the many different subcultures of Europe on the common-sense level of thought at which most of the doctors, coroners, official statisticians, families of victims, etc. worked in deciding whether or not a death was a suicide? (1967, 178-179).

Douglas adds that to locate a death within the category 'suicide' is not only to describe that death: it is to explain it (1967, 189). Atkinson makes a similar point (1971, 183). The coroner is engaged in the same enterprise as Durkheim: to explain suicide, to account for why-it-happened. The sociologist who uses the official statistics to construct theories of suicide, however, is theorising about theorisings: his is a second-hand enterprise.

It was suggested above that Douglas' characterisation of Durkheim's theoretical position was rather curious. Douglas' attitude to official statistics is also somewhat curious, for although his arguments might imply that the statistics of suicide cannot be used as a basis of sociological theorising, he proceeds to list sources of 'unreliability' in the statistics - which produce 'bias' in the 'testing' of sociological theories - thus implying the possibility of removing 'unreliability' (1967,203). The issue is whether official statistics are characterised by technical problems of reliability and unreliability: or whether official statistics are inherently inappropriate for the purpose of constructing (causal) sociological theories. Douglas never successfully distinguishes these two positions.

Atkinson pointed to this weakness in Douglas' analysis, and made the point that, for Douglas, a 'real' rate of suicide 'out there' does, after all, exist (Atkinson 1978, 65). Yet the point must also be made that Douglas' work was of central value in helping to establish the critical perspective on official

statistics in sociology. It is important to remember this, for an entirely uncritical approach to official statistics still flourishes.

Gibbs, for instance, discusses 'unreported' suicide, 'overestimation' of the 'incidence' of suicide, and so on, eventually concluding that although it is a "virtual certainty" that the suicide rate is not "absolutely reliable", it is to be regarded as "relatively reliable" (Gibbs 1968, 14). Gibbs points to no theoretical issue which precludes the use of official statistics in sociological grand theorising. Even Hindess claims that, in evaluating the work of Douglas and Cicourel, "..... no theoretical problems of any substance are raised by their arguments". (1973, 10). Goudsblom points to the "firm empirical basis" in Durkheim's study of suicide, deriving from his use of official statistics: "These were the facts which he tried to analyze without moral or emotional bias" (Goudsblom, 1977, 41). Goudsblom concludes that:

> In many ways Durkheim's study is still a paradigmatic example of sociological research based on officially-documented facts. (1977, 42)

The critical perspective on official statistics in sociology is by no means universally accepted. The issue, of course, is complicated for one may be 'critical' in different ways.* The present study as a whole attempts, amongst other things, a critique of the statistics of sudden death. Connerton's characterisation of the Frankfurt School's notion of 'critique' is useful here, i.e. critique as "oppositional thinking, as an activity of unveiling or debunking" (1976, 16-17); critique as an investi-

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* Taylor summarises four distinct positions adopted by sociologists in relation to the use of official statistics (Taylor, 1982,50).

gation of the conditions of possible knowledge; and critique as an investigation of constraints, distortions, and illusions (1976, 17-18).

The first choice is whether or not to use official statistics at all. If they are to be used, the choice is between using them as more-or-less reliable measurements of whatever they supposedly measure (e.g. 'incidence of types of sudden death') or using them as reliable records of the activities of rate-producing agencies. The important choice is in deciding <u>for what sociological purposes</u> official statistics are to be used.

The choices have theoretical and methodological underpinnings: and consequences. An attempt is made throughout the present study to render these explicit, visible, and open to discussion.

The present section of the study has been confined to an introduction to the topic of official statistics, not to a final resolution of the problems. In Chapter Five, specific statistics produced by coroners are examined, and the discussion resumed. The discussion of official statistics is concluded in Chapter Seven.

The final substantive section of the present chapter introduces some basic problems of sociological description and discusses, in particular, the contrasting nature of sociological understanding and sociological explanation.

1(5) <u>The Problems of Sociological Description and Understanding</u>

Sociological description, interpretation and understanding are all problematic terms. The aim of the present section of the discussion is to briefly explore some of the more problematic issues. An excellent starting point is Sacks' early paper (1963) on sociological description, itself inspired by a reading of

Durkheim's study of suicide.

If sociology is a science, this implies that literal scientific descriptions are being produced by sociologists. Sociology, however, uses a language to describe its subject-matter, and this language (as a tool of description) must itself be described (Sacks 1963, 2). Further, the sociologist (usually) knows the language of the members he studies, selecting the categories of his proposed description from this familiar language and the familiar things it describes. Sacks wished to render this taken for granted process of sociological description "strange" (1963, 1).

Language embodies descriptions. Sociological descriptions can be seen as descriptions-of-descriptions, akin to the second-hand theorisings-upon-theorisings which we noted above as a characteristic of positivist uses of official statistics. Yet Sacks' problem is not so easy to resolve, for if language is problematic, the object of study and the apparatus required for its study become identical. The solution lies not in an attempt to transcend natural language, but in a transformation of the problem into an imperative i.e. to view sociology's task as the production of descriptions of members' descriptions of what is taken to be the social world (Sacks 1963, 7):

> That persons describe social life (if they can be conceived as doing so) is a happening of the subject quite as any other happening of any other subject in the sense that it poses the job of sociology, and in contrast with it providing a solution to sociology's problem of describing the activities of its subject matter.
> (Sacks 1963, 7).

Importantly, descriptions cannot be complete, as a limitless number of "indexical details" might be elaborated. Thus the sociologist is obliged to add an "etcetera clause" to "permit

the description to be brought to a close". (Sacks 1963, 10). Possibly Sacks' concern with the "etcetera" problem was excessive: after all, incomplete descriptions may nevertheless be adequate, sufficient and, for all necessary purposes, comprehensive. This is the view taken in the present study. This does not imply, of course, that generalised descriptions should then be immediately constructed, and the description reified into what it is describing.

The distinction between the correspondence and congruence models of reality is relevant at this point.* The correspondence model assumes a differentiation between experience/perception of the world and what is really there: objects-in-the-world, then, have an objective, independent existence. Descriptions get 'better' as they correspond more closely to the thing-out-there: a literal, complete description would be the best description of all.

In contrast, the congruence model treats the 'perceived' object and the 'real' object as synonomous. A complete description would literally be endless. The congruence model clearly offers more, in terms of the aims of the present study, than the correspondence model. It does, however, imply problems for the possibility of description.

A stated aim of the research is a general description of coroners' work. This description can be adequate for present purposes, if necessarily incomplete. The latter-day ethnomethodologists' solution to the problem (turning to the microscopics of everyday life) has been rejected. Yet the status of the sought-for general description must be clarified, if it is to be

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* Deriving from Garfinkel, this distinction is usefully summarised by Atkinson (1978, 176-180).

distinguished from the generalised descriptions produced by positivism.

The general and the generalised description must be differentiated. The latter embodies reification, abstraction and objectivication absent from the general description. Moreover, the generalised description necessarily also 'explains', and imputes causality, in the context of a correspondence model of reality. Further, generalised descriptions are produced from theoretical and methodological bases left unexamined. More must be said of the nature of 'sociological explanation'.

It must however first be made clear that the status of descriptions remains problematic. So do most of the terms in common use.* The problem of language means that pre-descriptive 'descriptions' occur.**

To what extent descriptions are related to understanding and explanation is also contentious. However, the bases of sociological understanding, and how this might diverge from attempts at explanation, can profitably be explored.

Dallmayr and McCarthy (1977) discuss the development of verstehen, or interpretative understanding, in sociology, as a concept which throws light upon understanding and explanation. The latter two approaches came into conflict during the Enlightenment (Dallmayr and McCarthy 1977, 2). Positivism

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* Ford (1975) lightheartedly placed all problematic sociological terms within question marks, thus, ¿social world? ¿reality? ¿suicide?, highlighting their unresolved nature, their conditional status. Sudden death, the social world, etc. in the present study would ideally occur as 'sudden death', 'the social world', etc. throughout. But this continued use would be untidy and ultimately trivial.

** Conversation analysts in ethnomethodology seem to suppose that language is transcended, by being both subject and apparatus. This is most unsatisfactory.

subsequently reinforced the attack of 'scientific explanation' in place of 'understanding': all disciplines were obliged to adopt a natural-scientific method, or face "extinction" (Dallmayr and McCarthy 1977, 2). Dallmayr and McCarthy talk of "the claim of empirical science to absolute supremacy" (1977,3), with implications for psychology and philosophy as well as sociology. One might add that the positivists in sociology misunderstood the 'natural science method' they assumed they were adopting (Keat, 1979, 80).

Weber re-emphasised understanding in social inquiry. Natural and cultural sciences were for Weber quite separate (Dallmayr and McCarthy 1977, 4). Although Weber's work is open to numerous conflicting readings, the ideal of <u>verstehen</u> remains of lasting importance in sociology.

Positivist sociology has, of course, incorporated Weber's 'types of authority', 'social action', and so on, into its social systems, just as it has reduced Marx to a 'conflict theorist' who has given us 'social class', or Mead as a social psychologist who contributed the 'I' and 'me'.

Linguistic analysis and phenomenology challenged positivist modes of explanation. 'Understanding' was re-cast. Linguistic analysts emphasised the social nature of human action, the transformation of meanings into expressions through shared language, the understanding of action in terms of language. Winch drew from both Wittgenstein and Weber, approaching meaning through language, if criticising what he saw as Weber's over-subjective perspective (Dallmayr and McCarthy 1977, 7; Winch 1958).

Husserl's phenomenology, as a rejection of empiricism, focussed upon the <u>epoché</u> of phenomenological description and understanding i.e. the <u>suspension</u>, the grasp of the essence (eidos)

of the phenomenon. Thus eidetic understanding. Schutz adapted Husserl in the attempt to create a phenomenological sociology and, importantly, incorporated a non-positivist reading of Weber.

> ..... Schutz tried to effect a merger of Weberian sociology and Husserl's teachings by tracing the notion of meaningful social action to an underlying stratum or stream of constitutive consciousness. (Dallmayr and McCarthy, 1977, 10).

This occurs within the natural attitude. Schutz tended to devote more attention to the elaboration of Husserl's 'mundane' understanding than to 'eidetic' understanding proper: an emphasis even more readily developed by ethnomethodologists.

A more detailed discussion of Schutz's sociology, and its philosophical inspiration in Husserl, is useful in tackling the problems of description and understanding.

As a philosophical method, phenomenology arose as a challenge to the hegemony of empiricism, and the claim of positivism to be <u>the</u> mode of scientific inquiry. Husserl's work was also a challenge to nascent psychology and its attempt to render intellect the product of virtually mechanical processes (Dallmayr and McCarthy 1977, 219). Husserl was concerned with how the world is known. To 'get close' to the nature of knowledge, Husserl propounded the suspension, the bracketing-away of presuppositions to do with causation or explanation. Husserl referred to 'universal essences', taking account of the fluidity of the social world, he introduced 'mundane''descriptive psychology' too: hence the mundane and eidetic levels of description and understanding.

Husserl was not interested in creating a sociology. Yet any discussion of a phenomenological sociology must refer to Husserl, to its philosophical roots. The question arises of whether a

phenomenological sociology is possible. It is assumed that polemical writings on the impossibility of such a sociology may legitimately be dismissed (e.g. Bauman, 1973, 1976). However, such critics may be correct to suggest that sociologists often crudely misunderstand phenomenology. Hence, we briefly return to Husserl.

Experience is objectified only by the intentional acts (including thought) of individuals. Objects are objects 'only' insofar as they have been constituted as objects by individuals. The social world is a shorthand term for experiences and patterns of meanings constituted as 'the social world'. Phenomenology aims to describe this world without the presuppositions of empiricism. Koestenbaum (in the introduction to his translation of Husserl's Paris Lectures' (1964))picks out five key elements of Husserl's phenomenology:

a) The epoché: an attitude, aimed toward a pre-suppositionless description of experience. Theories (including the theory that the 'object' has some objective, independent existence) are suspended, bracketed-off. At the crudest level, this translates into a sociologically sceptical attitude.

b) Intentionality: the non-abstract nature of consciousness and experience. Consciousness is 'of': experience is 'of': consciousness and experience without this link of intentionality are meaningless. Further, the object of (my) consciousness is constituted by me: "..... objectivity is a function and project of the subject." (Koestenbaum, 1964, XXVII).

c) The transcendental ego and the 'reduction': by the 'reduction' (crudely, another form of the epoché), the 'transdental ego', the pure subject, the 'I', is made visible. The

transcendental reduction brackets away everything, leaving the ego.

d) Intersubjectivity: by bracketing the apparent objectivity of the other, the other takes on meaning as experience, not as object. Empathy in an extreme form (the interaction of subjectivities) is central here, and of major sociological significance.

e) Essences: logic is the science of objects, seen as essences: "eidetic science" (Koestenbaum 1964, LXIII). Logic refers to experience, not signs or symbols.

The summary above may place in context talk of a phenomenological sociology. It is only a partial summary. It is simple enough to refer further to Husserl (1970) or to some of the more interesting elaborations (e.g. Elliston and McCormick 1977).

In Schutz's sociology, intentionality and intersubjectivity remain crucial elements. However, Schutz was more concerned with the way in which the social world might be investigated than with pure descriptive logic.

Schutz noted that sociologists who rejected the received version of natural science as a model for sociology largely floundered in over-generalisation and an insubstantial theoretical base (1954, 258). His programme was to develop an alternative sociology (drawn from Husserl and Weber) which did not collapse in this way. Schutz put forward the following propositions:

a) The aim of sociology "..... is to obtain organized knowledge of social reality" (Schutz 1954, 261). Social reality denotes the experiential sum of interacting individuals: a shared, experienced world.

b) Empiricism, naturalism and positivism take for granted precisely those elements of social reality which, for Schutz, are problematic.

> Intersubjectivity, interaction, intercommunication, and language are simply presupposed as the unclarified foundation of these /empiricist/ theories. (1954, 261)

c) Experience, in Schutz's terms, cannot be equated solely with sensory observation (Schutz 1954, 262-263).

For the normal purposes of everyday life, commonsense knowledge of social reality is adequate, and is a reality experienced as having meaning. Moreover, others are experienced not as objects, but as action and experience (Schutz 1954, 263-264). Interactional social reality is necessarily inter-subjective, organised by the routine application of empathic understanding.

Schutz talks of the "common-sense experience of the inter-subjective world in daily life" as understanding - as verstehen - constituting the "first level construct" of social life upon which sociology builds "second level constructs" (1954, 269). Just as first-level constructs refer to the subjective meanings of actions, so too must the sociologist's second-level constructs. This is the point at which Schutz's thought particularly resembles that of Weber (Schutz 1954, 269-270) and sociology's second-level constructs can also be seen to resemble the descriptions-of-descriptions of Sacks (1963).

Upon this basis Schutz maintains (with Husserl) that general patterns, principles or forms may be identifiable, revealed in the particular. Further, this may be verified: phenomenology is not an esoteric form of guesswork. The broadly phenomenological method is internally rigorous.

In this section of the discussion, then, some problems of sociological description have been outlined, and it has been argued that general descriptions are defensible and possible. The aim of (adequate, if incomplete) description - i.e. under-

standing - has been distinguished from explanation as conventionally understood in sociology. Finally, the elements of phenomenological sociology have been briefly outlined, together with a review of its philosophical base. The discussion as a whole provides the foundation for proceeding with the research study.

1 (6) Summary and General Points

In sum, the aim of the study is to describe, and provide the basis for understanding, the work of coroners. More specifically, the processes whereby deaths are reported to coroners, dealt with organisationally, categorised, and finally 'settled' as statistical records, are studied, using material derived from interviews, observation and statistical analysis.

Crudely, it is a study of what coroners do. The present chapter has situated the study in relation to the major existing sociological work in this area, and also situated the study in its methodological and theoretical context. An attempt has been made to render the methodological choices and the theoretical framework 'visible': open to inspection. The theoretical inspiration is phenomenological although it cannot be judged, at this point, whether the research constitutes'a phenomenological study'. Schutz, Husserl, Weber and Mead are regarded as central figures in the attempt to produce any heuristic descriptive sociology. A brief explication of the positivist enterprise in sociology has been provided, together with some criticisms, but the present study would not claim to be anti-positivist. It is simply not interested in the questions traditionally asked within positivist sociology, nor in its methods.

It has been argued that descriptions based upon the present research can legitimately have the status of general descriptions.

It is possible that such general descriptions can be located within a structural or ideological context. The 'sociology of suicide', and criticisms of official statistics in suicide research, will be frequently referred to, but the study is not a study of suicide, nor a study of coroners' decisions about suicide in particular. It is a study of how coroners produce the available facts of sudden death.

The theoretical label that is attached to any piece of research is ultimately of minor importance. Curious muddles can arise from the indiscriminate use of ostensibly informative terms. Douglas' adventures into 'everyday life' are an example of a muddle (1973). Elsewhere, Douglas variously presents himself as an interactionist, phenomenologist, ethnomethodologist, existential sociologist, humanistic sociologist and, possibly, more. More important than the label is the theoretical base and its relation to methodology and the objectives of the research.

The present chapter has aimed only to introduce issues, not to finally resolve them. Theoretical issues and problems underly the whole study. For instance, Cicourel (borrowing inspiration from Schutz) noted that interviews must be based in a necessary community, the common scheme of reference (1964, 79). Every interview is a unqiue event in which the sociologist generates the patterns he 'finds' (Cicourel 1964, 81). For the present purposes of the study, this does not imply that interviews are without value. It means simply that interviews are not what they are assumed to be by the positivist and that they yield material about sociology itself in their 'results'.

Problems of meaning also arise in the observational area of research. Decisions about what to observe; how to conduct observations; how (and when) to record observations; how to

properly draw conclusions; and so on, can all be regarded as problematic. To be engaged in observation is also to be involved in interaction. Becker's point that the results of essentially qualitative field research tend to be accepted as a matter of faith in the sociologist concerned must be remembered (1971, 26). The solution in the present study is to make observation, argument, rationale, theoretical perspective and conclusions as visible as possible. This must be done in such a way as to accommodate the reader who disagrees with the conclusions reached. Enough reliable clues about how-it-was-done (which is not simply a technical recital of research methods) must be provided to allow another sociologist to do a similar study. This is not a reference to the repeatability of natural-science experiments. No sociological study can be repeated: the same observation, for instance, can never be done again. Provision can be made, however, for any practical attempt to carry out a similar study.

Statistics are used as descriptive records of coroners' decisions. Historical or regional variations in the statistics of sudden death are assumed to denote variations in coroners' practice. The use of statistics is perhaps the least contentious area of field research, provided it is understood that they are used as a qualitative resource. Statistics indicate features of the assembly of sudden death as a meaningful category. Cicourel pointed out that even apparently straightforward demographic facts, like birth or death,

> ..... assume relevance within the context of the everyday and organizational terms under which they were assembled, and the sociologist must often be prepared to study these everyday and organizational conditions. (1964, 140).

The present study examines some established problems in sociology, such as the problems of description, official statistics the processes of rate-production, and attempts to contribute to their understanding. The more specific rationale of the study has several elements. Firstly, although birth and death could be regarded as the most crucial sociological events, little is known of the sociological processes involved in the handling of sudden deaths: about one-fifth of all deaths in England and Wales. Secondly, the unqiue legal-medical office of coroner, and the considerable power associated with the post, has not been subject to any serious sociological attention. Thirdly, little is known on the most basic level of what the coroner is and does. Fourthly, an understanding of the coroner's work is central to any understanding of the routine and bureaucratic handling of death in industrial death. Fifthly, a range of other 'rationales' could be listed: the inquest (as a court of law) bears interesting comparison to its better known fellow institutions in the legal system proper; changes in the 'suicide rate' may be accounted for by changes in coroners' practice in recording suicide verdicts; and the informal, practical pattern of coroners' work may diverge from the formal procedural model.

Chapter One has been concerned with laying the foundations for presenting and discussing the material collected in the course of research. Chapter Two is concerned with providing another sort of foundation, by tracing the historical development of the office of coroner from its origin to the present day. Major legislation, and major formal changes in coroners' responsibilities, will also be outlined. An understanding of the history of the work of the coroner is a necessary precondition for an understanding of his present role.

A final reminder of our theoretical perspective can be taken from Sacks (1963, 10-11):

> The emergence of sociology will take a different course (when it emerges) from that of other sciences, because sociology, to emerge, must free itself not from philosophy but from the common-sense perspective. Its predecessors are not such as Galileo had to deal with, but persons concerned with practical problems, like maintaining peace or reducing crime. The 'discovery' of the common-sense world is important as the discovery of a problem only, and not as the discovery of a sociological resource.

CHAPTER TWO: THE ORIGINS AND DEVELOPMENT OF THE OFFICE OF CORONER

2(1) The History of the Coroner

The title of coroner, and the original duties associated with the post, were devised in 1194 by Hubert Walter, Archbishop of Canterbury, who had remained in England, in a position of considerable authority, when King Richard joined the Third Crusade. The coroner was 'keeper of the King's pleas', the Latin form of which became vulgarised into 'coroner', or 'crowner' (Williams, 1967, 1). Prior to 1194, the duties newly attached to the office of coroner had been the responsibility of county justiciars, sergeants and bailiffs (Hunnisett, 1961, 1). Indeed, some historians (e.g. Gross, 1892, 656-658) have argued that the coroner existed before 1194, and this is still an issue permitting some debate. Nevertheless, it appears to be certain that the title of coroner formally came into being in this year. It is also the case that when the ancient records are reviewed as, for instance, by Waldo (1911), the evidence for the coroner's existence prior to the late twelfth century is obscure. The issue can, for our purposes, be settled by Forbes, in his thorough survey of the early "crowner's quest": "The coronership was established in England in September, 1194." (1978, 5).

The instigation of the office of coroner had some essentially financial elements, for wars were costly, and local administrations in England were somewhat inefficient and corrupt. The coroner did not only arrange inquests: he was also a county court judge and law-enforcement officer. "He was, in fact, a revenue gatherer for the Crown." (Mendoza, 1976, 8). The Report of the Committee on Death Certification and Coroners (hereafter referred to by its

common title of the Brodrick Report) notes that the most important reason for the creation of the office of coroner

> ..... was the need for an official whose primary duty it would be to protect the financial interest of the Crown in criminal proceedings.
> (1971, 107)

The Brodrick Report adds that the early coroner's judicial role was subsidiary to his interest in financial matters and, moreover, that his concern for medical causes of death "was virtually non-existent." (1971, 108).

The medieval coroner's responsibilities were wideranging. He was enpowered to investigate housebreaking, wounding and rape, to hold inquests on the deceased, to hear pleas for sanctuary and to hear appeals and confessions, and to take part in the business of the county court (Hunnisett, 1961, 4-5). The coroner also had powers to levy fines. However, Hunnisett points out that the formal, statutory, model of the early coroner's work is misleading (1961, 5). In practise, the everyday task of the medieval coroner was to hold inquests on dead bodies, and the felonies with which he was concerned were homicide and suicide (Hunnisett, 1961, 5, 9).

Medieval coroners tended to be knights and landowners, but the post was generally regarded as inferior in status (and possibly in terms of material advantage) to that of sheriff (Hunnisett, 1961, 188). The coroner was a direct delegate of the king (Williams, 1967, 2). The coroner was also, however, elected to office (Hunnisett, 1961, 151-157).

There is no agreement amongst historians about the exact nature of the early coroner's work. His duties were undoubtedly far wider in their scope than they are today. In many ways, they were different in kind. "With half his mind he had to pursue the

work of a detective, with the other half that ofatax-collector." (Williams, 1967, 2).

After Ophelia's suicide in 'Hamlet', two rustics discuss the arrangements for her burial. They talk of the "crowner" pronouncing her fit for Christian burial: on the basis of "crowner's quest law."* Shakespeare's reference to the coroner dates from around 1600, when the coroner's importance had already declined considerably. This decline was associated with the rise of justices of the peace, who took over many of the coroner's judicial functions, the decline of appeals, and the abolition of certain fines (Hunnisett 1961, 197). The Brodrick Report notes that by 1500

> ..... almost the sole remaining function of any importance performed by the coroner was the holding of inquests into violent death, but even these no longer had the same importance as in the 13th century. (1971, 111)

To render the post of coroner more attractive, wider groups of people had been made eligible, the "knighthood" qualification was abolished, yet, during the fourteenth and fifteenth centuries,

> ..... extortion had become firmly established, was consistently practised and only rarely punished. The office therefore appealed increasingly to families which were struggling to rise and to the unscrupulous. (Hunnisett, 1961, 189).

More fundamentally (and of continuing relevance) it was becoming clear that the inquisitorial nature of the coroner's court conflicted with the accusatorial nature of other courts of law. In law, no-one is accused at the inquest; there is no prosecution or defence; and the coroner (or his jury) is not interested in matters of guilt or civil or criminal liability. The inquest is formally a 'court of record', and its structure is different from that of other courts. The dangers of conducting

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* Hamlet, Act 5, Scene 1

a de facto trial at the inquest are therefore quite evident. More will be said of this below. It is of relevance to an understanding of the twentieth-century inquest.

During the seventeenth and eighteenth centuries, underlying confusion about the proper scope of coroners' work continued. The coroner's independent existence (separate from medical, legal, judicial and administrative systems) led to practical problems about status and salary, although this independence later became emphasised as a virtue in the investigation of sudden (and possibly suspicious) deaths.

In 1751, an Act of Parliament designed to improve coroners' pay provoked a bitter dispute between coroners and the judiciary about the rightful limits of coroners' influence. The Brodrick Report sums up the matter.

> The eighteenth and nineteenth century justices on the whole took the view that the coroner was never intended to enquire into sudden deaths unless there was manifest evidence of violence, whilst the coroners contended that their jurisdiction was to include all sudden and unexplained deaths. (1971, 112).

Havard interprets this as the obstruction of coroners by the judiciary (1960, 57). Whatever view is taken of this period, it was evident that the duties of coroners had never been codified into any document, statutory or otherwise. Indeed, this remains the case today. It will be seen in Chapter Three below that coroners' practices owe as much to common law, and moreover, to convention, tradition and opinion, as they do to statute.

To some extent matters were clarified by the Births and Deaths Registration Act 1836 with its stipulation that all deaths (in England and Wales) must henceforth be registered. The Act forms the basis of certification and registration procedures today and also marks the beginning of the "medicalisation" of

coroners' work.

The report of a Select Committee in 1860 formed the basis of the Coroners Act 1887, a key piece of legislation. Coroners' duties were clarified, and the ancient emphasis on defence of the Crown's financial interests was replaced by an emphasis on investigation of the cause and circumstances of sudden deaths, in the interests of society as a whole (Brodrick Report, 1971, 114).

The value also increasingly became recognised (explicitly in the Report of the Select Committee on Coroners, 1910) of coroners' inquiries without inquest. Historically, a coroner's investigation and an inquest had been synonomous. Today, inquests are held on only a minority of coroners' cases (See Table 2(1) 1). The figures indicate that while both the total number of deaths in England and Wales, and the number of deaths reported to coroners, have <u>increased</u> substantially between the years 1920 and 1975, the number of inquests held has <u>fallen</u>, both absolutely and in percentage terms. This is not only a matter of legal changes. It is also related to the changing medical environment and to changes in the sorts of death dealt with by coroners. The specifics of coroners' work have been subject not only to changes in quantity, but also, and more significantly, to changes in kind.

A crucial change arose from the Coroners (Amendment) Act 1926. The Act represented a major curtailment of coroners' powers in matters of criminal law: specifically, in dealing with suspected cases of homicide. Section 20 (1) reads:

> If on an inquest touching a death the coroner is informed before the jury have given their verdict that some person has been charged before examining justices with the murder, manslaughter or infanticide of the deceased, he shall, in the absence of reason to the contrary, adjourn the inquest until after the conclusion of the criminal proceedings and may if he thinks fit discharge the jury.

TABLE 2 (1) 1: DEATHS REPORTED TO CORONERS AND INQUESTS HELD 1920-75*

	Year	Total Number Deaths England and Wales (a)	Total Number Deaths Reported to Coroners (b)	% of (a)	Total Number Inquests Held (c)	% of (b)
1	1920	466,130	53,714	11.5	31,496	58.6
2	1930	455,427	63,238	13.9	31.659	50.0
3	1950	510,301	83,571	16.4	25,784	30.8
4	1960	526,268	101,079	19.2	26,305	26.0
5	1970	575,194	133,356	23.2	24,870	18.6
6	1975	582,700	153,366	26.3	23,455	15.3

In practice, inquests adjourned in cases of possible homicide are rarely resumed: the matter is transferred to the criminal courts. However, this situation did not always obtain. The limitation of the powers of coroners and their juries under the 1926 Act arose, in Williams' words,

> ..... from a number of cases in the nineteen-twenties where inquests had turned into virtual murder trials. (1967, 53).

The ancient jurisdiction of the inquest in matters of criminal law had come to conflict with the ethos of criminal justice in the legal system as a whole. This is an important point, revealing the long-standing tension between the inquest and other courts of law, and a basic ambiguity associated with coroners' powers.

The Coroners (Amendment) Act 1926 and the Coroners Rules 1953 (S.I. 205) prescribe the essential elements of the contemp-

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* Columns 1-4 derived from appendices to Brodrick Report (1971, 370-373), columns 5-6 derived from unpublished Home Office statistics based on coroners' annual returns. War-time figures unavailable.

orary coroner's role although, as argued below, much is still left to convention and accepted practice. The Criminal Law Act 1977 is also of importance, finally removing the coroner's power of commital (except in cases of contempt), reducing the number of inquests to which juries are called, and replacing the verdicts of murder, manslaughter and infanticide by the verdict of unlawful killing. The Coroners' Act 1980, like the 1977 Act, seeks to implement some of the recommendations of the Brodrick Report (1971),principally those connected with the coroner's obligation to view the body, the rules governing exhumation, and the transfer of jurisdiction over a body from one coroner to another. The Coroners' Rules are also amended from time to time by statutory instrument. Amongst the provisions of the Coroners' (Amendment) Rules 1980 (S.I. 557) are the removal of the inquest jury's ability to supplement its verdict with a rider, and the replacement of the verdict of "justifiable or excusable homicide" by the verdict of "lawful killing". Table 2(1)2 indicates the range of verdicts currently available to the coroner or, in certain circumstances, his jury.

The role of the inquest, as one element of coroners' work as a whole, is discussed in detail in Section Three of the present chapter, and a sociological account of the inquest structure is presented in Chapter Four. At this point, it is sufficient to note that not all verdicts are of the same order: crudely, some are legal categories, some medical, and others social. A "killed himself" verdict had legal implications prior to the Suicide Act 1961 but nowadays does not. Coroners' returns to the Home Office (Brodrick Report, 1971, 386) indicate that up until 1938 two separate suicide verdicts existed: "suicide while insane" and "felo de se", the latter denoting self-murder.

TABLE 2 (1) 2: INQUEST VERDICTS AVAILABLE TO THE CORONER OR JURY

(1) Unlawful killing
(2) Killed himself/herself
(3) Attempted/self-induced abortion
(4) Accident/misadventure
(5) Execution of sentence of death
(6) Lawful killing
(7) Natural causes
(8) Industrial disease
(9) Want of attention at birth
(10) Chronic alcoholism/addiction to drugs
(11) Lack of care/self-neglect
(12) Open verdict

"Accident" and "misadventure" verdicts are synomous: yet coroners (as will become clear in Chapter Three) tend to make a practical distinction between the two. Similarly, an open verdict may have various meanings, signifying different perceived "sorts of event."

In the preceding discussion, the origins and development of coroners' work have been briefly traced. Legal, social and medical changes have been highly significant, and the actual genesis of coroners' investigations cannot be separated from the political environment of the twelfth century. A qualitative change in coroners' work, and a source of continuing controversy, originated in the nineteenth century when the process of medicalisation began. It is worth remembering that as recently as the seventeenth century discussions of witchcraft and devilry were a part of investigations into sudden deaths (Havard, 1960, 5-6). Havard indeed asserts that

> ..... for centuries coroners and their juries were reaching their verdicts on cases of sudden

> death almost entirely unencumbered by medical evidence of the cause of death. (1960,2).

Current procedures for certifying and registering deaths as a whole are discussed in the following section. The deaths which became the particular responsibility of the coroner are outlined, together with the procedural choices open to the coroner. The legal and procedural bases of coroners' work must, however, be seen in an historical context, and in the context of conventional and informal rules. The procedures described apply to England and Wales: the Irish systems (North and South) are rather different, and the Scottish system is substantially different.

2 (2) The Contemporary System of Death Certification and Registration in England and Wales.

The first step taken by the coroner, after the reporting of a death, is to decide whether he has, in law, any right or duty to enquire into its cause and circumstances (Brodrick Report, 1971, 155). If so, the death enters his jurisdiction. The coroner may decide that no post-mortem examination* is necessary, and that an inquest is neither required by law, nor considered, at his discretion, to be appropriate. In this case, the coroner completes a certificate known as "pink form A" which he sends to the local Registrar of Births and Deaths. The cause of death certified by the doctor originally attending the deceased may in such circumstances prevail without any additional active investigation by the coroner. Informal processes of consultation between doctor and coroner are of particular importance in "pink form A" cases. It might be added that

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* "post-mortem examination", "post-mortem" and "autopsy" are, throughout the present study, regarded as synonomous terms.

"death certification" properly refers to certification of cause of death: not to the registration of that death, which is a separate process.

Alternatively, the coroner may order a post-mortem, or hold an inquest, or both. If the coroner is satisfied with the results of the post-mortem examination, and an inquest is not statutorily required, then "pink form B" is completed, sent to the Registrar, and the coroner's involvement is at an end. The issuing of either pink form "A" or "B" (i.e. without, or with a post-mortem) is limited to natural deaths. The meaning of "natural death" is by no means self-evident, and involves the coroner in the exercise of judgement. An "unnatural" death, moreover, is not necessarily a suspicious death. Road traffic deaths are "unnatural". A lengthy illness resulting in death which was originally caused by, for instance, a mishap such as a fall, would also be "unnatural".

An inquest is held on deaths not dealt with by either pink form procedure. Inquests are mandatory in certain circumstances: centrally, on violent and/or unnatural deaths (including suspected suicide): deaths on the road or railways; deaths in factories and certain deaths on farms; deaths in prison. Additionally, the coroner may at his discretion hold an inquest on any other death: if the results of the post-mortem are not conclusive or, perhaps more usually, if there is strong public interest in a particular death or if suspicion would linger were the circumstances not made public. Inquest verdicts of "natural causes", for instance, would tend to fall into the latter category.

In short, approximately one-fifth of all deaths in England and Wales are reported to coroners. Coroners have three basic choices in dealing with a death: form A, form B, or inquest.

(The inquest is usually preceded by a post-mortem examination, although exceptionally it may not be). Table 2(2)1 illustrates the use of the available procedures. It can be seen that, in 1975, coroners dealt with almost 13% of reported deaths by "form A", 72% of reported deaths by "form B", and over 15% of reported deaths by holding an inquest. An autopsy is, then, held on approximately 87% of all deaths reported to coroners: perhaps amongst the most significant developments in medico-legal investigation over the last century. The choice of procedure made by particular coroners is however subject to considerable variation. Both these points will be seen to be of continuing relevance.

TABLE 2(2)1: USE OF PINK FORM A, PINK FORM B* AND INQUEST, 1975.

1.	Total No. Deaths, England and Wales	582,700	
2.	Total No. Deaths, Reported to Coroners	153,366 (26.3% of total 1)	
	2 (a) Male		89,010
	2 (b) Female		64,356
3.	Form A	19,526 (12.7% of total 2)	
4.	Form B	110,385 (72% of total 2)	
5.	Inquests	23,455 (15.3% of total 2)	
	5 (a) with post-mortem		23,014
	5 (b) without post-mortem		441
	5 (c) inquests completed		23,411
	5 (d) verdicts returned		22,352

* derived from unpublished Home Office statistics based on coroners' annual returns. The difference between figures at 5, 5(c) and 5 (d) is accounted for by the adjournment of some inquests opened in 1975, either indefinitely or until 1976, and the conclusion of some inquests opened in 1974.

Juries may or may not be summoned to coroners' inquests. However, the inclusion of a jury renders it (not the coroner) the sovereign body. All inquests included juries until the Coroners (Amendment) Act 1926 became law. Thereafter, juries continued to be statutorily required only in certain circumstances, although the coroner retained (and retains) the discretionary power to summon juries in any other case. The Criminal Law Act 1977 further reduced the mandatory requirement to summon juries. Most obvious was the jury's disappearance from inquests concerned with road traffic deaths although also of importance under the 1977 Act was the removal of the jury from inquests opened in connection with suspected homicide. Today, inquests must include juries in three, relatively infrequent, sorts of circumstance: where the death is statutorily reportable to a government official (including deaths in factories, mines or on the railway); where the death occurred in prison;* or where, in the words of the 1926 Act (Section 13),

> ..... the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public.

The third category is open to a variety of interpretations: a coroner's decision not to sit with a jury may be challenged, as it was successfully in the controversial case of Blair Peach.**

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* for the purpose of summoning a jury 'prison' did not include 'police custody' until the Administration of Justice Act 1982 (section 62) became operational in January 1983.

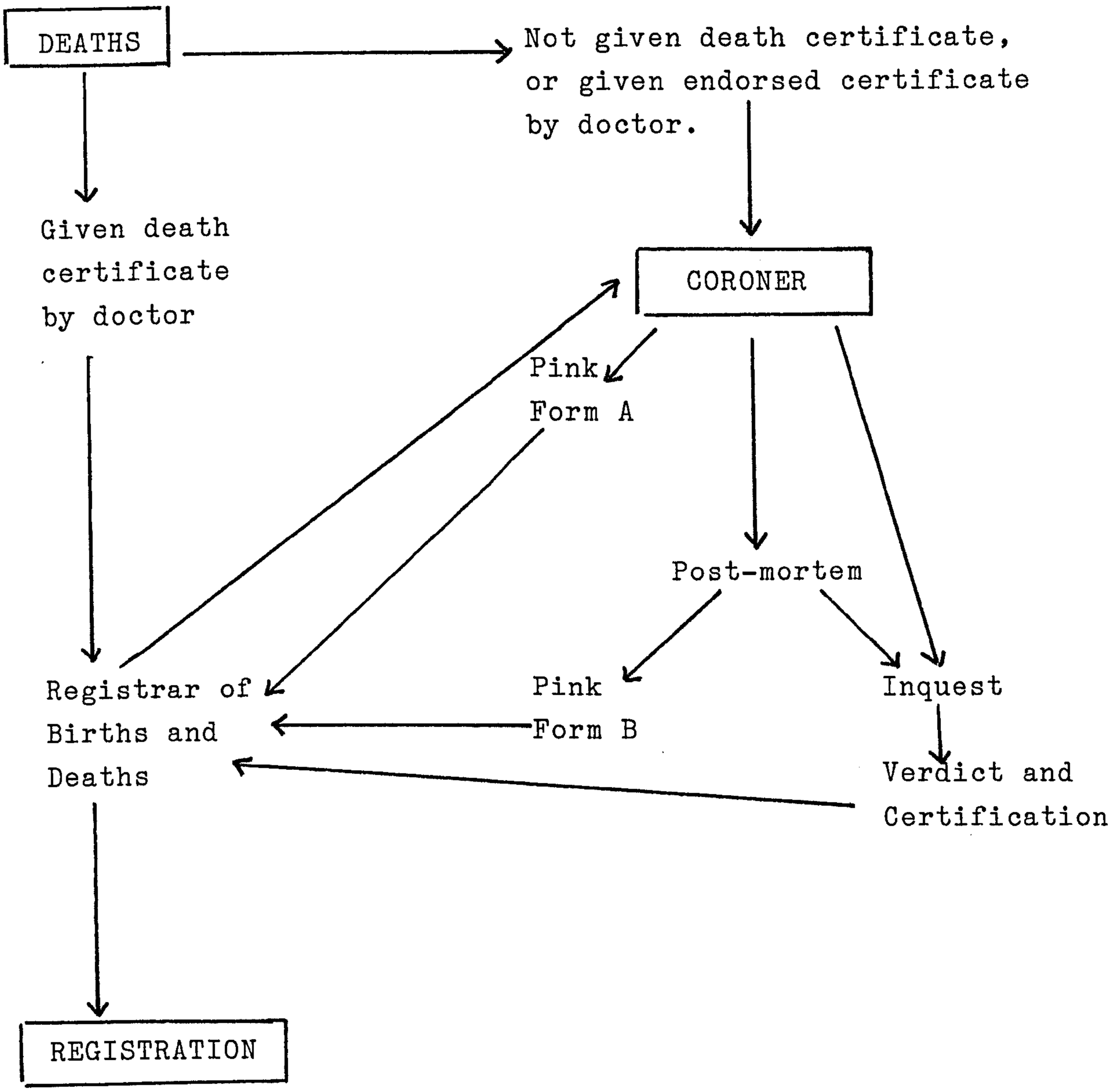
** Mr. Peach died following injuries received in a political demonstration in Southall, London, in April 1979. The inquest, opened originally in October 1979, was halted after the family of Mr. Peach was given permission by the Lord Chief Justice to apply for an order reversing the decision of the coroner not to include a jury.

The role of the inquest jury today tends to be a passive one, and certainly the decline of the jury cannot be seen in isolation from the decline of the inquest itself or the changes (specifically, the "decriminalisation") in coroners' work as a whole. More will be said of the inquest, and jury,in Section Three of the present chapter, and in Chapters Three and Four.

Figure 2(2)1 illustrates the process of death certification and registration in this country, and the various "routes" which might be taken by a death following referral to the coroner. The bulk of deaths are reported to coroners by doctors: although there is in fact no legal obligation upon a doctor to inform the coroner (or the police) of any death which he cannot certify. Members of the public are not obliged to inform any death to the police. However, there is a common-law duty upon any citizen who comes across a body to inform the coroner, if that death legally warrants an inquest: an obligation dating from the time when the "first finder" of a body was expected (literally) to raise a hue and cry (Brodrick Report 1971, 132; Hunnisett, 1961, 10-11). Those in charge of prisons and penal institutions are required by law to inform the coroner of deaths of those contained within the institution (Brodrick Report, 1971, 132). The Registrar is also obliged to refer back to coroners certain sorts of death: e.g. the death may have been certified by a doctor but cannot be registered because the doctor did not attend the patient within the fortnight preceding death; or because the death has not been properly certified, whether it has come to the Registrar from the coroner or direct from a doctor.

In practice, the bulk of cases are reported to the coroner by a doctor. Some are reported by the Registrar. Additionally, particular coroners may have informal rules of their own e.g.

Figure 2(2)1: The Process of Death Certification and Registration in England and Wales



that all hospital deaths in their area, occurring within twenty-four hours of admission, be reported. The "endorsed certificate" in Figure 2(2)1 refers to a case where death has been certified by a doctor, but for some reason the coroner is notified: this might normally be dealt with as a "form A" case. Figure 2(2)1 also illustrates the path taken by the bulk of "routine" deaths: direct from doctor to Registrar. The relatively rare event of an inquest without post-mortem is also indicated.

The exercise of coroners' discretion in the processes illustrated is a topic of continuing importance. It must also be added that other officials exercise similar powers of discretion and judgement: centrally, the doctor, but also the Registrar, the police officer (whether or not acting as coroner's officer), the hospital pathologist and, indeed, the undertaker. The investigation of any sudden death involves a network of interaction where the coroner retains central, and formal, authority.

Coroners' powers are clearly subject to changes via specific Acts of Parliament and, much more frequently, minor alterations through statutory instruments. Case law may also provide major changes to which the coroner has to accommodate. In the well-publicised Helen Smith case, the Divisional Court of the Queen's Bench Division originally turned down the deceased's father's petition to instruct the coroner to arrange an inquest.* It was held that, having occurred abroad, the death, irrespective of its possible circumstances, was outside the coroner's jurisdiction. The Court of Appeal reversed this decision.**

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*RV West Yorkshire Coroner Ex Parte Smith (1982)
** Halsbury's Laws, 1982, paragraph 609.

The coroner was thus required to hold an inquest, and a new duty was established - for all coroners - to hold an inquest, even where death occurred abroad, in circumstances where there is "reasonable cause" to suspect violent or unnatural death, and where the body has been returned to the coroner's jurisdiction.

Finally, there are two quite different circumstances where the body of the deceased is not required at all before an inquest may proceed. Firstly, coroners may open - and complete - an inquest where the death of a named individual is assumed. In December 1983, for instance, an inquest was opened on Home Office instructions concerning the disappearance of a soldier, on training exercises, four years previously. A verdict of accidental death was recorded. Secondly, the coroner retains ancient powers in the matter of treasure trove, which is unrelated to any death. Individuals who discover treasure trove have a duty to inform the coroner. If the goods were deliberately hidden (rather than lost) and consist of gold or silver (rather than any other valuable material) then they constitute treasure trove. The inquest is held to determine ownership and, normally, any such treasure trove becomes Crown property. In medieval times, this was doubtless a valuable source of income, consistent with the coroner's other revenue - gathering duties. Today, treasure-trove might well find its way into a museum, and the finder given a reward. Only seventeen inquests on treasure-trove were held in 1975. Coroners' comments on this remnant of their medieval duties are to be found below in Chapter Three.

2 (3) The Role of the Inquest

Circumstances in which a coroner must hold an inquest, situations in which he may judge that an inquest is desirable, the use of the inquest in comparison to the other available

procedures, and the use of the inquest jury, have already been outlined. The purpose of the present section of the discussion is expansion and clarification of some issues relating to the inquest, in order to provide a foundation for the substantive discussion of research material in the following chapters.

The coroner's task of ensuring adequate certification of death is routinely performed by ordering a post-mortem examination. Table 2(2)1 indicated that post-mortems are held on 87% of deaths reported to coroners: and that in the bulk of such cases (almost 83%) no further action is taken. Pink Form B is completed, and no inquest held. The post-mortem alone is sufficient to draw conclusions about cause of death where circumstances of death remain relatively unproblematic.

Given that the role of the inquest in detecting criminality has now so substantially declined, the question arises of why inquests are held at all: for what reason are post-mortem examinations sometimes supplemented by a formal inquest? Three sorts of answer can be given.

Firstly, the inquest allows an examination of <u>circumstances</u> of death where <u>cause</u> of death may already, for practical purposes, be unproblematic. Secondly, the inquest allows a <u>public</u> recital (unlike form "A" and "B" cases) of the facts-of-the-matter. Thirdly, and centrally, inquests take place simply because the law stipulates that they must take place. Coroners' comments at interview (Chapter Three) suggest that if the statutory requirements to hold inquests were less rigorous, inquests would be held less often.

However, given that the statutory requirements exist, the question of immediate interest is why they exist. For what reason are formal inquests statutorily required? An adequate

answer must refer to the history of coroners' work, the history of law, the development of medicine and medico-legal practice and the contradictions which characterise coroners' work.

The early inquest was centrally concerned with crime. The mandatory inquest in cases of sudden, violent and unnatural death was, at least to some extent, necessary in the detection of homicide. The modern inquest, however, while still statutorily required, rarely has any "criminal" role. Most immediately, this change derived from legal developments, such as the obligation upon the coroner to adjourn inquests in cases where a charge of murder, manslaughter or infanticide was to be made in another court (Coroners (Amendment) Act 1926), the removal of the coroner's power of commital and the introduction of the verdict of unlawful killing (Criminal Law Act 1977) and other less central developments such as the decriminalisation of suicide (Suicide Act 1961). However, legal changes can themselves be accounted for by identifiable underlying forces. The criminal role of the inquest in this sense has declined in the context of the rise of an organised police force, the development of medical and, in particular, pathological knowledge, and the establishment of an adversary system of justice in which the inquest became an inappropriate institution. The original reasons for the legal obligation to hold an inquest have to some degree withered away, while the legal obligation itself remains, and the functions of the inquest have qualitatively changed.

The contemporary inquest can be regarded as a supplement to the normal processes of death certification, whether that certification is made by a doctor alone, a coroner by"form A", or a coroner by "form B". In the latter case, although the post-mortem may have established cause of death conclusively, if that

death is "unnatural" an inquest is required by law. However, an unnatural death today is not necessarily, nor usually, equivalent to a suspicious death.

Of course the inquest does continue to deal with some suspicious and possibly criminal cases. However, it is in exactly such cases that the powers attaching to the coroner's inquest have been removed. Herein lies a contradiction of the inquest, for its structure remains essentially unchanged whilst its functions have undergone substantial alteration.

The Brodrick Report noted that

> ..... the coroner is now a part of the ordinary process of certifying the medical cause of death and not simply an agent for enquiring into violent or suspicious deaths. (1971, 4).

In this routine practice of certifying cause of death, the post-mortem is of central importance. Yet the inquest retains a supplementary importance: an importance left undefined, and subject to different interpretations.

The inquest is a court of law. The quasi-medical task performed by this court is unique in that it necessarily involves a reconstitution of what-happened, a structuring of real-circumstances and, thus, a verdict and a categorisation of the death. The rationale of the contemporary inquest is uncodified, fluid, and spans law and medicine in an undefined way.

The Brodrick Report recommended a basic change in the inquest in the following terms (1971, 190):

> We consider it essential that a change be effected in what the public expect of an inquest, away from the attribution of blame and towards a merely fact-finding inquiry. In the long term, we can think of no more effective means of achieving this change than to abolish the "verdict" in its popular sense ..... We recommend that the term "verdict" should be abandoned and replaced by "findings".

It is not a concern of the present study to make policy recommendations: it is sufficient to note that the inquest may invite controversy. Further, although the powers of the inquest in matters of criminal law have declined since the passage above was written, the inquest remains an inquisitorial court of law concerned with constructing a discrete verdict, and is not a fact-finding enquiry along the lines of, say, a Department of the Environment public enquiry. One may wish to note that the inquest's "public" status is not absolute. Where the coroner considers national security is involved, all or part of an inquest may be held in private.* In early 1984, a national newspaper obtained a High Court injunction preventing the coroner from proceeding with such a "secret" inquest until a full hearing took place in the High Court. It was also re-established in 1982 that the High Court has power to "interfere" with the findings of a coroner's court under the authority of common law, judicial review, and the Coroners' Act 1887 section 6.** Finally, one might note that judges in fact retain a common law power to act as coroners (although no cases of this are evident) and this common law power appeared to be recognised by the Coroners' Act 1887 section 34. In all these ways, the inquest is far from "separate" from the judicial system as a whole.

Police personnel and medical personnel are key members of the coroner's organisational system. The present chapter concludes with a brief consideration of the role of the police and of the medical profession in relation to coroners' work.

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* Coroners' Rules 1953, S1 1953 No.205 r.14.

** Halsbury's Laws 1982, paragraph 611.

2 (4) The Coroner's Officer and the Police

The coroner is assisted in his everyday activities by the coroner's officer, generally a serving police officer. In a large jurisdiction, presided over by a full-time coroner, there may be one or more policemen seconded to full-time work with the coroner, while in small rural jurisdictions, police personnel may act as coroners' officers where the need arises, and otherwise go about their normal duties. Coroners' officers themselves depend upon the services of other police officers, ranging from C.I.D. staff to patrolmen and police photographers. Coroners' investigations, in short, are routinely carried out by the police. Relations between coroners and the police, the autonomy given to coroners' officers, and the practical advantages and disadvantages of a police-manned system of medico-legal investigation (as articulated by coroners during interview) are discussed in Chapter Three.

The institutional links between coroners and the police have clear historical origins. Local constables have assisted coroners since medieval times. Policemen have formally acted as coroners' officers since the instigation of modern police forces in the Nineteenth Century (Brodrick Report, 1971, 248). The links between police and coroners can not only be accounted for by the suspicious or criminal nature of some deaths, but also by the traditional role of the coroner as a law-enforcement officer concerned with many matters other than sudden death.

The attitudes and practices of coroners themselves are subject to variation: not surprisingly, the work of the coroner's officer also permits some flexibility. It is worth emphasising that not only do coroners routinely delegate the work of investigation to their officers, but also that such officers

effectively delegate tasks to other police personnel. This has implications for the focus of the present study on "coroners' decisions". It also poses the question of how far routine police work is an element of coroners' work itself.

A Home Office study of the work of coroners' officers was appended to the Brodrick Report (1971, 256-259). It seems to be the only official consideration of their position. It noted:

> The formal position of the police officer seconded for duty with the coroner is a curious one. As a member of a police force, he is nominally subject to the direction and control of his Chief Constable ..... The coroner's officer enjoys the same conditions of pay, discipline and nominal hours of duty as his police colleagues ; ..... Nevertheless, insofar as he acts as the representative of the coroner, it is the coroner who is really responsible for his actions and who is in effective control of his working day .....
> (1971, 256).

The everyday delegation of authority to the coroner's officer was also examined in the Home Office study:

> ..... most coroners do not expect to see anything in writing about a case at least until a decision is required about its disposal, i.e. a decision as to whether a Pink Form A or B should be issued or whether an inquest should be held. Supplies of pink forms are normally held in the coroner's office, to be released individually to his officer for use in a particular case, but in some jurisdictions the coroners' officers hold a supply of blank pink forms which may even be already signed, and which they complete on the verbal authorisation of the coroner.
> (1971, 257)

The historical connections between coroners' work and police work may be identifiable but, as one might expect, the necessity for the modern-day coroner's officer to be drawn from the ranks of the police (and, indeed, to formally remain a serving constable or sergeant) is from time to time called into question. For

instance, it may be that hospital staff see the interest of the police in a sudden death as pointless or intrusive; or that the family of the deceased resent the presence of a uniformed officer; or that police authorities would prefer to devote available manpower to what is perceived as "police work" proper. The Brodrick Report concluded that the essential duties of a coroner's officer could indeed be carried out by a trained civilian, and recommended that police officers should cease to serve as coroner's officers (1971, 251). All coroners interviewed in the present study rejected this conclusion, but in November 1980 the Home Secretary announced that consideration was being given to the introduction of civilian coroners' officers initially in the Metropolitan Police Force area. Some police forces have indeed since started to employ non-police personnel in this capacity (where the size of the workload justifies a full-time appointment) often under "civilianisation" programmes affecting a range of staff. The police or civilian status of the coroners' officer is another area of coroners' work currently undergoing change and, to some degree, controversy.

It might finally be added that a coroner's officer is not in any sense a <u>deputy</u> coroner. The deputy, like the coroner, must be trained in law or medicine, or both, and be of five years' experience in his profession. The deputy exists to carry out all the coroner's functions in the absence of the coroner himself. All coroners nominate one or more deputy and it is quite possible for the coroner in one area to serve as deputy in another jurisdiction.

Relations between coroners and the police are close and long-established. Such relations are of relevance in the emergence of coroners' categorisations about particular deaths. So too

are the relations between coroners and doctors, considered below. Indeed, "coroners' work" is not solely the work of coroners at all. A number of personnel interact within a structured setting defined, primarily, by the coroner, but subject to operational definitions by a variety of staff at several levels. The culmination of the process in the coroner's own formal categorisation must be considered alongside the work of other key participants.

2 (5) The Doctor and the Pathologist

Relations between coroners and medical staff occur on several different levels. While links between coroners and the police are institutional, links between coroners and doctors are informal: but nonetheless of central importance.

The reporting of a death to the local coroner provides the first contact with the doctor. Informal consultations at this point may determine the procedure (pink form A, B, or inquest) to be used: or the procedure may be statutorily defined. If a post-mortem examination is to occur, it is likely that the coroner will contact a particular pathologist with whom a practical working relationship has been established. (It is not unknown for doctors untrained in pathological medicine to carry out post-mortems). It may be that a specialist in some area of pathology is called upon: or it may be that a police surgeon, or a Home Office pathologist, is used. The coroner (or his officer, or the reporting doctor) is engaged in making choices prior to the post-mortem being carried out. The reporting doctor may, of course, be a general practitioner or a hospital doctor.

Should an inquest be held, specifically medical evidence is

of crucial importance. It is worth noting that this has not always been the case. Post-mortems, medical evidence and medicine in general are (viewed historically), relatively recent additions to the 'proper work' of the coroner. The "medicalisation" of coroners' work dating from the Births and Deaths Registration Act 1836 has been noted above. The use of post-mortem examinations has waited not only upon developments in medical knowledge during the last hundred years, but also upon moral and legal developments. Williams noted that in the 1930s, and before, post-mortem examinations were a "rare and last resort" (1967, 33). The continuing expansion of medical competence, and the use of sophisticated techniques and equipment, have a bearing on the prevailing profile of coroners' work: a state of affairs not without its problems, such as in the controversial and delicate decisions required in the case of a patient who might be kept alive indefinitely on a life-support system.

In short, it might be said that medicine, per se, is an increasingly important part of, or adjunct to, coroners' work; that this has implications for the nature of "coroners' work"; and that this change is relatively recent. In particular, it is worth noting the contemporary coroner's concern with cause of death is in a sense different from that of coroners over previous centuries.

The abandonment of the office of coroner in favour of the medical-examiner in parts of the U.S.A. and elsewhere represents an explicit recognition of, and a particular response to, the nature of medico-legal investigation today. However, the comments of the coroners interviewed in the present study reveal a large measure of disagreement on the subject of medicine as a

whole. It will be seen in the next chapter that one of the first interview questions, designed to discover whether particular coroners perceived their work as part of the legal system, judicial system, medical system - or as something separate from all these - produced a wide range of views: views which lend support to the thesis that different coroners define their work in different ways.

Historical factors can also be taken as relevant to the study of medicine and coroners. The bureaucratisation of medicine associated with the post-war National Health Service in Britain formalised coroners' access to medical facilities in general. More abstractly, the growth of medical ideology in Western societies has influenced the ways in which birth, death and illness are regarded and dealt with. The extent to which bureaucracy and ideology are of relevance to the task of the present study is discussed in detail in Chapter Six.

Doctors and policemen are not the only personnel with whom the coroner interacts in the course of his work. However, they are key personnel, and represent the tension in coroners' work between, on the one hand, social control and law enforcement and, on the other, the pursuit of the "neutral" medico-scientific facts-of-the-matter.

An adequate framework appears, at this point in the discussion, to have been provided for the presentation and evaluation of the research material. For the sake of clarity, Part Two of the study is divided into three chapters, following the "natural" division between the three main methods of collecting information, i.e. interview, observation, and documentary/ statistical search. Thus, Chapter Three presents the information collected during interviews with the coroners of five counties in the North of England.

PART TWO

CHAPTER THREE: CORONERS' ACCOUNTS: AN EXPLORATION OF THE PERCEPTIONS AND ATTITUDES OF CORONERS IN FIVE COUNTIES.

3 (1) Introduction

The boundaries of coroners' areas were, along with those of local authorities in England and Wales, redrawn in 1974. Five counties, containing fifteen coroners' jurisdictions, were chosen as the target areas for research interviews; the coroners were approached and interviews were carried out in 1978 and 1979. Although reference will be made to the "fifteen coroners" of these Northern counties, two qualifications should be noted. One coroner's district had, between reorganisation and the time of interview, been absorbed into its neighbours. The ex-coroner thus interviewed has been included amongst the sample. In another district, the interview had to be conducted with a full-time coroner's officer rather than with the coroner himself. In the latter case, certain information could still be collected (e.g. the full-time/part-time or legal/medical status of the coroner) but other information (e.g. the coroner's own subjective views or informal modes of practice) could not be gathered.

The interviews used pre-set questions permitting any reply the coroner might wish to make (see Appendix I).The overriding concern was to allow a largely unstructured interview which still remained rigorous enough to collect detailed information about: coroners' accounts of their own work; coroners' perceptions of their role; and coroners' attitudes to and theories about sudden death.

As will be seen below, considerable variations were found to exist between coroners, in many senses. The variation between coroners in terms of part-time/full-time status, urban/rural area, and scale of work, was a deliberate feature of the research design, and is briefly summarised in the form of Table 3 (1)1. The variations which subsequently emerged in coroners' views and perceptions are a major concern of the present chapter.

TABLE 3 (1)1 CHARACTERISTICS OF CORONERS' JURISDICTIONS IN THE INTERVIEW SAMPLE

COUNTY	CORONER'S DISTRICT	FULL/PART-TIME JURISDICTION	NO. OF DEATHS* REPORTED 1975
1	A	FULL	1527
2	A	PART	418
2	B	PART	388
3	A	PART	513
3	B	PART	140
3	C	PART	180
3	D	PART	132
3	E	PART	192
3	F	PART	169
3	G	PART	580
4	A	FULL	1745
4	B	FULL	1961
5	A	FULL	2356
5	B	FULL	2622
5	C	FULL	3003

* derived from unpublished Home Office statistics based on coroners' annual returns.

Jurisdictions in the area of study ranged from a rural area handling approximately 130 deaths each year to a largely urban

area dealing with 3000 such cases. Table 3 (1)1 also indicates that six coroners interviewed hold full-time appointments, the remaining nine being part-time. The ratio of full-time to part-time coroners amongst those interviewed (2:3) is thus rather different from the ratio throughout England and Wales.* This imbalance has the advantage of making available the views of those coroners who deal with the largest number and widest range of cases each year.

Amongst those interviewed, the longest-serving coroner (including periods as deputy or assistant deputy) was appointed in 1946: the most recently appointed started work in 1971. Against the general pattern, the latter was not a deputy prior to his appointment as coroner. Thirteen of the fifteen coroners are qualified in law but not in medicine; nine of these thirteen are the part-time coroners in the sample; and most (but not all) of these nine are still practising solicitors.

Two of the sample, both full-timers, are medically qualified and although, significantly, both also have legal qualifications, it remains true, as one of them put it, that they "came in through medicine". The medical or legal bases of coroners' work formed the initial substantive issue in the interviews.

Coroners were asked whether they saw their job as part of the legal system, the judicial system, the medical system, or as none/several of these.

Four coroners defined their office as "judicial", and two as "medical". One of the latter expressed the view that coroners' work is "gradually becoming an extension of community medicine." The remaining nine coroners either broadly defined their job as

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* In 1976 only 22 of the total 180 coroners in England and Wales were full-time (Thurston, 1976).

"legal" or suggested that it cannot be said to fall into any single category. For instance, one coroner saw his job as "a bit of a hybrid" and suggested that while the inquest is a judicial inquiry, the bulk of his work is administrative and medical in character. Another coroner saw his job as having a "strong medical element" but a "judicial function". A distinct, and significant, point of view amongst some coroners was suggested by one part-timer: the coroner's task is to represent the public in cases of sudden or unexplained death, to "prevent a police state", and to conduct investigations independent of both police and medical personnel. As such, the office of coroner cannot be said to be simply "legal" or "medical".

A related perspective was offered by another part-timer. The coroner's job, while being part of the "overall" legal system is also part of the "body politic", including Parliament and courts of law. Moreover, the coroner's job is "political" insofar as it involves decision-making (most importantly at inquests) and insofar as the decisions may have social and political consequences.

A full-time coroner with a legal background did not see his job as part of the legal system in the "ordinary sense": rather, it is part of the system of "civil administration", the process of accounting for births, deaths and marriage.

In sum, while the two medically-qualified coroners saw their job as being, essentially, "medical", the remaining coroners expressed a range of views, some highly elaborate. All coroners emphasised the independence of their office and their investigations: examples of independence from doctors, police officers, central government and public pressure were cited. Yet organisationally "coroners' work" is not an independent area

of activity. This is a topic of relevance throughout.

3(2) The Coroner's Officer and the Police

In Chapter Two, the links between coroners and the police were briefly outlined. A number of questions upon this matter were included at interview, starting with the questions of how far coroners' officers* act on their own initiative and how far they are responsible for the practical everyday work of the coroner's office.

A full-time coroner replied that "ninety-per-cent of the work" is done by the coroner's officer who acts "entirely" on his own initiative. All coroners gave similar sorts of answer: a part-timer said that, as coroner, he "never goes out of this office" and that "it's not my job to be the investigating officer"; another part-timer reported that his officers do "a great deal of the running about." A general view seemed to be that, as the greater proportion of coroners' work is perceived as unproblematic, coroners' officers do not need to refer to coroners before proceeding with enquiries. The bulk of deaths handled by the coroner are thus being seen as "normal" (following Sudnow's (1965) usage) even given the fact that they are "non-normal" insofar as they have been reported to the coroner at all. However, particular sorts of case were regarded as requiring the coroner's own personal sanction: two coroners gave the example of organ transplants following death in hospital. One of these coroners added that his officers occasionally "overstep the mark" and have to be "brought back into line." Furthermore, police officers who are familiar with the normal practice of one coroner

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* At the time of interview, all coroners' officers were members of the police force.

may, it seems, be required to adopt rather different procedures when carrying out investigations for another coroner. This would especially apply where the "beat" of the rural policeman straddles the jurisdictions of more than one coroner.

Indeed, the geographical peculiarities of a particular coroner's area often accounted for variations in practice. A coroner may have several, regular, full-time officers;or he may rely when necessary on the regular use of officers otherwise engaged in normal police work; or he may rely solely on the policeman on-the-spot, who may or may not have dealt with coroners' cases before. Even where police officers are seconded full-time to coroners' work, they may work from the same building as the coroner and keep in daily touch with him, or be based elsewhere in the jurisdiction with little or no direct contact with the coroner. A full-time coroner went into a little more detail: with several officers based in different towns within his large jurisdiction, he defined his officers as means of liaison between the policeman on the scene and the coroner himself. He emphasised that his officers had no part in the day-to-day running of the coroner's office: the "secretarial" functions of the office (carried out by civilian staff) and the "police work" functions of the office (carried out by the coroner's officers) were clearly distinguished. This distinction did not seem to have any general applicability.

The same police officers may or may not regularly act as coroners' officers: the important factors would be the full-time/part-time status of the coroner, the geographical size and characteristics of the jurisdiction, and the scale of work involved. The extent to which police officers do regularly work for the coroner would seem to be important, given the suggestion

made above that coroners' officers are in fact responsible for a considerable amount of "coroners' work". It seems reasonable to suppose that continuity amongst coroners' officers bears some relation to the continuity of particular coroners' practices.*

The six full-time coroners interviewed all had full-time officers. One coroner had three sergeants and two constables at three different locations within his area, while another had three full-time officers at two towns. The coroner in an adjoining jurisdiction could rely upon a full-time officer in his own urban area, but in the rural parts of his jurisdiction tended to rely upon the local police force. Two further coroners had four and two full-time officers respectively, while the remaining full-time coroner had two full-time officers plus a retired police officer responsible for office administration.

The nine part-time coroners presented quite a different picture. Two tended to rely on <u>particular</u> officers, but in neither case were these officers seconded full-time to coroners' work. The majority of the part-timers, being responsible for geographically large but almost entirely rural areas, made use of the local policeman in the place where death occurred. In one such case, the coroner supplied his own handbook to members of the police force who might be involved in an investigation of sudden death.

Two part-time coroners, whose jurisdictions included significant urban centres, did to some degree have the regular

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* In informal conversation, a coroner's officer recounted the story of one coroner (subsequently interviewed) who, after his appointment, proceeded to replace his officers fairly frequently. Informal pressures appeared to modify this practice, leaving the work to officers who "knew the job". This has implications for the regularity of everyday decision-making in bureaucratic organisations.

services of particular officers. One coroner reported that he is "allowed" a full-time officer in the urban area where most of his workload originates: the officer has a substantial degree of delegated authority and "probably does ninety per-cent of the work" before the coroner himself becomes involved. However, in the southern, rural, edges of this coroner's jurisdiction, local policemen act as the coroner's officer when the need arises. The remaining part-timer interviewed similarly has regular officers in the urban area where he is based himself, but relies on the local police officer outside this immediate area.

Thus coroners' officers may or may not be seconded full-time to coroners' work, and may or may not have regular experience of this work. The full-time regular officer has learned (and perhaps helped to establish) local rules of how things are done. He may have been at his job in the area longer than the coroner himself. This continuity (akin perhaps to the continuity associated with a constant civil service in government departments irrespective of particular political control) is rather difficult to ensure in areas without full-time or regular coroners' officers. The coroner who issued his own handbook to police officers was essentially making available a standardised interpretation of how things are done.

In Chapter Two attention was drawn to the recommendation of the Brodrick Report that the work of the coroner's officer be henceforth a civilian responsibility (1971, 251). This recommendation has to some extent been enacted,* but the comments of coroners interviewed signify that to coroners it was an unpopular idea. The "police approach" to investigations, the network of intra-police contacts and, in the words of one coroner, the fact that "it is part of any policeman's training to act as

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* see Chapter Two above

a coroner's officer if necessary" were mentioned as virtues of the present system. The nature of police training and the "police approach" were not only consistent with the work of the coroner's officer, but were also a necessary qualification for the job. Doubts were also expressed about a civilian's ability to secure the necessary co-operation from doctors, relatives and the police force itself, posing the issue of what sort of authority would be accorded a civilian coroner's officer.

The part-time coroners tended to emphasise that there would not be enough coroner's work in their areas to keep a civilian fully occupied. More fundamental objections came from a full-time coroner. It would be "the greatest tactical mistake" to have civilians in the job, for several reasons: the coroner's officer is the link between police and coroner and the civilian could not exercise sufficient authority in this role; police officers are aware that "anything" is possible in the case of a sudden death and coroners' officers, as policemen, can be relied upon to work in a typical police way; and police time is saved, not wasted, under present arrangements, for if the officer were to be a civilian, much "coroner's work" would have to be referred back to the regular police anyway.

Four coroners expressed rather more mixed opinions: although none were in favour of the proposal. One coroner considered it desirable that all police contact with the family and friends of the deceased, in the course of a coroner's investigation, be carried out by non-uniformed officers: a practice not currently universal. Another (full-time) coroner would prefer coroners' officers to be members of the C.I.D.: because "in this job", one needs "a high index of suspicion." The two remaining coroners could see no objections in principle to the employment of

civilians, but saw practical disadvantages. The part-time coroner considered a civilian coroner's officer would have to be given a quasi-police authority to be able to do his job: much as a traffic-warden enjoys in his strictly-defined area of concern. His full-time colleague anticipated that retired police officers would still be the most common entrants to any civilian coroner's officer system, and that other civilians would meet resistance in their work from the police as a whole. He thought it desirable that any coroner's officer be given legal training (as distinct from the legal elements of routine police training) and concluded that good coroners' officers have special characteristics not possessed by all policemen.

The employment of police officers in coroners' work can be seen to ensure smooth access to the skills and resources of an organised, trained and bureaucratic network: the police force as a whole. Thus "police work" and "coroners' work" shade into common areas and the routine handling of sudden deaths is accelerated. The boundaries between "coroners' work" and "police work" overlap: just as do the boundaries between "coroners' work" and "medical work". In terms of the organisational requirement to despatch sudden deaths into appropriate categories, this situation has practical advantages. That coroners' officers work in a "police way" lends smoothness, speed and predictability to coroners' work. The possibility of introducing non-police into the pivotal role of coroner's officer was perceived by coroners as potentially disruptive: organisational practices would have to be reformulated.

The interviews were finally (in this section) directed to the role of the police in general. Coroners were asked simply to make any comments they wished upon the police. A full-time

coroner summed up the attitude of the majority of coroners:

> We're intimately wrapped up with the police, we depend on them.
>
> The police do all the investigation for us.

Two part-time coroners added the comments that "we should be in a mess without them" and the police play a "vital" role in any coroner's investigation. A full-timer added that the police, in the nature of their general work, become familiar with emergencies and situations regarded as trying, unpleasant or distasteful: hence, they are particularly suited to work with cases of sudden death. The typical pattern of normal police work is, again, being perceived as an essential part of coroners' work.

Other coroners offered more specific comments on the role of the police. A part-time coroner had experienced difficulty in having the police make the kind of extensive enquiries he would have preferred and suggested that their initial judgement of the facts-of-the-matter may influence or limit the scope of their subsequent investigations. This is consistent with the comments of another coroner that the police aim for a definite conclusion of the case as soon as possible: and thus tend to dislike open verdicts, as these leave the case open for police purposes. Such comments are unsurprising, given the bureaucratic emphasis (in police work as a whole) on the clear-up rate. Another part-time coroner cited certain instances of conflict with the police authorities, adding that smooth police-coroner relations are important and possible provided the coroner is recognised as the ultimate authority in sudden death cases: a point restated by several coroners.

Authority and independence emerge as important issues. A

full-time coroner saw his work as "almost an extension" of police work but, importantly, the coroner is an independent official, and the "separation of powers" is crucial. The coroner's authority was a topic perceived as important by another full-timer: the police are there to assist in the investigation under the charge of the coroner. This coroner also pointed out that all police officers involved in homicide enquiries are acting for the coroner and, in this capacity, assume powers attaching to the coroner which they would not normally possess qua police officers: for instance, a common-law right to enter property without a warrant and the power to charge persons, in certain circumstances, with preventing the coroner from holding an inquest.

Coroners are on-call twenty-four hours a day. As one part-time coroner pointed out, the police exercise discretion in the degree to which they choose to use their power to call the coroner at all times: good co-operative relations between police and coroner make "everyone's jobs easier." However, coroners' comments suggest that the smooth organisational fit between coroners and police is coupled with the fact of the coroner's overall authority and (in particular examples given) the occasional need to explicitly draw attention to this authority.

A part-time coroner perceived "two faces" of the police. The sympathetic attitude of police officers toward the relatives of the victim of a sudden death was characterised as being strikingly different from normal police attitudes to suspects in the course of normal police work. Finally, a full-time coroner, noting the co-operative nature of his work and the reliance upon police efforts, nevertheless suggested that the police may "cut corners" in investigations, and the coroner himself must look more closely. (Again, some characteristics of

police clear-up practice are here perceived as over-hasty for coroners' purposes). Although the true-story for the police almost invariably corresponds to the true-story for the coroner, it was suggested that the coroner is more thorough: and this was regarded as important in the small number of cases where it would make a difference to the eventual categorisation. This coroner cited a particular case. A man died after leaving a suicide note. The police formed an initial working categorisation of suicide and would, said the coroner, have "stuck with suicide" as the true story had not the coroner's insistence on extensive pathological tests revealed death through "natural causes" (the final categorisation) following a heart attack.

It should be added that the case above is not cited here to suggest that coroners' true stories are truer than police true stories. The point is simply that, notwithstanding the considerable (and, for our purposes, highly interesting) organisational overlap between coroners' work and police work, the fit is not perfect. It should also be made clear that coroners' accounts of the role of the police have been presented here to draw out and identify points of relevance and critical interest. <u>All</u> coroners emphasised that, in short, they needed the police: the part-time coroner's comment that "we should be in a mess without them" can be taken as a general sentiment.

Coroners' relations with the police are not confined to the coroner's officer. At points, coroners' work and general police work are indistinguishable. Furthermore, at points coroners' work and medical work are indistinguishable. Medicine in general is explored in the following section of the discussion and, while parallels are found with coroner/police interaction, the issues are complicated by the re-emergence of the question

of whether coroners themselves are legal or medical officials.

3 (3) The Doctor and the Pathologist

Coroners' work and medical work merge at two points: in the reporting of any death to a coroner(usually, although far from exclusively, by a doctor in general practice) and in the ordering of a post-mortem examination in form 'B' and (the bulk of) inquest cases. Post-mortem examinations are usually conducted by local hospital pathologists.

Initial interview questions on the topic of medicine referred to the post-mortem examination. In particular, if smooth organisational continuity is sought in coroners' "medical work", it might be expected that coroners establish working relationships and interact informally with particular pathologists. If this is so, it might also be the case that coroners can expect unproblematic access to the facility for a post-mortem: something which, in formal terms, coroners cannot take for granted, as the institutional links which exist between coroners and the police do not exist between coroners and doctors.

The full-time coroners, whether from legal or medical backgrounds, had indeed established working relationships with individual pathologists. "You get to know the ones you can rely on" said one such coroner, adding that he also acquired practical knowledge of how to call upon particular specialists in, say, toxicology or histology. Two other full-time coroners indicated a similar working pattern of regular use of local hospital pathologists supplemented by specialists in certain circumstances e.g., forensic pathologists or, in one case, the pathologist at a local hospital for infectious diseases who would carry out post-mortems on deaths in that particular hospital. A further

full-time coroner was unique in having at his disposal a purpose-built medico-legal centre, containing immediate facilities for post-mortems in addition to the coroner's office and coroner's court.

A pattern of organisational interaction, characterised by relations with individual pathologists and relatively easy access to the post-mortem examination (and hence, of course, the post-mortem report, a key artefact in coroners' work) was a general feature of the work of the full-time coroners. This was not so amongst part-time coroners, dealing with comparatively few deaths and tending to be responsible for geographically large but sparsely-populated areas. The mundane fact of physical distance between coroner and pathologist, in the areas covered by part-time coroners, assumes a significance for the prevailing pattern of interaction in coroners' work.

Thus, while two part-timers endeavoured to use their "own" pathologist at the nearest hospital, and another part-timer tended to use several pathologists with which he had worked before, none of these pathologists was based within the coroners' own areas. The jurisdiction of one part-time coroner included neither a mortuary nor a National Health Service hospital within its boundaries. Further, the tendency,in common with full-time coroners, to use specialist pathologists in certain cases increased the element of physical distance. One part-time coroner indicated that if there was the possibility of criticism or controversy surrounding a death in hospital, he would not use a pathologist from that particular hospital.

Despite variations in coroners' relations with pathologists, no coroners explicitly reported any difficulty in getting a post-mortem examination carried out. However, some reported delay.

Smooth working relationships between coroners and pathologists appear to be less problematic in an urban than in a rural area and the urban/rural distinction tends also to correspond with the full-time/part-time position of the coroner himself.

The post-mortem report has been referred to above as a "key artefact". Its meaning, however, is not self-evident, and depends upon the process of interpretation. Coroners were thus asked whether the task of interpretation of the report is seen as difficult. A medically-qualified coroner expressed the view that a coroner has "got to be trained in medicine to understand what he (the pathologist) is talking about." This view was atypical amongst those interviewed. None of the solely legally qualified coroners interviewed (thirteen of the fifteen) reported difficulties in interpretation: one such coroner said that although post-mortem reports were at first "a different language altogether", in the course of time "we get used to it." Another indicated that he frequently telephones the relevant pathologist to clarify specific parts of a report but, equally, the necessary language is learned very quickly.

Thus the consensus of opinion amongst those coroners interviewed (having no medical qualifications) is that a practical working knowledge of the necessary elements of pathological medicine is acquired by the coroner in the course of his own practical work. One coroner emphatically added that he encountered no problems in interpreting post-mortem reports having deliberately (but informally) "trained" himself, in his early years as a coroner, by attending post-mortem examinations, observing, and asking questions.

The coroners with no medical training thus perceived no problems in interpreting and using pathologists' reports on post-

mortem examinations. This in itself is an unremarkable conclusion given that any professional occupation would tend to draw from informally-derived stocks of practical knowledge as well as from the body of formally-acquired knowledge which was, in the case of most coroners interviewed, purely legal knowledge. However, it is sociologically interesting that this process of inter-pretation was seen by all coroners in the sample as being un-problematic. The practical (coroners') problem of using the post-mortem report in order to come up with the "right answer" is of course wholly separate from the sociological problem of inter-pretation and understanding, and we do not attempt here to blur the distinction, nor to suggest that "unproblematic" post-mortem reports are "really" more of a problem than they seem to coroners. To restate, it is not the concern of this study to make observations about the reliability of coroners' practices. Nevertheless, the point remains that an individual coroner does not necessarily interpret a post-mortem report in the same way as one of his colleagues might do and, indeed, given the differences in coroners' backgrounds and the varying type and scope of "typical work" in particular coroner's areas, it seems likely that the interpretive process does vary from one coroner to another: especially, as we have noted, as methods of "picking up" a working knowledge of pathology tend to be rather haphazard.

The interpretation of post-mortem reports is an important element in the process of classification of sudden deaths. Thus coroners' attitudes toward the post-mortem report again influence the officially-recorded facts-of-the-matter. The interpretive process can be seen as a further element in the construction of the facts of sudden death.

It would now seem appropriate to examine the more general issue of relations between coroners and medicine and, in particular, the boundaries of "coroners' work" and "medical work". Before doing so, however, let us briefly note that it is not only coroners who are engaged in the processes of interpretation and construction. Coroners' officers, in their investigations, are involved in similar processes and so too (to refer to our previous topic of discussion) are pathologists who themselves use their own particular knowledge and experience in both carrying out and reporting their examinations. (The pathologist, giving evidence at an inquest, tends to refer to his <u>opinion</u> as to cause of death). The extent to which coroners' constructions interconnect with the constructions of other officials - all of which are elements in creating the true story - has considerable importance for the study as a whole.

The full-time coroners interviewed tended to agree that medicine, broadly speaking, figures increasingly largely in coroners' work. Indeed, historically, this is patently so. However, coroners' interpretations of the significance of medicine varied. One full-time coroner, noting that the bulk of his time is occupied by form 'B' cases (requiring a post-mortem examination but no inquest) drew the conclusion that medically-qualified coroners might appropriately learn the necessary elements of law as the norm: rather than vice-versa. Another full-time colleague (with a legal background) agreed that medicine is today more precise, but considered that this very precision creates more work for the coroner, not less, as doctors become less willing to certify deaths in the less rigorous way that obtained in the past. A further full-time coroner agreed that medicine plays an increasingly important part in coroners' work but this

does not alter the need for a "legally minded" coroner who can evaluate all evidence independently.

Part-time coroners' views varied too: one echoed the argument above that the coroner is properly a legally-qualified man who can assess all evidence, not giving undue weight to the specifically "medical" evidence. The assumption here appears to be that the solicitor-as-coroner is an arbiter (if need be) between the conflicting (or, more usually, simply untidy or unformed) facts-of-the-matter, whereas the doctor-as-coroner remains more of a doctor than a coroner. One coroner indeed saw medicine as becoming increasingly imprecise: that as the limits of knowledge are pushed back, the areas of ignorance are more visible, and the sphere of medical opinion, rather than fact, is entered. Thus, he argued, the coroner, as a legal officer, should define the boundaries of his investigation and decide what weight is to be given to medical evidence as a part of the total stock of available evidence.

A part-time coroner went even further from the position taken by his medically-qualified colleagues. He did not feel that medicine was of increasing importance - he "hasn't experienced this" - and would, in any case, refer and defer to the specialist knowledge of the pathologist when appropriate. Finally, one coroner drew attention to his "preventative" function: to a public role in amplifying the origins and nature of a disease like asbestosis. This "public health" role is, then, yet another stated aspect of the coroner's routine work.

Differing attitudes toward the use of Pink Forms 'A' and 'B' cast further light on attitudes toward coroners' work and medical work. Largely, the use of the post-mortem examination is regarded as uncontentious: the necessity, or lack of necessity, is seen

as straightforward. However, there is discretion, a topic which is discussed more fully below. The discretion involved in using Form 'A' and 'B' can be illustrated here by taking two extremes.

One coroner indicated that he never uses Form 'A':that is, a post-mortem examination is invariably held. However, one of his colleagues did not accept the principle or practice of universal post-mortems: amongst the reasons were humane considerations for the family of the deceased who would be spared the distress of the post-mortem. Interestingly, this coroner accepted that some deaths must "slip through the net" when post-mortems are not held but he maintained that post-mortems were frequently unnecessary. To find two coroners taking opposite points of view on a specific issue is not confined to the post-mortem examination. Nor is it especially surprising that individual coroners, much like individual teachers or other members of a profession, have varying views. What is of importance - and consistent with the general strand of our argument here - is that the varying views of individual coroners have significant and major implications for the individual coroner's work and the facts-of-the-matter that are ultimately produced.

Finally, in this section of the interview, reference was made to systems of medico-legal investigation outside England and Wales and, in particular, the medical examiner, who has replaced the coroner in some states of the U.S.A. (see Brodrick Report, 1971, 99-102). Practice varies, but medical-examiners tend to be trained in medicine, specifically as pathologists. The medical-examiner investigates broadly the same range of deaths as the British coroner, but has no power to hold a public hearing such as the inquest. If he suspects that the death warrants judicial or further police investigation, he refers it to

the District Attorney. The medical-examiner can thus be said to be concerned with the 'fact' and 'cause' of the death as the coroner is, but not with its 'circumstances' in the same sense as the British coroner. Another significant difference between British and American systems is that the medical-examiner tends to be a local political appointment* and, hence, is subject to some degree to the vagaries of the American political scene. (For early descriptions of the medical-examiner in the United States, see Turkel 1953, 1086-1092; Gradwohl 1950, 491-494; Brinkhous, 1956, 253-259). Enthusiasm for the medical-examiner system has been based in its seemingly skilled and precise nature providing, one Chief Medical Examiner said, "a much better overall investigative service" than the coroner (Curphey, 1951, 132) and, to some extent in the United States as in Britain earlier this century, the feeling that the coroner's court was open to inappropriate uses of power. Curphey relates the "distinct abuses and corrupt practices under the existing coroner's system" in New York City in 1914 to its replacement by the office of medical-examiner the following year (Curphey 1951, 130). Available literature tends to assume that the medical-examiner has proven a worthy successor to the coroner: another Chief Medical Examiner claiming it is "conceded generally" that the nature of the medical-examiner's investigation of sudden death, "which recognises its essentially medical character from the very outset", is superior to the "old quasi-judicial coroner's system." (Helpern, 1965, 1267). These assertions are interesting in the light of coroners' comments on the nature of their work

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* It is worth noting that the American coroner may be similarly appointed, so the distinction between 'American system' and 'British system' does not necessarily correspond to the distinctio between 'medical examiner' and 'coroner', but we use the American/British dichotomy as a useful shorthand here.

and, during interview, coroners were asked their opinion of the medical-examiner system. Amongst those coroners who were familiar with the American system, there was a marked lack of enthusiasm for it. One coroner felt that, unlike the British coroner, the medical-examiner would not be able to allay suspicion or gossip by bringing a death "into the open." Another coroner felt the medical-examiner shared the disadvantage of the Scottish Procurator-Fiscal in lacking the facility for a thorough public consideration of the death. A full-time coroner who had some professional contact with medical-examiners in one part of the United States felt the system could work satisfactorily but, again, thought the medical-examiner's role was rather restricted and lacked a public dimension.

The second disadvantage of the American system referred to by coroners was the medical-examiner's alleged lack of independence. A full-time coroner summed this up in saying that the medical-examiner faces a basic difficulty in being both the pathologist concerned with the case, and the ostensibly independent arbiter of the facts-of-the-matter. In England and Wales, these are two distinct roles. Another coroner considered that this concentration of responsibility upon one person leads to the possibility of abuse as well as inaccuracy, and emphasised what he saw as the "separation of powers" i.e. the checks and balances arising from the co-operative nature of sudden death investigations in Britain. A part-time coroner made the point that the British coroner cannot (except in very exceptional circumstances) be dismissed: the implication being that he therefore can have no reason to produce other than the objective, correct result.

Only one coroner approved, strongly, of the medical examiner and, in particular, the explicit emphasis on pathology and

specialised medical investigation. However, his views were plainly not shared by his colleagues.

From medicine, in the widest sense, the interview moved on to a consideration of the coroners' inquest: the legal-procedural outline of the inquest presented in the preceding chapter may now be examined in the light of coroners' perceptions of the inquest today.

3 (4) The Role of the Inquest

In Chapter Two above, we discussed the historical development of the inquest or, rather, its decline, if decline is defined in terms of frequency of use and in terms of powers within criminal law. We noted that "the coroner's task of ensuring adequate certification of death is routinely performed by ordering a post-mortem examination", and that the inquest's centrality has gradually withered away. Yet the inquest remains the key public forum for formal resolution of the unformed, potential, facts-of-the- matter. Many coroners will never experience the controversy and divergence of views which have characterised some inquests in recent years but all coroners face the task, however routinely, of imposing order, in a public forum, on the various strands of potential evidence and, from those, of producing a verdict. In short, notwithstanding changes in the formal significance of the inquest, changes in its frequency and manner of use, and what might be viewed as its decline, its role as a formal structure for the construction of categorisations remains of central interest in the present study.

During interview, the initial focus on the inquest was as an unique court of law. In particular, its status as a court of record appeared to be a productive basis for discussion. Indeed,

it became clear that the term "court of record" may be used in widely differing ways and is open to many interpretations.

One coroner contrasted the court of record and the court of trial, defining the inquest as a court of record insofar as it cannot apportion blame, nor name those individuals who, in another court, might be found to be liable. Another coroner similarly commented that no questions of blame are to be decided at an inquest, thus it is a court of record in being "an inquiry into how someone came by their death."

Thus the "neutral" status of the inquest proceedings (in matters of blame, liability etc) is being emphasised, and the inquest's standing as a "court of record" is being defined in terms of this neutrality. However, several coroners noted that although the inquest itself may not arbitrate in matters of guilt or innocence, the evidence obtained (and recorded) at an inquest can be, and is, used in subsequent prosecutions in the criminal courts. Although the unique institutional position of the inquest vis-a-vis other courts need not be discussed again at this stage, one can conclude that the inquest's unique, 'separate', location does not denote a complete break from the ordinary processes of criminal courts. Indeed, one full-time coroner suggested that the inquest may be used as a "dummy run" for a subsequent prosecution. It might be suggested that the relation between the inquest and other courts remains an uneasy one: but that this is unsurprising in the context of key historical factors, discussed above.

Some coroners, then, see "court of record" in terms of "neutrality". A part-time coroner did not wish to make the distinction between court of record and court of trial but instead referred to the inquest's legal status as an "inferior

court of record", pointing out that many other courts are also "courts of record" even where they are criminal courts: another coroner made precisely the same point, substituting "petty" for "inferior". So here "record" is not being defined in contrast to "trial", but is being defined in a formal legal sense.

Again, a full-time coroner saw "court of record" referring to the inquest, as <u>records</u> are permanently kept of its deliberations, and are admissible in law as facts-of-the-matter. He also, in making the point that the coroner retains a power of commital in cases of contempt, not possessed by the chairman of a public inquiry, seemed to be emphasising <u>court</u>-of-record as well as court of <u>record</u>. Finally, a coroner agreed that inquests are indeed courts of record, but he personally prefers to "go beyond" a mere recording of the facts: another interpretation.

It is reasonable to suggest that a seemingly straightforward term like "court of record" is open to different interpretations and can be given different shades of meaning: the comments above are illustrative of this. Thirteen of the fifteen coroners interviewed agreed that an inquest is such a court, but it is important to emphasise that this agreement is not necessarily based on shared meanings.

The point is made in the present study that coroners' professional activities and the very nature of the "office of coroner", practically understood, are based to a much larger degree than is routinely supposed on individual coroner's particular perceptions and attitudes, and definitions of their own job. (Coroner's background, training, geographical location etc. may be relevant factors in the development of these perceptions, and historical factors have a general relevance in creating the conditions for diversity). Our aim, in discussing

the "court of record", is to suggest that the range of varying perceptions and meanings is not confined to the "looser", more manifestly "discretionary", areas of coroners' work but also influences discussion of ostensibly straightforward clear-cut legal terms such as court-of-record. Our developing thesis can be applied even to areas of coroners' work thought to be "given", or patently non-arguable.

Coroners had more to say on the general subject of inquests and, again, the "formal" outline of the inquest can usefully be compared to coroners' own definitions of the situation.

In addition to identification of the deceased and establishment of cause of death, what might be seen as the purpose of the inquest? Coroners' views can be summarised as follows.

1) The inquest has a key public element: allowing public "ventilation" of circumstances of death as one coroner put it, or as another said, placing a public forum where a private inquiry, or trial by press or television, might otherwise exist.
2) The inquest has a role in detecting criminal involvement: here coroners' views diverged. One point of view was that the modern coroner has only a marginal criminal role and that routine police investigations prior to the inquest would already have detected criminal factors.
3) The inquest allows the coroner to make public recommendations about, for instance, a general health hazard: a public advocate role.
4) The inquest publicly clears suspicion and removes misinformed gossip e.g., demonstrates that standards of medical treatment have been satisfactory in the case of a death in hospital; or establishes whether a death in prison or police custody was influenced by the fact of containment.

It can be seen that the perceived usefulness of an inquest - what we might call its practical purpose - is closely connected to its public status, and this 'usefulness' manifests itself in more than one way. Alongside the powers of the inquest decreasing in matters of criminal law, the coroners interviewed tended to emphasise the inquest's continued importance in removing unwarranted suspicion: as one coroner put it, "letting the public see that justice is being done."

It can fairly be said that the English court of law as a public arena is (like the use of the jury) in general terms part of an ancient tradition that is constitutionally and culturally respected. The privacy accorded to those participating in a juvenile court, or, latterly, to the male accused in a rape case, while seen as desirable, is exceptional. Edward Thompson (1980) draws attention from a civil libertarian perspective, to what he sees as curtailment of this ancient principle. Notwithstanding Thompson's general argument, it seems that in coroners' courts in particular, the public dimension has remained surprisingly constant, and the jury's disappearance from road traffic inquests tends not to be mourned. In passing, however, it is to be noted that, in controversial cases, the inquest may, far from removing blame and suspicion, in fact do the opposite, for participants may define a role for the inquest which it is <u>structurally</u> incapable of fulfilling. An elaboration of this point appears elsewhere (Fenwick, 1980). It should again be added here that inquests in general are, despite these comments, very uncontroversial: and their 'ordinary' nature was a starting point for our consideration of coroners' categorisations. To echo Chapter One, early ethnomethodology at least gave sociology the clue that it is in the unexceptional, rather than the

dramatic, that attempts at description and understanding are to be located.

To return from our digression, coroners defined the purpose of the inquest as being (in addition to its formal task of identification etc.) connected to its public nature. One coroner, however, saw the inquest as no more than "a categorisation of the slot the death fits into" and that its verdict tends to be clear from the start. Another coroner characterised the inquest as an inexpensive automatic form of inquiry, saving the authorities the trouble of calling numerous different sorts of inquiry into all manner of deaths. Finally, a third coroner saw the inquest as a "public recital",as a "resume", of part of the investigation, largely for the benefit of the public and interested parties. "I have now reached the stage where in 90% of inquests the only statement made in open court is the verdict", said one coroner in subsequent correspondence.

Of course, it is not any dramatic revelation that the outcome of an inquest might typically be unsurprising, nor need it be read as any attack upon its legitimacy that this might be so. Indeed, the same might be true of other courts of law, as Carlen found in her description of magistrates' constructions of justice (Carlen 1976). It is reasonable to conclude, however, that inquest verdicts routinely have the character of foregone conclusions. Let us also note that the inquest is seen by coroners as having more than one purpose, that the purposes of the inquest extend beyond formal and ostensible purposes, and that recording the verdict may not be the sole, nor even the main, point of the exercise <u>so far as coroners themselves are concerned</u>.

Asking coroners directly whether they considered the inquest should be a public or a private inquiry produced an emphatic

majority response: "most definitely" and "vital" that the inquest remain public. Two coroners reserved their judgements to a limited extent. One, while agreeing that inquests should remain public, nevertheless regretted the public discussion of personal tragedy and the distress frequently involved for the family of the deceased; the other felt that, in some circumstances, the inquest may be a "tremendous source of damage" and the English system "too rigid" in its insistence on public hearings when compared to the Scottish system. The example of suicide was given. Notwithstanding these particular opinions, the preference of coroners was clear in favouring the present 'public' system.

Members of the public do not routinely learn about coroners' courts by attending them in person. In this sense, the courts' public status has an abstract meaning based, in practice, on public reporting in the press.* Indeed, no members of the public other than family members, witnesses, jury and press reporters were present at any of the inquests attended during the present study. It seemed useful, therefore, to ask coroners their views of press reports of inquest proceedings: or, in our terms, what are coroners' perceptions of press constructions?

There was a tendency to evaluate press reports according to their local, regional or national coverage. Local newspapers were seen as having some positive functions (e.g., in a highly rural area, providing information which would otherwise be provided by gossip or speculation) by some of the coroners: another coroner

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* The absence of local reports of inquests involving "public interest" stories of suicide or mystery in Scottish newspapers distinguishes them from their English equivalents.

made himself "approachable" to local reporters. One coroner, who saw little of value in the city newspaper - "bloody awful" - saw more balanced coverage in the county newspaper. Indeed, more than one coroner suggested a lack of balance in newspaper reporting: particular facts might be given greater emphasis than they warrant, while important facts are understated: a problem of balance, rather than accuracy. This problem (of re-constructing the inquest's structured assembly of the facts within a newspaper) is touched on in Chapter Four below. Finally, coroners interviewed tended to see the national press as being more sensational than the local press. It might be added here, however, that national newspapers will tend only to attend (and hence report) inquests which are seen as controversial or non-routine. Such inquests necessarily lend themselves to sensational reporting more than the inquests typically reported locally could do.*

Although the Criminal Law Act 1977 rendered the appearance of the inquest jury even less frequent than before (most noticeably in road traffic deaths) the comments of coroners on the value of the jury were collected. Views were diverse. One coroner suggested that juries, in diffusing the decision making process, demonstrate that the verdict is not the conclusion of one man, the coroner, alone, and a more general feeling was perhaps summed up by the coroner who said that the jury "occasionally latch onto something." Three coroners added specific positive comments. The jury is of use, said one coroner, where the identity of the deceased is in doubt - a reference to a formal property of the inquest's range of functions, and interesting

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* "Perhaps the Press have a vested interest in ignorance as it is a ripe source of controversy and therefore news" said one coroner, in subsequent correspondence.

for that reason - and because the jury provides "someone outside of the establishment" with an opportunity to ask questions. A further coroner referred to the usefulness of jurors' local knowledge, and the most favourable comment came from a part-time coroner who recalled "many cases where I have been indebted to the intelligence of the jury." One might balance against this the coroner who commented that "coroners' juries are a dubious advantage to anyone" and three other colleagues who thought the jury did not have a very useful role.

The discussion of juries and their purpose, if any, leads back to a topic discussed above: that is, the extent to which verdicts may be clear-cut from the start of the proceedings. Some relevant comments are as follows: that only rarely is anything hitherto unknown discovered during the inquest; that (the coroner) tries to keep an open mind and has occasionally encountered "surprises"; that coroner, coroners' officers and attendant solicitors would have a "fair idea" of the likely result; that "we go into the inquest with some preconceived ideas from the file ....." but nothing is final until the recording of the verdict; and that, by the time an inquest is held (i.e. some time after the death), relevant evidence has been collected, and few contentious matters are still to be decided.

The final comment above is consistent with the view that the process of arriving at the recorded facts-of-the-matter is a structured, organisational process; that the sorting and construction of an organised account takes place in the routine activities of coroners' officers, pathologists, etc; and that it is unsurprising that the verdict tends, itself, to be unsurprising. The role of the jury is, from an organisational point of view,

undoubtedly a peripheral one: although one might care to offer various other reasons why the jury "should be there". That, of course, is a separate question, and not one which concerns us.

A related issue, touched on in interview with some, but not all, coroners, was the extent to which any of the participants in the process of constructing the facts of the matter might seek to impose their particular definition of the situation: in other words, had coroners ever experienced any pressure? In reply, the attitude of the family was most often mentioned.* The family of the deceased may object to the idea of a public hearing, to the carrying out of a post-mortem, and to a suicide verdict. One coroner said that clergymen may also express an antipathy to suicide verdicts. Two further, contradictory, pressures had been experienced by two other coroners. One reported that the Home Office "exerts some pressure": it "encourages" the use of the open verdict rather than a definite verdict of suicide. His colleague indicated that "great pressure is brought on us by the police to arrive at a definite verdict" rather than an open verdict, explaining that, for the police, an open verdict constitutes an unresolved case with the possibility of further investigation, while other verdicts effectively close the matter.

Mention of suicide might remind us that, although it is a statistically minor part of coroners' work, it occupies an important position within received public knowledge (and within sociology). Its significance was therefore examined in a little more detail in interview with coroners.

Adding the phrase "while the balance of mind was disturbed"

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* The Brodrick Report (1971, 229) indicates that dissatisfaction with inquest verdicts of suicide, by relatives of the deceased, accounts for almost all of the few High Court appeals against coroners' decisions.

to suicide verdicts recalls the legal and moral environment of coroners' work over the centuries. Is the phrase still used, despite its contemporary lack of any legal meaning? Three coroners said they used the terminology; nine did not; and three gave mixed answers. Those who used the phrase explained this in terms of: tradition; the coroner's own religious standpoint; compassion for relatives; and, historically, the distinction between "deliberate" suicide (a crime against God, and a matter affecting insurance premiums) and suicide as above - the disturbed nature of the mind apparently softening the blow.

Those coroners who did not use the phrase referred to the same distinction between felo-de-se (self murder) and the perhaps less censorious "suicide while insane": a distinction formerly recorded on coroners' returns, and having legal consequences, but nowadays obsolete. Two coroners, elaborating on their reasons for not using the phrase today,also expressed reservations about the supposed link between suicide and health or ill-healthof "the mind", and about the wisdom of speculating on this at an inquest.* Another coroner said he would not use the phrase because of consideration for the family's feelings: an interesting contrast to the coroner above who did use the phrase for precisely the same reason, and an excellent example of how coroners' own reasoning can lead to opposite points of view about the same aspect of their work. The remaining coroners took a pragmatic view of whether reference to the deceased's mental health or state of mind might be appropriate in the light

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* Published statistics indicate separate colums for "felo-de-se" and "suicide-while-insane" on coroners' returns to the Home Office up to 1938. When the published figures resume in 1957, there is only one column for suicide as-a-whole (Brodrick Report, 1971, 386). As a legal category, "felo-de-se" disappeared formally when the Suicide Act 1961 became law.

of circumstances.

Moving on, it became clear in interview that it is standard practice not to actually use the word "suicide" at an inquest. Now, purely semantic arguments are of little relevance here, but, clearly, language is a key element in the construction and reconstruction of reality. In this sense, whether or not coroners use a particular phrase, or say the word "suicide", is important. Rather than "suicide", the majority of coroners interviewed (consistent with the wording of their returns) used "killed himself/herself" although two coroners would not even say this - they might simply refer to the method used, e.g. death was self-administered. Against the general pattern, one coroner said that he continues to use the word "suicide" at inquests and in his verdicts, despite Home Office advice to the contrary. In law, of course, the different words a coroner may choose have no significance whatsoever: in legal terms, suicide is a single category, irrespective of what one may call it. In sociological terms, however, it is of interest to recall, from Chapter One, the importance of language in constructing reality and constituting the world as-it-is-known, and to consider our discussion of the sociology of death in Chapter Six below.

Following Atkinson (1973, 1978), and ground that is now familiar, the next area of consideration was the kind of evidence looked for in arriving at a verdict of suicide. As one would expect, the presence of a note, a history of ill-health, evidence of depression, and previous suicide attempts were indeed mentioned by coroners. Additionally, it was of interest that many of those interviewed emphasised that suicide must today be <u>proven</u> before the verdict is recorded - not merely <u>suspected</u>, however strongly.

Let us not discuss in detail the "cues" used by coroners in reaching suicide verdicts, but note that the matter can be seen in terms of key events as well as in terms of isolated cues. For instance, one coroner picked out the importance of the initial police investigation - a preliminary key event - within which were sub-events (the collection of statements; finding a piece of tangible evidence such as a bottle of tablets). A further key event would be the post-mortem examination. Thus there are points of significance within the developing process of reconstructing the facts-of-the-matter. To pick out individual cues tells us relatively little about this process. Isolated cues, furthermore, can point in the "wrong" direction: as we have seen, a coroner indicated one case where a note had been left, and death indeed occurred, but was eventually found to be due to "natural causes", intervening between the expressed intention and "the act". Such a case recalls our ever-present philosophical and definitional problems, for although something called "the fact of intention" and something else called "the fact of death" were present, fortuitous circumstances removed something else called "suicide" from having taken place.

Previous suicide attempts were often seen as a pointer toward a suicide verdict although, again, the widely differing perspectives of different coroners were illustrated by the coroner who saw previous suicide attempts as a negative piece of evidence: i.e., if previous "attempts" have failed, how do we know this successful attempt was not also meant to fail - but accidently succeeded? Such reasoning, of course, depends on the theory one holds about suicide attempts and their typical meaning (are they 'meant to fail', and so on).

Consistent with Atkinson (1978) once more, interviews

confirmed that methods of death in themselves pointed toward, or away from, verdicts of suicide: crudely, a hanging is probably suicide; a road-traffic death probably is not; a drowning is more contentious. Again, one need not elaborate the well-established point that the "method of suicide" is itself part of the evidence. However, overall changes in method are of interest. It is nowadays, in most parts of the country, not possible to use domestic gas as an agent of poisoning (although strictly speaking it can still be an agent of suffocation and, of course, an explosive). Self-poisoning with prescribed and commercially-available drugs is now the primary means of suicide. Some coroners noted that this change has made their task more difficult for the circumstances and nature of drug overdoses are less "obviously" cases of suicide than were the circumstances of death by domestic gas: intention to die is less readily inferred. One can reasonably suppose that suicide is, for coroners' purposes, also more difficult to prove. This may ultimately bear on changes in the "suicide rate", as may the shift in the burden of proof.

Views of suicide (whether held by coroner, layman, sociologist, psychiatrist or whoever) embody theories about it. For instance, in looking for evidence of depression in deducing that suicide is an appropriate verdict, one implicitly accepts a theory that people who commit suicide tend to have been depressed, and that people who are depressed are more likely to commit suicide than those who are not. It was of interest to ask coroners to make some of their theories explicit, especially if this revealed more than one sort of theory, which indeed it did.

One coroner distinguished an impulsive act of suicide (e.g., while depressed) from a conscious act (e.g. committed by those in

pain, chronically sick or lonely) of suicide. Another coroner suggested that those committing suicide are often under the influence of alcohol or drugs. (This latter point is highly interesting, for one can speculate upon how far the intoxicated can properly be said to have intention to die, and the consequences for one's definition of suicide if it must, indeed, include intention). Many coroners saw suicide as falling into one of several possible categories (as in 'impulsive' and 'conscious' above) and one coroner listed these in terms of motives: an incurable illness or disease; a wish not to burden relatives; mental disorder; a financial crisis; an emotional upheaval; an act of courage to save others; a biological imbalance. This sort of typology is as subtle and extensive as any derived from standard psychiatric and other classifications, but is derived from practical activity and, in turn, influences that practical activity. Finally, it is instructive to note the coroner who had given reflective thought to the nature of suicide, seeing it as an act which almost everyone has considered, however vaguely, and as an idea which fundamentally provokes fear. He did not necessarily link it to mental disorder. So coroners' theories about suicide are as varied as academic or commonsense theories. It is a mistake to suppose that coroners are collectively engaged in a monolithic enterprise, using the same sorts of theory as one another in the same sorts of way. The interviews clearly indicate this is not so.

Discussions with coroners (within the general area of suicide) touched upon the role of the Samaritans and the nature of attempted suicide, but the final specific aspect to consider here is the suicide rate and, in particular, coroners' views (in the late 1970s) of why the suicide rate in England and Wales

was falling, at a time of international increase. We need not, at this point in the discussion, return to our consideration of the problem of social reality, but it can be suggested that an account of changes in the suicide rate is in principle possible purely in terms of changes in the rate-producing process. No judgement need then be made about assumed changes in the 'natural' category of 'suicidal behaviour' or about economic changes such as unemployment. Changes in the rate-producing process plausibly include the newly-introduced burden of proof together with the typical characteristics of self-poisoning which make that proof less readily accessible. Other things being equal, those two factors might rule out a suicide verdict where one would hitherto have been recorded. Such an account, then, needs to make no mention of behaviour-out-there: that question is left open.

Coroners' comments lent considerable support to a 'rate-producing' account. This in itself is interesting, given that sociologists (e.g. Bagley 1972), psychiatrists(e.g. Barraclough, Jennings and Moss 1977) and the press* can, without apparent difficulty, produce positivist explanations of 'why fewer people are committing suicide': or, latterly, of 'why more people are committing suicide' in the light of the often assumed link with unemployment.**

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* May 1977: "Life's Good When Times Are Hard. Remember that favourite saying that we British are at our best when we've got our backs to the wall? Well, there are statistics to prove it. Since Britain was first swamped by the current economic storms, our suicide rate has dropped by a third, according to World Health Organisation figures. Everywhere else, more people have killed themselves than ever before ..." This frequently heard thesis from the late 1970s was not so often articulated during the subsequent recession.

** For a sceptical discussion, see Platt (1982).

Several coroners did not offer those sorts of explanation. Indeed, their accounts were similar to our own developing perspective. For instance, a part-time coroner said that "suicide is not decreasing" - rather, verdicts are changing. He also said that, in his experience, open verdicts were being recorded more often. Another coroner explicitly referred to the "false impression" given by a declining suicide rate: it is, he said, a matter of how suicide is defined, and where the statistics came from. Reference was made to the High Court appeal case in the early 70s when, in overturning a verdict of suicide, it was established that suicide must be proven.* A full-time coroner made the same point, adding that he had searched his own records, and drew the conclusion that by adding together those open verdicts he privately thought to be suicide, with actual suicide verdicts, there had been no change. Such comments are illuminating, although we do not wish here to commence 'recalculations' of the rates.

The differences between coroners were not absent in discussing the question of proof. One coroner said the law expects him to "sit in judgement", looking for a "reasonable probability" of suicide: those who say suicide must be proven are, he said, wrong. As always, the differing perceptions of individual coroners - and the differing nature of their particular work - were quite clear.

Finally, open verdicts were discussed. Their status as a repository for uncertain or unproven suicides will not be pursued but it is of interest that open verdicts can be seen as verdicts with specific uses and meanings, and not only as a shorthand term for the absence of a definite verdict. For instance, one full-time coroner said that he returned an open verdict "whenever I'm

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* See Chapter Seven

not convinced it's one thing or another." He added, however, that an open verdict might be recorded where there is an impasse, or conflict, between two possible, but definite, verdicts - e.g. suicide and misadventure - which is rather different from being unconvinced by either one. The same verdict might also be recorded, he said, where there is simply, quantitively, not enough evidence: or where it might do harm of some sort to be more precise. Here, then, from a single coroner, are four sorts of basis for an open verdict: unconvincing nature of the evidence; difficulty of choice between possible verdicts; lack of evidence; instrument of prudent caution. In a preliminary way, it can perhaps be seen that an open verdict - like much else in coroners' work - may carry various, different, meanings.

Other coroners referred to the familiar area of borderline suicide/accident in discussing the open verdict: in particular, to lack of evidence of intention. Within this category of 'borderline' cases, a particular <u>means</u> of death was referred to i.e., drowning. Drug-overdose cases were also mentioned.

However, to elaborate our point above, the open verdict may be seen to have more than one meaning and, indeed, to have specific functions. A part-time coroner suggested that the open verdict may be useful in certain circumstances, as it allows the police to continue their investigations without the matter being formally concluded by the coroner. Another coroner saw the open verdict as a valuable "standby", and another saw it as indicating in all cases that "some essential element is missing."

Uniquely, a part-time coroner suggested yet another instance where the open verdict might be used. He cited an inquest where he did not believe the evidence given on oath by the family of the deceased. It was at variance with their original statements.

An open verdict was therefore recorded.

It is fairly clear that the open verdict, an apparently inconclusive column on coroners' returns, can have a multiplicity of meanings. It can function not only as "lack of verdict" but also as an implicitly meaningful verdict (in more than one way) in its own right. Again, coroners had different attitudes towards the verdict: one said he would like to see the open verdict recorded more often - "the lawyer in me speaking" - another said that the open verdict is "not a verdict one encourages." The diversity of coroners' attitudes and perceptions is, again, clear: ultimately, these attitudinal differences become qualitative differences of meaning.

Finally, using one coroner's account and a newspaper report, it is of interest to consider the emergence of an open verdict from disparate strands of evidence, and the reasoning which lies behind the emergence of this verdict.

An inquest recently held by the coroner's deputy was elaborated. The deceased had drowned. The post-mortem examination ruled out the presence of alcohol or poison. Evidence suggested that the individual's social life had been normal. There was held to be some indication of depression, but not of intention to die, particularly as there was no note. The individual could have been trying to jump over the waterway. There were seen to be sufficient tablets and commercially available drugs in the deceased's flat for him to have taken his life <u>that</u> way: had he wished to.

In such a case, the strands of evidence, and the implicit meaning they are held to contain, do not lend themselves to immediate reconstruction as an obvious verdict. In this sense, it is a 'typical' open verdict, not because open verdicts are

characteristically similar (we have seen that they are not) but because it 'typically' indicates a construction not akin to the more immediately coherent, cohesive sorts of evidence found in non-open verdicts.

In this particular case, the press reported the coroner's deputy as follows:

> ..... there is nobody who can say whether he was pushed, fell, slipped, jumped or intended to take his own life.

3 (5) Discretionary Authority

There are many areas in which coroners exercise discretionary authority. There are many areas in which judges, policemen, lawyers and Governments exercise discretion too, of course, but before examining this more general topic, the particular views of coroners will be briefly discussed.

Discretion may be a misleading term: it is easy, but wrong, to suppose that a discretionary decision is an arbitrary one. It is useful to remember that the law itself embodies discretion and that statutes relating to coroners' duties do not invariably prescribe inflexible, or even fairly exact, procedures. Furthermore, beyond the area covered by statute, within the province of convention and tradition, discretion operates more freely. Not surprisingly there were differences of opinion amongst coroners interviewed: one said he had "every discretion", another that he had very little. However, the general view was that discretion is exercised at several points in the investigation.

At the initial stage, the coroner has to decide whether or not a case properly falls within his jurisdiction: judgement is central. Moreover, this initial decision is based - in part - on informal processes e.g. on liaison with the doctor who referred

the case. Here, the law can be interpreted in various ways. Frequently a doctor might informally discuss the circumstances of a death before making a referral. In some cases, the decision might be clear-cut. As one coroner pointed out, where a death certificate is referred back to the coroner from the Registrar (see Figure 2(2)1), the decision to accept has "nothing to do" with the coroner: he must accept responsibility. Violent deaths are also clearly the coroner's responsibility in this sense. Yet the statutory responsibilities are hardly precise:

> Under section 3 of the Coroners' Act 1887, a coroner has a duty to make enquiries whenever he is informed that there is lying within his jurisdiction the body of a person who there is reason to believe may have died a violent or unnatural death the cause of which is unknown or has died in prison or in any place or circumstances which, under another Act, require an inquest to be held.
>
> (Brodrick Report, 1971, 50).

The ambiguity of the law - at the very <u>first</u> stage of the process - was well illustrated by the ultimate judgement in the Helen Smith case.*

Although the Registrar of Births and Deaths has a statutory duty to report certain deaths to the coroner, the only obligation on anyone else, including doctors, to report any death to the coroner rests in common law:

> ..... the deaths into which a coroner has a duty to enquire are nowhere set out in clear and unmistakable terms.
>
> (Brodrick Report, 1971, 51).

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* As we have seen, the coroner's initial decision not to accept that the death was within his jurisdiction, and hence an inquest would not be held (because death occurred abroad) was upheld by the Queen's Bench Division but then revised by the Court of Appeal. Amongst the many journalistic accounts of the Smith case are Wilson and Harrison (1983).

After the initial decision to accept, the next step in the process where discretion is exercised is in deciding whether to use pink form 'A' or 'B'. The nature of the death, the geographical area, and the coroner's attitude are crucial here. In terms of attitude, as we have already noted, one coroner saw post-mortems as generally unnecessary, while another said he never used pink form 'A', reasoning that if a death is properly a matter for the coroner at all, then a post-mortem is desirable. Coroners' geographical areas revealed some interesting differences too. A coroner in a large rural jurisdiction commented that many people, living in relative isolation in the country, rarely see their G.P. In the event of death, the doctor would therefore be obliged to notify the coroner (if he did not, the Registrar would in any case refer the death back) even in apparent cases of natural causes. This inflates the coroner's workload by producing a number of form 'A' cases which might never reach the urban coroner. Here, the physical area in which the coroner works produces 'extra' coroners' cases, which adds another dimension to our consideration of the rate-producing processes, and has implications for geographical statistical comparisons.

Returning to the subject of discretion, we find that although the law specifies the circumstances in which an inquest is to be held (although even this has been the object of appeal), the coroner retains an absolute discretionary power to hold inquests on any other death, with or without a jury. Further, as one coroner pointed out, he also has the authority to decide what constitutes admissible evidence.

We have already noted that there is no logical conflict between law and discretion, for law itself embodies, and structures, discretion. One coroner's remarks provided a further interpre-

tation of this: while coroners are obliged to hold an inquest on all unnatural deaths, the category of 'unnatural death' is open to argument - or to discretion. Even a fairly clear-cut statutory requirement, like the 14-day rule, is certainly interpreted more or less strictly. And within common law, as we have noted, discretionary authority can clearly be exercised more freely.

A coroner reiterated the words of the Brodrick Report in saying that no single document codifies the law and practice of coroners' work. This coroner added that circumstances often force the coroner to exercise his personal judgement, giving the example of a doctor believing he can certify, where the coroner has to decide whether the proposed "cause of death" is directly related to what the doctor has been treating the patient for. If the doctor were to say "it must have been a heart attack" is he making a clinical judgement, or repeating the words of relatives who knew the individual had a history of heart trouble, and thus, as the coroner put it, "carrying out his own private inquest?" Here, then, the coroner exercises his discretionary authority and, as the title of this section of the discussion suggests, 'authority' is as significant as 'discretion' for, to put it simply, what the coroner says 'goes', for most practical purposes. This is important, and we have already noted that the historical development of coroners' work has left a substantial authority vested in the office of coroner today: greater, for instance, than that of a chief constable of police. It is not surprising that the development of coroners' work over such a long period, without any one point at which the nature of the office of coroner was systematically evaluated or codified by the state, has led, on the one hand, to a large 'quantity' of authority and, on the other, to a large degree of discretion and

flexibility in the use of that authority.

A coroner pointed to his own wide discretion in law and also to that of the doctor, police officer, and so on: indeed it would be possible, as this coroner had done, to construct a flow-chart of all the possible "paths" a death might take, to the point of eventual registration, and identifying the points at which the discretionary decisions of coroners and others influence the eventual "destination" of the death. Several coroners indicated, as we have noted, that statutory duties - especially to view the body, which was mentioned by three coroners - contain the possibility of discretionary decisions.

The coroner's authority is not exercised in isolation: other officials exercise judgment and discretion too. For the moment, let us note that, in the important historical and legal context, the individual coroner determines - to a significant degree - the nature of his work, the way investigations are carried out, special local procedures to be followed (e.g. that all deaths in hospital within 24 hours of admission be notified to the coroner), and the way his authority is exercised. These processes influence the final result: i.e. the verdict, the officially-recognised construction of events, the facts-of-the-matter. Coroners' own perceptions and opinions, as recorded here, are a relevant part of this process. There is also an interesting sense in which individual coroners' opinions can be regarded as being as authoritative as the medical or legal opinions which constitute coroners' handbooks. It was often pointed out during interviews that reference books such as 'Jervis' (Purchase and Wollaston (ed), 1957) or Thurston (1976) essentially reflect opinions and accepted practice, not any definitive statement of the law. One coroner interviewed had,

as we noted, prepared his own booklet on procedures.

Finally, our conclusions about coroners' discretionary authority can briefly be considered in terms of what "discretion" means.

The practice of police discretion has been recognised within sociology for some time (e.g. Lambert, 1969; Box 1971) and could be said to operate on two levels: firstly, the discretionary power of a Chief Constable in deciding priorities within his force (e.g. a rigorous pursuit of drinking-drivers or a 'crusade' against prostitution) and, secondly, the practical discretion of the individual policeman at work. In the latter sense, "discretion" refers to the straightforward fact that the police officer cannot investigate every suspicious situation he comes across or hears about, nor can he arrest, or even speak to, every single person who might possibly have infringed a law of some kind. So, "discretion", in both this practical sense and at a higher policy level, essentially means <u>choice</u>. To say that discretion is to be defined in terms of choice does not imply that choices are arbitrary or random. They may have a systematic pattern. As Cain found in her study of urban and rural policing (Cain, 1973) these patterns may refer to the values of the particular community. (We might also recall some of the comments made by coroners from urban and rural areas). Such a systematic pattern in the exercise of discretion may properly be seen as a 'typical' pattern, and 'typical' patterns of police discretion would have a relation to police training, among other things.

"Typical discretion" also includes stereotyping of situations, events or people as falling into some pattern already recognised, or perceived as being typical, routine, or normal, as in Sudnow's "normal crimes" (1965). We can recall here the "emergence" of

inquest verdicts and the process of "routine" construction from the disorganised unstructured (potential) facts-of-the-matter.

Baldwin and McConville (1977), in a study which concluded that the organisational end-product (justice) in the Crown Court may be seen as the result of negotiation between the parties, (within a structure which defines the power of the negotiators) and which suggested that informal processes be recognised as crucial influences on the end-product were essentially discussing the exercise of discretion. So too was Carlen (1976) in her study of the justice produced in Magistrates' Courts. Baldwin and McConville, of course, make further conclusions (1977, 101-116) about the propriety and the desirability of the system they describe and its alternatives. These need not concern us here, nor would we wish to draw a parallel between that study and our present project, except to point out that discretionary power and negotiated reality are not confined solely to coroners' work but are to be found in other parts of the legal, judicial and law-enforcement systems.

In conclusion, it can be said of coroners' discretionary authority that:

(a) it is to be defined in terms of choices (i.e. discretion);

(b) choices are exercised within the context of the considerable powers of the office of coroner (i.e. authority);

(c) discretionary authority is not arbitrary or unstructured, but tends to be characterised by patterns, and these broad, general, patterns and processes can, largely, be understood in terms of historical factors;

(d) coroners' discretionary decisions are not made in isolation, as the coroner interacts with others who are themselves responsible for choices;

(e) notwithstanding the broad processes which characterise coroners' constructions in general, a very considerable individual discretion rests with the particular coroner, whose own attitudes and perceptions influence the nature of his own work.

3 (6) Conclusions: Coroners' Accounts

We have considered perceptions of coroners' work as articulated by coroners themselves. Table 3 (1)1 indicated the characteristics of the jurisdictions chosen for study and to these should be added some features discussed above: the urban or rural nature of a particular jurisdiction, the medical or legal nature of an individual coroner's training, and so on. Even at this mundane level (training, geography etc.) we began to identify differences in coroners' perceptions and the way these differences contribute to the definition of what "coroners work" means for particular coroners - and how this influences what that, particular, coroner does in the course of investigating and classifying a sudden death. Against this pattern of individualised definition of their own activity and role by coroners, we contrasted general features of the rate-producing process and the typical processes which characterise the construction of the true story. This discussion, read in conjunction with the details of the formal legal model of coroners' work and its historical development serves as a description of what coroners at the time of interview were doing in the course of their work. The three standard reference sources (Purchase and Wollaston 1957; Brodrick Report 1971; Thurston 1976) are necessarily limited in providing such a description in their concentration on the formal model, which is itself open to interpretation and debate.

Arising from the description, then, of what-coroners-do, the following conclusions can be suggested.

1) The 'coroner system' is not a discrete set of activities/institutions: that is, the activities and institutions associated with what-coroners-do are not separate from the legal/judicial system, the medical system, or the police system. This is so in some obvious organisational ways: for instance, that police officers have generally been responsible for collecting evidence, interviewing witnesses or, where an inquest is held, organising the proceedings; or that doctors are bound to be involved at the stages of reporting a death, carrying out a post-mortem, or in pronouncing when death occurred. A study of the organisation of coroners' work has, then, at the very least, to make reference to the location of that work vis-a-vis other organisations. To put it another way, the use of a term such as 'coroner system' as a convenient shorthand must be recognised as precisely that, for it is an abstraction, referring to something which, although structured, is highly diffuse. Finally, it remains more appropriate to see the 'coroner system' as not discrete, rather than as not independent. (The coroner system is independent in a sense, insofar as the coroner himself has ultimate authority over any investigation: and, of course, to conclude that the coroner system is 'not independent' may carry an implication which is not intended). It is the lack of 'separateness' which is of interest.

2) The points of overlap between coroners' work and police work, medical work, or legal/judicial work add to the routineness, the predictability, of the bulk of the work that comes before a

coroner. With overlapping "systems", and working practices built up between different officials, deaths can be processed, categorised, in an organisationally smooth way. So the links between coroners' work and other sorts of work have practical advantages for the coroner in fulfilling his responsibility in each particular case. Nonetheless, coroners find it prudent to assert their formal independence from - and authority over - all other officials involved.

3) If there is any tension within the process of categorising a particular death, it is likely to exist at the points of overlap with the work of other officials. Any such tensions or differing definitions-of-the-situation are, however, likely to be absorbed into the emerging construction of the true story, rather than being left as explicit conflicts.

4) The precise boundaries of coroners' work are not obvious in practise, nor are they rigidly defined. The boundaries have certainly changed over the centuries, and continue to change with new legislation, statutory instruments and Home Office advice, but the end result of this process of change (i.e. the boundaries of coroners' work today) is not clear-cut. This refers both to coroners' work as distinct from other sorts of work, and to coroners' work as practised by particular coroners in their own jurisdictions.

5) What constitutes coroners work for a <u>particular</u> coroner is <u>substantially influenced</u> by that coroner's individual perceptions and attitudes. It is not only that coroners (like anyone) may interpret their work in rather different ways but, moreover, that coroners may define or help to determine the nature of what 'their work' actually is.

6) We can refer to the organisationally-produced end-product of any coroners' investigation as the true-story of that death. The true-story is the formal result of a process which may itself be both formal and informal: and it is recognised, legally and publicly, as the record of the facts-of-the-matter. Without wishing to adopt a position of total relativism, it can still be maintained that studies which aim to re-classify coroners' decisions (e.g. to render suicide statistics 'more reliable') are of extremely limited value, resting on the questionable philosophical assumption that real numbers of a naturally-occurring type-of-death are knowable and the questionable practical assumption that a researcher can somehow carry out a coroner's work better than a coroner can. In the present study we have termed the end-result of coroners' investigations 'true stories' because, in practise, this is what they are. The way in which true stories are constructed has been illuminated. Whether one might wish to challenge the plausibility of particular true-stories from some stock of knowledge (psychiatry, medicine, sociology) is altogether a separate issue, and one we leave open.

7) The inquest is not separate from other courts of law. Aside from cases, up to recent times, when inquests were treated as criminal courts in, for instance, naming the individual said to be guilty of murder, there remain less spectacular ways in which the inquest is linked to other courts. The notes of proceedings of the inquest may be used in other courts. The inquest may be used as a 'dummy-run' for a subsequent prosecution in another court. More superficially, inquests where witnesses are legally represented may certainly look like other courts even though their function is not the same.

The presence of an inquest jury creates a similar image. The inquest is unique, its origins are ancient, and as an inquisitorial forum it is a singular part of the courts system of England and Wales. Nonetheless, it does not exist in a vacuum, and its proceedings as well as its verdict may have implications beyond the issues which concern the coroner.

8) The inquest is the most visible and most formally-structured layer of a process which, in its entirety, covers far more than the inquest proceedings themselves. Included in this process are medical reports, the results of the post-mortem examination, statements to the police, and so on. From these elements, an emergent true story is forming before the case reaches the stage of the inquest: "order" is being established from unformed pieces of potential evidence and structure is being imposed. If form 'A' and 'B' cases are added too - where no inquest is held - it becomes clear that the inquest, although the most formal and most public element of coroners' work, is a relatively small part of the total process. There are several grounds on which it can sensibly be argued that 'inquests are important' (not least because they are public) but it does not therefore follow that inquests are at all important in establishing 'cause of death', 'identity of deceased', etc: such matters are almost invariably already 'known'. The inquest is important, structurally, not for what it <u>discovers</u>, but for what it <u>does</u>: i.e. formally conclude the matter by providing the binding definition-of-the situation.

9) The inquest must be considered, also, in historical terms. The structure and functions of the inquest have been subject to

considerable change but some structural features still refer to functions which no longer exist, especially in former areas of criminal jurisdiction.

10) Very little of coroners' work is contentious, and it is remarkably uncontroversial. The 'reclassification' of verdicts to provide 'better suicide statistics' for instance - or the controversial nature of some deaths in prison or police custody - refer to an extremely small part of coroners' work. Insofar as coroners' work as a whole is the focus of the present study, it is important to note that the processes described refer to this whole range of work. Similarly, in Chapter Four below, the discussion of observation at a coroner's court will refer not only to suicide verdicts, but to other verdicts and their construction. In short, what can be taken as of <u>sociological</u> importance in the work of the coroner may bear no resemblance at all to particular policy or political matters of assumed importance in the work of the coroner.

11) The press do not necessarily present inquest reports in line with what coroners perceive as the significant elements. The press can be seen as undertaking a reconstruction of the coroner's construction of the facts-of-the-matter. This reconstruction is interesting as a subject for sociological study - one might wish to look for characteristic features of press reconstruction - but the press report does not provide substantive information about 'what coroners do'. The press report provides information about how the press reconstruct constructions: in this sense, the press can be seen as object of study in its own right.

12) The assembly of a verdict of suicide is not based on isolated cues, or separate, specific pieces of evidence. The construction of any verdict can be seen as a process within which there are key events: these events, together with other stages in the investigation process such as the post-mortem examination, can be termed 'points of significance'. At these points of significance, the profile of the eventual construction is considerably influenced.

13) The open verdict is not (only) a term for absence-of-verdict. It is used as a construction in itself, as denoting one of several true stories which are not otherwise accommodated within the range of available verdicts.

14) Within coroners' work, discretionary choices are available and this discretion is not capricious, but tends to be exercised along lines which typify routine coroners' investigations. Discretion characterises coroners' work in general, and discretionary decisions of a particular kind may also be made by individual coroners.

15) Discretion, and the whole process of construction whether at an inquest or by one of the non-inquest procedures, is exercised within the context of the individual coroner's considerable authority. Reference, again, can usefully be made to historical factors. The final significant feature of coroners' true stories is that they are, generally, binding. The coroner is entrusted by the state with the formal responsibility of accounting for approximately one-fifth of the deaths in England and Wales.

The conclusions above are based upon field interviews with coroners: the next step in our discussion of how unexpected

deaths are 'accounted for' is to consider the results of systematic observation at a coroner's court. Conclusions so far can thus be evaluated in terms of an ethnographic study of the inquest.

CHAPTER FOUR: AN ETHNOGRAPHY OF THE CORONER'S INQUEST.

4 (1) Introduction

The three empirical sources for our conclusions about coroners' work are: what coroners say; observation of what coroners do; and analysis of the statistical products of coroners' activity. The present chapter discusses the results of observation at coroners' inquests and, in a much more limited way, observation of non-inquest work (e.g. visiting the scene of a death) in the rare instance of such work becoming observable. Informal observation, itself contributing to empirical material, was also possible at many, perhaps unexpected, points (e.g. during the many weeks in a coroner's office collecting and copying statistical material - see Chapter Five below). However, observation in its rigorous form was observation of the formal, public, coroner's inquest.

Fifty inquests were attended, over a period of eight months, in the urban centre where a full-time coroner was based. Tape recordings are not permitted in open courts of law: very detailed written notes were made during inquests and re-written as soon as possible afterwards. Observation, in terms of numbers of inquests attended, detail collected, and what is intended to be a rigorous consideration of the material produced, can be regarded as systematic. In addition to this central period of systematic observation, two further inquests were attended (in the same jurisdiction as before) at a later date, purely to provide an informal, impressionistic, element in considering the conclusions reached during the observation period proper. Further - in the jurisdiction of another full-time coroner - it proved possible to visit the scene of a road traffic incident

and, three months after the deaths, to attend the inquest. This was an invaluable and unique opportunity to 'follow through' the process of construction from the beginning of a coroner's involvement to the end.

Thus, the empirical basis of the present chapter is systematic observation of fifty inquests: supplemented by additional, observed, inquests and other, normally non-observable, parts of coroners' work. The period of systematic observation took place prior to the interviews discussed in Chapter Three above.

It was decided to concentrate upon only one coroner in order to observe the range of verdicts and the range of circumstances in which constructions take place. It was felt that this was more appropriately done within a single jurisdiction. Observation of inquests in several jurisdictions would have permitted comparisons of how individual coroners conduct inquests in their particular ways, but this sort of comparison between coroners was covered by interview rather than by observation. By focussing upon fifty inquests in a single court, the detailed social organisation of that court became visible. Thus we are less interested here in individual coroners' particular perceptions: the aim, instead, is to approach an ethnographic study of a single coroner's public,formal, domain, a detailed and intensive study of that particular 'society'. It might be said that other coroners might conduct their inquests rather differently. That, without doubt, is to some degree so, but is not of relevance insofar as comparative material is not being sought in this part of the study.

To briefly review the position already outlined, a methodology presupposes a theoretical stance (whether or not the researcher makes this explicit) and a practical framework for research

practice. The perspective adopted in the present study has already been made clear. The elements of the empirical activity have been outlined. It remains only to restate the visibility of the research process, i.e., that its assumptions (including theoretical stance) are open to inspection, its practice (as well as its results) are clearly described and, thus, it can be judged by its internal logic, irrespective of whether another researcher might have chosen a different path.

Observation at inquests potentially involves an ethical problem not raised by individual interviews with coroners or by a private statistical search: attending inquests might be seen as an intrusion into private grief. This was considered before commencing this part of the study. It was decided that the inquest is a public forum and does not require the special permission to attend which would be required to observe, say, a juvenile court. Coroners' courts typically involve attendance by witnesses, police, medical staff, press reporters and, in some cases, jurors. It was not felt that the presence of another added to the distress of relatives. In practice, all inquests were attended with the prior knowledge of the coroner or his officer. Seating and note-taking were arranged with care: often, the least obtrusive solution was to sit with newspaper reporters. On completion of the period of systematic observation, it was quite clear that no problems of an ethical kind, or in terms of personal contact with participants, had arisen.

The discussion of the results of this part of the study are prefaced by procedural notes and details of verdicts reached at inquests attended.

4 (2) Procedural Outline

The formal properties of the inquest were discussed in Chapter Two above: let us briefly restate that in Chapter Two, Section Three, it was suggested that inquests are conducted for three sorts of reason. Firstly, an examination of "circumstances" of death is permitted even where the immediate, medical, "cause of death" is already, for practical purposes, established. Secondly, a public forum is established. Thirdly, inquests are held simply because the law stipulates that they must be.

Tables 4(2) 1 & 2 indicate some of the descriptive features of the fifty inquests attended during the period of systematic observation.

TABLE 4(2)1: VERDICTS RECORDED AT INQUESTS ATTENDED

Misadventure	36
Suicide	10
Open Verdict	3
Adjourned*	1
Total	50

* Inquest adjourned indefinitely under 1926 Coroners (Amendment) Act, s.20(1), i.e. where a person has already been charged with murder, manslaughter or infanticide.

TABLE 4(2)2: JURIES AT INQUESTS ATTENDED

Inquests with Jury**	21
Inquests without Jury	29
Total	50

** A considerable number of these inquests would today not be held with a jury: observation took place before the 1977 Criminal Law Act was fully implemented. This might be considered fortunate insofar as a sociological resource was "captured" before becoming, if not extinct, rather rare.

Tables 4(2)1 and 4(2)2 can be linked together by noting, firstly, that all twenty-one inquests to which a jury was summoned were concluded by verdicts of misadventure and, secondly, that no juries were present at any of the thirteen inquests where open verdicts or verdicts of suicide were recorded. Inquests with juries tended to be held in a larger, and more formal courtroom than the smaller-scale non-jury inquests: the apparatus and ritual of the courtroom, expected by conventional wisdom to be normal features of courts of law, were much more visible at jury-inquests. Yet the similarities between even the jury-inquest and other courts of law should not be taken too far: the differences are equally striking. The unique nature of the inquest must be remembered.

Carlen talks of the magistrate entering the court as follows:

> His entrance to the courtroom is both staged and heralded. The opening of the court is signalled by an usher calling 'All Stand' and 'Silence in Court.' When everybody in the courtroom is standing in silence the magistrate enters, his appearance being staged via the door of which he has the exclusive use and which appears to seal off those innermost areas of the court to which the public never has access.
>
> (Carlen 1976, 31).

This passage almost exactly describes the entrance of the coroner to the jury-inquests attended, if "coroner's officer" is substituted for "usher". An account of magistrates' courts and <u>some</u> coroners' courts can indeed include common elements of ritual and formal procedure, pointing to underlying meanings about the role of law and those who personify it and, in the widest sense, to social control. Yet two sorts of reservation about this comparison must be made. Firstly, the observation of ritual and formal practice can imply more significance than is warranted: for instance, in discussing "innermost areas ..... to which the

public never has access" one could refer to a library, a University, a railway station or a shop as readily as one might refer to (any) court of law, and with no more significance. This is certainly not to say that ritual and procedure are unimportant (they are discussed below) but they are areas to which a spurious importance can be attached. Secondly, other features of Carlen's description of the magistrate's court are not applicable to the inquests attended, the difference hinging on the degree of formality. On a mundane level, for instance, witnesses at an inquest tend to sit beside or near the coroner, rather than standing in the 'dock', and they might often be addressed by their forenames. More generally, what we might call the "deprivation of information" so often revealed in Carlen's study - for instance, the client arriving at 10.00a.m. as instructed, but not appearing until 12.30 without being offered an explanation (Carlen 1976, 27) - is far less obviously the case in a coroner's court.

The structure and procedure of the inquest is highly important but similarities with other courts of law must be treated with caution. The status of the inquest as an inquisitorial, not an adversary, forum is again of relevance.

In 4(3) below, a detailed account of the process of categorisation, based on observation and drawing from specific inquests, is given. It may be useful to preface such an account by a simple descriptive sketch of inquest procedure. Let us suppose that a jury is present at this particular inquest. The description is drawn from fieldnotes.

At this inquest, eight jurors, all male, have been summoned. Two solicitors are in attendance, together with civilian and police witnesses. A senior police officer is also present: he

does not participate in the proceedings. Prior to the start of the inquest, the coroner's officer has been meeting jurors individually, checking details and, in appropriate cases, paying expenses.

The coroner's officer opens the inquest formally with the words "all rise"; the coroner enters; and (as this is the first of three inquests held at one session), the coroner's officer briefly addresses each juror, telling them that they are required to determine the causes and circumstances of three deaths. The names of the deceased are given. The coroner himself calls each juror by name. The coroner's officer asks the jury as a whole to stand, and the oath is taken. The jury is asked to return a true and just verdict.

The coroner addresses the jury: it is reminded that the inquest is a court of record, not a court of trial, and the jurors are told they have two duties: to return a true verdict, and to decide whether criminal negligence has been proven to exist. It is pointed out that the inquest does not apportion blame, nor seek compensation. The central concern is said by the coroner to be to discover "when, where and by what means the deceased came to his or her death."

The inquest is now in progress. As witnesses in turn give their evidence, they individually take the oath. First witness: a relation of the deceased; general and biographical information is presented. Second witness: a police officer; photographs and plans of the scene of death are presented. Third witness: a member of the public who was near to the scene of the death. Fourth witness: another member of the public; a witness to the incident. Fifth witness: another police officer; detailed questions about the scene of the death are given. Sixth witness: a pathologist; the results of the post-mortem examination are

read out to the court and an opinion of cause of death is given.

In this sample case of an inquest-with-jury, no further witnesses are called. Witnesses, individually, may or may not have been asked questions by the solicitors or other properly "interested parties." The coroner is likely to exercise a close control over the propriety of particular questions. The coroner's own questions to witnesses may be quite informal and conversational, amounting to what would, in other circumstances, be leading questions.

Finally, the coroner sums up. A verdict may be suggested to the jury, or a range of possible verdicts may be suggested. It may be that the coroner advises the jury that a particular verdict is <u>not</u> appropriate, but otherwise makes no suggestion.

The jury may not necessarily retire to consider the verdict: it may be decided and expressed in open court after brief consultation between jurors. The coroner formally records the verdict and would tend to add comments, especially if the family of the deceased are present.

At this inquest, the coroner's officer formally concludes the proceedings by "all rise".

An inquest conducted without a jury is less formal than the above account suggests. In the absence of the jurors, those present may comprise: the coroner; his secretary; the coroner's officer; police and civilian witnesses. Those present may number only six or seven in total. A newspaper reporter may or may not be present. The most formal elements of such an inquest are simply to rise when the coroner enters and leaves and, of course, for witnesses to take the oath before giving evidence. Such an inquest may be quite brief in duration.

The inquest described above is not meant to represent all

inquests, nor are particular details meant to have any large degree of precision. The "procedural outline" above is a sketch of a coroner's court: it assists in the understanding of the detailed "process of construction" presented below.

4 (3) Observing the Process of Construction

It was stated in Chapter One above that society (and phenomena within 'it') acquire apparent objectivity because members of society define (and continually redefine) phenomena as real (Walsh 1972, 19). What coroners do, and produce, at an inquest also has this ostensible objectivity, this facticity, precisely because coroners, and other interacting participants at the inquest, similarly define and redefine the reality of their particular world by their activities: the reality of the circumstances of the death; the true story; the facts-of-the-matter; the procedures and structure of the coroner system itself. Attending inquests is a means of getting close to this production of reality. The material collected by observation complements that collected at interview and in statistical searches toward the same objective of making visible the process of construction.

In her study of magistrates' courts, Carlen was centrally interested in the operation of rules: in both their "abstract" and their "situated" meanings, and in the performance of "rule users" (Carlen 1976, 5). An inspiration here is Schutz, who, in Carlen's words, directed himself to "..... the taken-for-granted nature of the implicit rules of social interaction." (Carlen 1976, 8). Rules are perhaps unrecognised in those everyday situations where meanings are unproblematic, shared, and obvious, but when meanings become more problematic - as in the coroners' task - then rules become significant. Some of the rules in coroners' work have been discussed already and, it might be noted,

in a mundane sense formal rules are invoked generally in situations where dispute or unclear meaning exist, whether in a court of law, a football match or a traffic system. At the inquest, the implicit rules (and the activities of those using them) are just as important as the formal rules.

To summarise: observation of the inquest begins with a focus upon the production and reproduction of reality and upon the importance of rules. It also includes an initial recognition that coroners' work is, for coroners, largely normal and routine. Sudnow's description of a 'normal crime' (1965) can be easily translated into the coroner's 'normal death' and its subordinate categories: normal suicide, normal accident, and so on. Sudnow, conducting research in an American Public Defender office, saw normal crime as the routine classification by court officials of diverse unformed instances of law breaking into manageable, stereotypical, categories: normal crimes are phenomena seen as having typical features, typically happening in certain places in typical circumstances, and typically being carried out by certain people, being offences for which the Public Defender can "..... provide some form of proverbial characterisation." (Sudnow 1965, 260).

In the context of the normalisation of deaths at the inquest, there ceases to be any need to search for characteristics of the death or the deceased other than those consistent with the emergent true story: a similar point to that made above in discussing coroners' comments at interview. Sudnow saw the construction of the normal crime as a practical way of organising the world in the Public Defender office: a form of "practically tested criminological wisdom." (Sudnow 1965, 275).

It might be said that Carlen and Sudnow were concerned with

institutions and relations referring to explicit social control and that coroners, at their inquests, do not have the same interest. It might then be said that, as coroners are not agents of social control, conclusions about the nature of the inquest need not bear any resemblance to conclusions one might wish to make about other courts of law. However, such a view of the inquest would be sociologically quite naive. The coroner is, in conducting his inquest, concerned with social control. This need not imply control in any overt or quasi-political sense, of course, but it is clear that the inquest is indeed a mechanism of control in several specific ways: there are residual powers in matters of criminal law; discretionary powers over the admissibility of evidence and conduct of the inquest; the symbolic authority represented by the formal characteristics of the inquest; the central responsibility for providing the officially sanctioned definition of the true story. Despite the withering away of many of the coroner's former powers, the inquest retains the shell of a control apparatus: it could, in the working lifetime of at least one of the coroners interviewed, despatch individuals undefended, and not present, as murderers. The separate issue of participants' perceptions of the modern inquest might also be considered: a study by Barraclough and Shepherd of spouses' reactions to the inquest found one remarking:

> You feel up for trial, you feel as if you might be had up for prison for something you've done.
> (Barraclough and Shepherd 1976, 110)

The question of social control is complex and can usefully be reconsidered in our concluding comments. Let us consider whether Cicourel's early work (1968) may be of use in drawing

together our preliminary remarks. It was suggested in Chapter One that Cicourel's work still has much to offer in terms of theory and method. Cicourel's work on the "negotiation of dispositions" in the courtroom (1968, 292 ff) predates later sociological work on the negotiation of justice in general: the ethnographic style of this section of his study also informs the presentation of inquest material below.

Cicourel, in looking at the practical arrangements for the product known as juvenile justice, suggested that members' (here, the police officers') "background expectancies" and "sense of social structure" provide the means for transforming disorganised objects into "recognizable and intelligent displays making up everyday social organisation." (1968, 328). The parallel with coroners' (and coroners' officers' and other officials') translation of "disorder" into "order" is quite clear, and it might also be remembered that Cicourel described such "background expectancies" as <u>invariant</u> (1968, 328). This characterisation, of course, is open to misunderstanding. Invariant can simply be taken to mean systematic and non-arbitrary: having structure. Again, the parallel with the coroner's officers' initial categorisation of a death is apparent when Cicourel describes the arrival of the police at the scene of an alleged infraction of the law:

> ..... their sense of social structure and memory of past events in the neighbourhood provide initial interpretations as to what happened. (1968, 328)

Cicourel's conclusions as a whole also draw attention to the methods by which conversational interchanges or accounts are transformed into documentary records (1968, 332). Cicourel's concerns here have since influenced the development of microscopic

ethnomethodology. The relevance to the present study is in terms not only of witnesses' accounts being assimilated by the coroner into the emergent facts-of-the-matter (to be officially recorded) but in terms of witnesses', and relatives', verbal accounts being transformed into written evidence - tangible versions of potential true stories - at very early stages of the investigation of a death. Amongst such tangible documents, the pathologist's report of the post-mortem examination expresses not even a structuring of a conversation, but what is explicitly referred to by the pathologist as his opinion as to cause of death. The post-mortem report, indeed, becomes a "key document", as we have already noted.

If, in the following passage the term "sudden death" is substituted for "delinquent",the proper concerns of an ethnography of the coroner's inquest are perhaps made rather more clear:

> the "delinquent" is an emergent product, transformed over time according to a sequence of encounters, oral and written reports, prospective readings, retrospective readings of "what happened", and the practical circumstances of "settling" matters in everyday agency business. (Cicourel, 1968, 333).

Insofar as the coroner is engaged, at his inquest, in a practical task of "settling matters", the question arises: what is the status of an ethnographic approach to the description of such a task? Perhaps the resolution of such a question is in a consideration of alternatives to ethnographic interview/observation. One alternative to an ethnographic approach at the inquest is a purely formal-legal description: and that has already been offered above. Another alternative is to go further than ethnography into a sociolinguistic analysis of verbal interaction: that, however, would involve practical difficulties

(for instance, inquest proceedings cannot be recorded on tape) as well as a shift in the stated interests of the present study. In terms of our present concerns and overall aims, an ethnographic account provides a practically-adequate description, i.e. a basis for understanding. Fabian comments that "ethnographic knowledge" is valid not in terms of adherence to a "scientific code" of some kind, but in terms of "communicative processes." (Fabian 1979, 1). Indeed, Fabian asserts that ethnography becomes less "objective" in adopting a supposedly "analytical" stance, rather than an "interpretive" perspective (1979, 1).

Fabian's comments are consistent with the approach to the inquest adopted here, although the separate issue of objectivity can, for now, be bracketed away as an unnecessary digression. Fabian's central point is quite simple:

> The point is not that we should rather communicate than formalize when doing ethnography, but that we should realize that all aspects of the production of ethnographic knowledge, including formalizations, occur in communication.
> (1979, 23).

In sum, the following ethnographic account derives from work in more than one area of sociology, but owes some inspiration to the body of work carried out in both British and American judicial settings. Carlen's concern (1976) with the operation of rules and the problem of meaning remains important, and her comments on the physical structuring of the courtroom and the tangible manifestations of institutional authority remain important too, although the applicability to a coroner's court should not be overstated. Other sociologists - such as Parker, Casburn and Turnbull (1980, 240) - have also discussed the relevance of the court proceedings themselves, even the "atmosphere" (1980, 240), in the production of justice. This requires cautious

consideration. Sudnow's concept of normal crime (1965), aside from affording a simple translation to 'normal death', can also inform a discussion of the creation of true stories, and of the 'practical wisdom' underlying true stories about sudden deaths. Cicourel's early study (1968) of the negotiation of reality and typifications involved in the production of something called juvenile justice also forms part of the basis on which descriptions are to be offered.

Two further points, although simple, can,finally, be restated. Firstly, death and dying are social affairs (Sudnow, 1967) and as De Vries has pointed out, the management of information about death is itself a subject for sociological study (De Vries, 1981, 1082). Clearly, the coroner's role in the management of such information is a central one. Secondly, a constant and underlying concern throughout the following account of the coroner's inquest is Berger and Luckmann's depiction of the social construction of reality (1967). Sociologists, of course, have looked at this process of construction in a number of settings, such as in Homan's account of "old-time pentecostal" believers (1981) or Cashmore's account of Rastafarians (1979). The process of construction at the inquest may now be illustrated. The following accounts are based upon fieldnotes recorded at specific inquests attended during the observation period. The material collected at each inquest is, first of all, presented in detailed note form: the setting is described, the participants are listed, and the evidence of each witness is then presented. Footnotes are kept to a minimum, but at certain points are included for the sake of clarity. The inquest is then discussed, where appropriate referring back to the numbered notes of each piece of evidence. Newspaper reports of the specific inquests discussed are then

presented,which allows consideration both of the characteristics of press reporting and of the means by which coroners' work is publicly "known". Finally, discussion of the inquests presented below moves to a general level, differences and similarities in inquest procedure are identified, and provisional conclusions drawn out.

Inquest A

A1. The setting is a large courtroom in police headquarters. Present: eight male jurors,* two solicitors, several civilian and police witnesses. A police officer of rank - described by the coroner as a "police chief" - is also in attendance, apparently as an observer with a potential interest in any subsequent criminal proceedings. A reporter from the local newspaper is also present.

A2. The coroner's officer has been meeting jurors individually, prior to the start of the inquest, to check identity and details, and to pay them if they have taken time from their normal employment.

A3. The coroner's officer formally announces the entrance of the coroner with the words "all rise". As inquest A is the first of three consecutive inquests to be held this morning, the coroner's officer addresses the jurors, telling them they are here to discover the causes and circumstances of the three deaths to be dealt with today. The deceased are named individually. The coroner interrupts to call each juror by name too. The coroner's officer then asks the jurors to stand, at which they repeat an oath (which again includes the names of the deceased) and are

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* The number, and gender, were unchanging features of all jury-inquests attended.

asked by the officer to return a verdict "true and just".

A4. The coroner addresses the jury, announcing that three fatal road accidents are to be considered - the word "accident" is used at this stage - and reminding the jury that this is not a court of trial, but a court of record. The jury is told that it has two duties: to return a true verdict;* and to decide whether criminal negligence has been proven to exist. The coroner points out that the inquest is not a means of apportioning blame nor of seeking compensation. The central task is to discover "..... when, where and by what means the deceased came to his or her death."

A5. The preamble to the morning's programme of inquests has merged without formal break into the specific proceedings of 'inquest A'. Mr. Crompton, the son of the deceased, is called to take the oath.** The coroner asks a very general opening question about the health of the deceased. The witness replies that his father took a considerable amount of sickness leave from work as he suffered from bronchitis: he was not at work at the time of death. The coroner asks specifically about the eyesight of the deceased. The witness replies that his father wore glasses only for reading. Brief questions upon the location of death, and upon identification by the witness, follow. The coroner invites questions from solicitors and jurors. No questions.

A6. The second witness - Police Constable Oakley - is called. He will be called again later to give his own evidence, but at this stage he is required only to read out to the court the statement of the police photographer who attended the scene of

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* The jury returns a verdict: the coroner, in formal terms, merely records it.

** All names are, of course, fictitious.

the incident, to make the photographs available to the court, and to produce his own plan of the scene, including road markings, measurements, and position of vehicles. There are no questions from solicitors, police chief, or jurors.

A7. The third witness - Mrs. O'Malley - is called. The first witness was called because of his blood relationship to the deceased and because he could be assumed to possess biographical information - and also, importantly, because he identified the body and can therefore make a statement, on oath, to that effect at the inquest. The second witness was called because of "professional competence", attendance at the scene, and presentation of tangible documents to the inquest; crudely, it was his job to be there. The third witness, however, is called to give evidence at the inquest only because of capricious circumstances: she happened to be there at the time. The coroner asks Mrs. O'Malley for a general, developing account of what happened. Mrs. O'Malley says that she was waiting at a bus-stop and saw Mr. Crompton senior step from the pavement on the other side of the road. So far as she could tell, he didn't look before crossing the road. He took two or three steps, then fell backwards, losing his balance before being hit by the car. (After setting the scene thus, Mrs. O'Malley is asked about the speed of the vehicle and weather conditions). Mrs. O'Malley continues that she didn't think the car was going very fast as it only carried Mr. Crompton a few yards along the road as it hit him. She thought the car's headlamps were illuminated. She adds that the road was wet and "greasy" but it was not raining at the time. The coroner invites questions from the properly "interested parties" as before. For the first time, solicitor 1 asks a question:What was Mr. Crompton wearing? Mrs. O'Malley replies that he was wearing a "darkish" grey coat. She adds that the road lighting was not very

good and that Mr. Crompton seemed to "shield himself" before being hit. Solicitor 2 also asks a question: did Mr. Crompton fall to the ground before the car hit him? Yes, he lost his balance. There are no questions from the jury.

A8. The fourth witness, Mrs. Fowler, was also waiting at the bus-stop. Questions cover the same ground as the questions asked of Mrs. O'Malley: an account of what happened, road conditions, the sequence of movements and events. In Mrs. Fowler's construction of the day's incident, there is a consistency with Mrs. O'Malley's account, although Mrs. Fowler is more demonstrative, less hesitant. Mrs. Fowler says that Mr. Crompton only took two steps, then fell, adding that he could have lost his balance. He "staggered" before falling backwards. As he hit the road, the car struck him. Mrs. Fowler had not seen the car until this point. The car pushed Mr. Crompton "a couple of yards" along the road. It had its headlights on. As for the weather, it was an "awful night", and it's "ever so dark on that road." At the coroner's invitation for questions once more, solicitor 1 again asked about the fall. Was Mr. Crompton actually on the ground, or still falling, as the car struck him? In answer to this direct question, Mrs. Fowler could not be sure. Did she hear a car horn, or a sound of brakes? No. Nor were there any nearby stationary vehicles. There are no questions from solicitor 2, the jury, or the police chief.

A9. P.C. Oakley is called again. He is reminded by the coroner that he is still on oath. He gives very detailed evidence, in distinct segments. First of all, P.C. Oakley reads out a statement he has prepared detailing the incident as a whole. The car (model is stated) was driven by Mr. Parrish (address stated) who was alone in the vehicle. Mr. Crompton had been walking to a bus-stop and Mr. Parrish had been driving home. Mr. Parrish "braked hard" to avoid

Mr. Crompton. Mrs. O'Malley and Mrs. Fowler were the only eye-witnesses but neither saw the car before impact. The coroner asks what was the significance of the car pushing the deceased (only) a few yards forward. P.C. Oakley replies that this indicates the car was not travelling at high speed. P.C. Oakley attended to Mr. Crompton's injuries - not thought to be serious at the time - until the arrival of an ambulance. He adds that all streetlights were found to be working, but were nonetheless not very effective. (Starting with the report on the brightness of the streetlights, the second segment of P.C. Oakley's statement continues with similarly 'technical' points). The road was constructed of separate concrete blocks, which become slippery in wet conditions. The car was found to be roadworthy. (The final part of P.C. Oakley's evidence appears as an evaluation - a drawing together of the existing drift of his account). Mr. Parrish had told P.C. Oakley that he was travelling at about 30 m.p.h.; P.C. Oakley now adds, at this stage, that he is satisfied that the driver did not act recklessly and that Mr. Cormpton stepped into the road without looking. The coroner then asks P.C. Oakley to read out in full Mr. Parrish's statement: he does so, and the speed of the car (now 28 m.p.h.) the gear it was in at the time, the use of dipped headlights, and the emphasis on not being able to avoid Mr. Crompton are again mentioned. (Thus, the final segment of P.C. Oakley's evidence has again been a formal statement, this time from the driver of the vehicle). The coroner invites questions. Solicitor 1 moves to explicit theorising in his question to P.C. Oakley: was there any mud on Mr. Crompton's shoes? (solicitor 1 amplifies his question by saying that the deceased would have crossed a grass verge to get to the road, and could therefore have slipped, especially as it had earlier been raining). The witness replies that no traces of mud were found on the shoes, nor were any

obstacles likely to have caused a fall found. Solicitor 1 also asks if there was any conversation with Mr. Crompton en route to hospital: the reply is 'no'. Solicitor 1 finally asks about contact between P.C. Oakley and Mr. Crompton's family since the incident. Solicitor 2 asks if Mr. Crompton was going to catch a bus on the same side of the road as he had been walking: 'yes'. Why then was he crossing the road at all, asks Solicitor 2? P.C. Oakley replies that there was no obvious reason for this. Evidence from this witness thus concludes on an indefinite note.

A10. The only medical witness, Dr. French, consultant pathologist to the local Health Authority, is called. After an opening, facilitating, question from the coroner, Dr. French's evidence is given in short, precise pieces, with no elaborated speculative reasoning. The deceased was admitted to (the local hospital) with sustained multiple injuries, an operation was performed, but Mr. Crompton's condition deteriorated and he died on (date). Following a post-mortem examination, Dr. French found abrasions, blood in the lungs, old fractures of some ribs, recent fractures of other ribs, together with fractures of the collar bone and pelvis. The skull was intact and the brain "normal". Death was said to be due to "..... acute broncho-pneumonia following multiple injuries." Solicitor 1 is again the only source of questions. Would Mr. Crompton have been capable of a short dash, despite his breathing troubles? Dr. French "would have thought so." Did he hit the ground before the car hit him? "I wouldn't like to commit myself."

A11. The final witness, Mr. Parrish, the driver of the vehicle involved, is called. He takes the oath, but the coroner immediately asks the jury to excuse him from giving evidence. The coroner adds that he is sure the jury has already reached its

verdict. The jury assents to this request and statement.

A12. The coroner sums up. Basic details (e.g. those involved) are combined with elements of the emerging explanation: the road was wet but in good repair; the deceased appeared to fall before impact; the car was not travelling very fast; the driver had "no chance of avoiding collision." The evidence of the two eyewitnesses that Mr. Crompton appeared to be looking downwards, rather than at the car, was mentioned. The coroner concludes that from the "limited evidence", no blame can attach to the driver, and the coroner suggests a verdict of misadventure.

A13. The jury (without withdrawing to another room) return a verdict of misadventure. The coroner records this verdict formally, and each juror signs the inquisition sheet. The coroner, and solicitors, express sympathies to the family of the deceased, who are in court. "All rise."

Inquest A lasted one hour. Several features of this particular inquest were found at all inquests attended. The most immediately striking feature, to a casual observer, is the contrast between the formality of the inquest 'structure' (the opening of the proceedings; the seating arrangements) and the informality of its 'content' (the conversational nature of the coroner's questions and the civilian witnesses' replies; the fact that the coroner's questions would certainly be 'leading questions' in other courts). It would not be inaccurate to suggest that, after the commencement of a formal procedure and the erection of a strictly-defined structure around the proceedings, the coroner minimises the significance of precisely this formality, and maximises the impression of an informal, almost intimate, occasion.

Inquest A was also of some general applicability in demon-

strating the inactive role of the jury. Of course, the jury participated in the proceedings in the legal sense that it returned a verdict, and was there to ask questions or seek clarification: and, importantly, inactivity is not in itself synonomous with superfluity. Nonetheless, the jury's role was - at all inquests attended - passive. As we have already noted, juries would today not (normally) be summoned to a road traffic death.

To find the coroner suggesting a particular verdict to a jury is normal practice. It was particularly interesting, however, to find the coroner at Inquest A referring to the death in question as an "accident" at the very start of proceedings.* The word "accident" may have a very general meaning in everyday usage. However, it has a specific meaning in terms of coroners' work, and although at Inquest A the accidental nature of the death was never (so far as the participants were concerned) in question, it remains of interest to hear its use at the commencement of the inquest.

The appearance of the police witness on two separate occasions during the inquest was also a general feature of inquest procedure. Equally, it was normal for drivers of vehicles involved in some way with the death to be excused evidence. This latter feature of the inquest is in part to avoid the appearance of a trial. The coroner in this particular case made it clear, at interview, that he seeks to protect the driver in such cases from incriminating himself, especially in response to solicitors' questions. In such cases, the witness' earlier formal statement

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*There is no significance in contrasting the suggested "accident" with the verdict of "misadventure" here. Accidental death and misadventure have the same formal meaning.

remains available to the court, and may be read out by the coroner.

It was stated at the beginning of Inquest A, as it normally is, that the inquest is not concerned with matters of blame or liability. Indeed, at none of the inquests attended were any attributions of blame made or implied. One might note, however, that the coroner is concerned with the absence of blame: with the de facto 'aquittal' of someone around whom suspicion might otherwise fall. It is quite normal to hear the coroner comment that "the driver was not in any way to blame" or even "one cannot find fault with anyone except the deceased."

At Inquest A, the first public indication of the likely true story to emerge came in the coroner's introductory comments (A4), and the evidence of the first witness (A5) serves to sketch in the biographical details. The evidence of the first bystander (A7) provides the first coherent practical explanation for what happened: the deceased didn't seem to look before crossing the road; the car wasn't going very fast; the road was wet; the deceased had been wearing a dark coat; and so on. The evidence of the second bystander (A8) reinforces this emerging account. The evidence of the police witness (A9) provides more detail, consistent with what has already been heard, and the explicit suggestions that the driver had not been reckless, and that the deceased stepped into the road without looking, carry an authoritative note of skilled and professional evaluation. After hearing the medical evidence, it is thus, in the case of Inquest A, a straightforward matter for the coroner to recommend the'obvious'verdict to the jury.

Before moving on to consider another - rather different - inquest, a further dimension can be examined. The way in which coroners' work is routinely 'known' is by reading newspaper

reports of coroners' inquests. Inquests may attract national or regional press coverage if there is an expectation of controversy. It is quite normal, at other inquests, for a local press reporter to attend. Let us consider the report of Inquest A from the local evening newspaper.

The report is headed: 'Riddle of Why Man Crossed City Road'.* Thus the concluding words of P.C. Oakley's evidence (A9) have been selected as the 'lead' for this particular story because of their unresolved, indefinite, nature. Of course, this 'riddle' formed only a passing element in the evidence as a whole and, in any event, was not a matter which would have materially affected the coroner's or jury's conclusions. Nevertheless, the heading of the report indicates how one element from an accumulation of generally consistent and, to the participants, unsurprising information, is selected in terms of its assumed newsworthiness.

The first paragraph of the inquest report concentrates on descriptive scene-setting and exoneration of the driver:

> A 61-year-old City man who slipped when crossing City road and fell on his back was hit by a car which did not have a chance to avoid him, a City inquest was told yesterday.

Thus, in these opening words the matters of potential contention at Inquest A have become straightforward descriptive details (he slipped; he 'fell on his back'; he was <u>then</u>, implicitly, hit by the car), and the driver's 'innocence' is also established at the start.

The report then states the verdict, followed by the pathologist's evidence of cause of death. The evidence of Mrs. O'Malley (A7) and Mrs. Fowler (A8) is then briefly merged. The evidence

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* 'City' is here substituted for place and street names.

of P.C. Oakley is also given in reported speech, other than one direct quotation. "I am satisfied the driver was not driving carelessly and had no chance of avoiding the accident." The report concludes with a brief summary of the driver's written statement to the court, which had been read aloud by the coroner, and a final direct quotation from the driver's statement: "He seemed to hesitate and fall back on the road. I braked but could not avoid hitting him."

Further discussion of the nature of reporting by the media of mass communication appears elsewhere in the study. At this point, it is interesting to consider the similarities between the process of construction at the inquest itself, where order is imposed upon diverse strands of information, and the newspaper's process of construction, where the stock of information and emergent true story publicly revealed at the inquest are further compressed into a self-contained, miniature, account of 'what-really-happened'. The differences between the coroner's and the newspaper's management of information can also be examined. The most obvious difference, in the case of Inquest A, is the coroner's minimisation of unresolved or inconsistent elements, and the newspaper's emphasis on some small area of mystery and continuing puzzlement. This has sociological relevance in terms of account - production, and commonsense notions of coroners' work gleaned from newspapers.*

Having examined in some detail an inquest-with-jury, let us consider an inquest where the verdict was returned by the coroner himself, in the absence of jury or the legal profession.

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* No other sorts of relevance interest us here, if indeed there are any: it seems neither surprising nor sinister that newspapers would wish to select elements calculated to catch the reader's eye.

Inquest B.

B1. The setting is a room, no larger than the sitting room of a private house, in the coroner's office. Present are two newspaper reporters, a pathologist, the coroner and his officer, a police constable and the 'police chief', and four civilian witnesses.

B2. Inquest B is the third of three no-jury inquests held on this particular morning. The coroner has given no general formal address. Each inquest today lastsapproximately half-an-hour. All witnesses at Inquest B take the oath before giving evidence and 'all rise' as the coroner enters or leaves. Aside from this, the setting is informal. The coroner and some participants sit at the table in the centre of the room. Others sit on loosely arranged chairs around the room.

B3. The first witness - Dr. French, the pathologist responsible for most local post-mortem examinations - gives evidence. He reads from his post-mortem report: the death of Mr. Roberts, aged 37, was due to cardiac and respiratory failure caused by drowning. Mr. Roberts showed no sign of previous ill-health - the point is given some emphasis.

The coroner asks no questions, but adds that an analyst's report indicates 260 mg alcohol present per 100 ml blood, more than three times the legal limit for driving. (Dr. French leaves the inquest).

B4. The second witness - Mr. Roberts senior, father of the deceased - is asked to give an opening, biographical account (see A5). His son moved to a village outside City six years ago, where he had also lived in his younger years. Mr. Roberts junior had always been of good health. The coroner asks if the deceased had any troubles. Mr. Roberts replies that his son had been divorced

in January (five months earlier).

B5. The third witness, Susan Jones, is called. The coroner asks how long she had known Mr. Roberts junior (about nine months). The coroner asks about his general health: Miss Jones replies that he was in "good health, always cheerful." The witness is asked to give an account of events on the evening in question (see A7). Miss Jones and Mr. Roberts went together to the Village Motel, where he drank three pints of lager. They were joined by two friends, and went on to a disco, after Mr. Roberts had changed into lighter clothing: it was a hot summer's evening. Mr. Roberts continued to drink at the disco, and repeatedly said he would go for a swim, as it was "so hot". As the disco drew to a close in the early hours, Mr. Roberts went swimming: Miss Jones saw him enter the water, and splash about. One of their friends said he could no longer see the deceased in the water; others came to help; someone called out that he had been found, and an ambulance was called. The coroner invites questions. The police chief asks Miss Jones how the deceased had entered the water. She replies that he dived in - there is a suggestion that he may have been entangled in his own clothing.

B6. The fourth witness, Edward Arkin, had been a member of the group of four who that evening went first to the Village Motel and then to the disco. He is asked about the alcohol consumption of the deceased that night: he replies that he estimates Mr. Robert's consumption as approximately three pints in the motel and a further five pints at the disco. Mr. Robert's expressed an intention to go swimming. Mr. Arkin saw him dive in after removing some of his clothing and then saw him at the water's edge removing the rest of his clothes and remarking upon the coolness of the water. The two men chatted intermittently as Mr. Roberts swam

around. Mr. Roberts then made to swim to a buoy, but appeared to turn sharply away, and Mr. Arkin lost sight of him. After shouting, and receiving no reply, Mr. Arkin ran to the clubhouse for help. Lights were illuminated on the water, and then a boat launched. Mr. Roberts was picked up by the boat, and a doctor present in the group tried to revive him. The coroner asks a final question about the weather that night. It was fine, warm and clear, and the moon was shining. There are no questions.

B7. The fifth witness is Dr. Smith, a G.P. who happened upon the scene, as he had been involved in organising the disco and was still in the clubhouse. He found the body of Mr. Roberts in a few feet of water, and an examination Dr. Smith describes as "cursory" led to the conclusion that Mr. Roberts was dead. The time of death is given. Attempts at revival are reported to have been futile. No questions.

B8. The final witness is P.C. 3476 from the local police station (outside City). He attended the scene, and reads from his prepared statement (see A9). No questions.

B9. The coroner sums up, drawing together three elements: Mr. Robert's previous health, a sketch of the evening's progress, and the presence of alcohol. The coroner says that the deceased had been in "apparently perfect health." After visiting the motel and arriving at the disco, he announced his intention to go for a swim several times. He appeared to have drunk approximately eight pints of lager. After taking a swim, he could not be seen. A boat was launched. After finding him,a doctor present found resuscitation impossible. The coroner then re-emphasises the alcohol level: 80mg alcohol per 100ml blood is said to be the legal limit for driving a motor vehicle, and the deceased's blood

contained 260mg alcohol per 100 ml blood. The coroner adds that the deceased's ability to swim was negated by the alcohol consumed. The coroner concludes that Paul Anthony Roberts died from cardiac-respiratory failure after drowning in Pool Waters while in a state of alcoholic intoxication. The coroner returns and records a verdict of misadventure. 'All rise'.

The most obvious differences between Inquests A and B are ones of scale and formality. The absence of a jury at Inquest B also meant a different setting. Verdicts of misadventure were produced at both inquests.

A closer examination of Inquests A and B suggests that an underlying similarity of processes of construction is more significant than surface differences of ritual and formality. In both cases, a relative of the deceased is invited to give a general opening biographical account (A5, B4). (The pathologist's evidence (B3) at Inquest B is, unusually, given first, so that the pathologist can leave to keep another appointment). The health of the deceased is a factor at both inquests, and at Inquest B the good health of the deceased is emphasised several times (B3, B4, B5). Furthermore, his characterisation by a witness as "always cheerful" (B5) counterbalances any significance which might (against the grain of other evidence) have been attached to any troubles he had (B4). In both cases, despite different settings, circumstances and characteristics of the deceased, there is a similarity in the structuring of the emerging overall account of what happened. Again, similarities of 'location' (as part of the total evidence) and of 'scope' can be seen in the witnesses' replies (A7, B5)to the coroner's general 'tell me what happened that evening' question.

A point of contrast between the two inquests is the degree to

which the coroner implies a public safety role for the inquest. It was noted in Chapter Three above that coroners may make recommendations or express views at an inquest with the object of removing some general source of danger: a coroner might, for instance, comment on safety procedures in a case involving death at work. At Inquest A, although evidence was given about matters such as the effectiveness of street lighting and the composition of the road itself (A9), the coroner and jury did not suggest any connection between these conditions and the death. At Inquest B, however, there was an implicit 'public warning' element in the emphasis given by the coroner to the presence and amount of alcohol (B9). Indeed, the fact of alcohol was held responsible,explicitly, for undermining the deceased's normal swimming ability. At other inquests, the 'public safety' element may be more, or less, clear-cut than at Inquest B.

The report of Inquest B in the local evening newspaper is headed, in blunt terms, as follows: "Gallon of Lager - Then Drowned." The complete report is only four paragraphs long. The first paragraph brings together the amount of alcohol, the disco, the swim, and the subsequent drowning. The second paragraph reports the verdict and the cause of death, the latter including a reference to alcoholic intoxication. The third paragraph reports the level of alcohol to blood. The fourth paragraph runs as follows:

> He (the coroner) said there could be no doubt it was a large amount alcohol (sic) that caused Mr. Roberts, a healthy man and good swimmer to drown.

The report of Inquest B thus refers in its headline and in its text only to alcohol. This is a stark example of a newspaper report selecting one theme from the evidence presented at the

inquest and offering that theme as a total explanation for events. As in the newspaper report of Inquest A, this report is a miniature and simplified construction of the facts-of-the-matter, deriving from part of the ordered and structured construction already produced at the inquest. The newspaper report of Inquest B is less complex than the report of Inquest A. While the 'A' report lays a (simplified) pattern of different strands, combined with the element of mystery, before the reader, the 'B' report offers a short but, within its terms, complete explanation. It can perhaps already be seen that reports of inquests in newspapers do not proceed in a uniform way - the 'A' report leads with mystery; the 'B' report with bluntness and, implicitly, censure - but do possess a structure and characteristics which denote that they are indeed newspaper accounts, not the accounts of coroners, policemen, sociologists or whoever.

Two inquests have now been considered, one with a jury, one without. Verdicts of misadventure were returned at both inquests. It has been suggested that despite formal differences between the two inquests, in terms of the structuring of accounts and the production of the true story essentially similar processes could be identified. Let us now consider whether this is so at an inquest which produced a different verdict.

Inquest C.

C1. The setting, as at Inquest B, is a small room in the coroner's office. Present are: the coroner, his secretary, the coroner's officer, a police chief and police constable, the husband and daughter of the deceased, and the family's lodger. There is no jury. There is no newspaper reporter. As at Inquest B, all witnesses take the oath, and all rise at the entrance and departure

of the coroner, but otherwise formality is at a minimum.

C2. The first witness is Mrs. Jacobs, daughter of the deceased, Mrs. Hart, aged 80. Mrs. Jacobs and her mother lived together. The coroner's questions begin by referring to events thirty years ago, when Mrs. Hart's other daughter had died, of natural causes, at an early age. The coroner asks Mrs. Jacobs whether this event caused her mother "much disquiet and depression." "Yes." In fact, says the coroner, Mrs. Hart "never really recovered?": "No." The coroner's questions move to matters of Mrs. Hart's health. Mrs. Hart's daughter indicates that the deceased suffered from arthritis, and was "quick tempered". The coroner's questions now refer to time and place of death. Mrs. Jacobs replies that her mother seemed "all right" when she last saw her alive on the evening in question. When Mrs. Jacobs brought her mother a cup of tea the next morning, she found a letter, pills strewn around, and her mother's handbag on the floor. Mrs. Jacobs immediately presumed her mother dead, and called an ambulance. The coroner asks whether Mrs. Hart ever talked about taking her life: Yes. Mrs. Jacobs adds that Mrs. Hart's father used to talk about it too. (Mrs. Jacobs is about to move back to her seat when the coroner, as an afterthought, asks about identification). Was Mrs. Jacobs quite sure that the deceased was her mother? "Yes". No questions from the police chief.

C3. The second witness, Miss Southern, a lodger with the family, and friends for over 30 years, is asked by the coroner whether she is aware of the death of Mrs. Hart's daughter in the 1940s: "Yes". The coroner asks Miss Southern's opinion of the "lasting effect" of this upon Mrs. Hart, again enquiring about the existence of depression. The witness replies that Mrs. Hart "never got over

it." (Consistent with the sequence in C2, the coroner asks about Mrs. Hart's health). Did the deceased ever complain about arthritis? Yes: "all the time". She had also recently developed pains in the arm. The coroner finally asks whether Mrs. Hart seemed depressed on the night of the death. Miss Southern replies that on the contrary, she seemed in "good heart". No questions.

C4. The third witness is the police constable who attended at the scene of death. (Consistent with Inquests A and B, he reads from his prepared statement). He went to the house on the morning after the death. He found Mrs. Hart lying in bed, and yellow tablets on the floor. He also found a box, empty, with an indication that the pills had been prescribed three years earlier. He also found "the letter". There are no questions from the police chief, but he mentions that he too visited the scene of death, and is therefore familiar with it. He appears to be the police constable's superior officer.

C5. (The fourth witness, Dr. Cohen, a pathologist at a hospital outside City, is not in attendance. The coroner reads out his statement). Details are brief. Following a post-mortem examination, Dr. Cohen found pento-barbitone in the stomach and liver of the deceased, rigor mortis had set in,and there was evidence that the deceased had suffered from high blood pressure. In Dr. Cohen's opinion, the cause of death was cardiac and respiratory failure due to barbiturate poisoning.

C6. The coroner sums up. His first point, consistent with the questions addressed to the witnesses (C2, C3), refers to the deceased's depression, explicitly linked to the death of her daughter over 30 years ago. This event had a "profound effect"; she was "grief stricken"; and suffered a "reactive depression from which she never recovered." Again following the line of his

questions,the coroner includes the health of the deceased in his summing up. Mrs. Hart "was in much pain" from her arthritis. It would appear that "..... while in a mood of depression she took her own life." The letter left by Mrs. Hart is not read out. The coroner says that it includes the words "God forgive me." The coroner returns and records a verdict that Mrs. Hart "killed herself while the balance of her mind was disturbed." The coroner also expresses sympathy toward the family. 'All rise'.

Inquest C was the subject of a detailed post-inquest discussion with the coroner which sheds considerable light upon the publicly-presented construction of background circumstances and the overall account of the facts-of-the-matter. In particular, it is clear that, at this particular inquest, the depiction of relevant factors was exceptionally selective. Inquest C as a whole will be discussed after briefly presenting a further inquest which resulted in the same verdict.

There is no press report of Inquest C as no newspaper reporters were present.

Inquest D

D1. The location of the inquest is, once again, in the coroner's office. There is some delay in starting because of a major traffic holdup in the area. The coroner eventually decides to start despite the non-arrival of the deceased's father.
(Personnel present: see inquests B and C).

D2. Dr. French, pathologist at City hospital, reads out his post-mortem report on the deceased, Michael Grant, aged 19, who was found dead in his car by the banks of City river. Dr. French indicates that Mr. Grant had seemed to have been in normal health. Alcohol revealed 66 mg alcohol per 100 ml blood and 77% saturation

by carbon monoxide. Dr. French gives the cause of death as asphyxia due to carbon monoxide poisoning. There are no questions from any of the 'interested parties'. (Further delay: deceased's father not present: the coroner decides to take the police evidence in the meantime).

D3. The second witness is P.C. 9026 from the police station near to City river. Reading from his report, the witness indicates that at 7.30 a.m. on (date) he came across the car parked by the river. The driver appeared to be asleep and the engine was running. The police officer found a hose running from the exhaust pipe into the car. Empty spirit and soft-drink bottles were beside the deceased. (The witness then details the arrival of the doctor, and subsequent identification of the body by the deceased's father). The coroner asks a question about the exact way in which the hose was placed in order to lead back into the car. (Arrival of the deceased's father).

D4. Mr. Grant senior gives evidence immediately upon his arrival. He is asked by the coroner for details of his son's age and address. The coroner then asks Mr. Grant to talk generally about his son. Mr. Grant - "you appreciate this is difficult" - begins by saying that he is separated from his wife, and that they have two sons, who are twins. The two boys went to the same school, but were graded differently. The deceased did well at G.C.E. 'O' level but "went to pieces" at 'A' level. His twin brother, by contrast, secured a place in higher education. Mr. Grant senior tried to re-assure his son about his seeming failure, and he did not pressure him to succeed, but the deceased just wanted to be alone. Mr. Grant senior adds that many people, like his son, spend time alone, and do not wish to socialise.

Mr. Grant continues that his son had consulted a doctor (although not telling his father at the time) and, although his son was depressed, there were no physical problems. (The coroner asks when the deceased left school). The witness replies that his son left school last summer and had applied for jobs without success. "Most of these firms don't even bother to reply." The deceased had stayed with his mother for a while. The coroner then moves on to what he calls the deceased's "withdrawal", and the coroner (not the father) continues that the deceased "just withdrew" and his state of mind was reinforced by not finding a job. Mr. Grant continues his evidence: on the evening prior to the discovery of the body, Mr. Grant senior came home after having had a drink, and went straight to bed, leaving his car keys on the table. His other son had gone away to fix up accommodation before starting his degree course. Next morning, Mr. Grant found one note on the table addressed to himself, another to his wife. It was Mr. Grant's birthday and initially he took the letter to be a greeting card. The coroner now explicitly asks Mr. Grant for "his theory". Mr. Grant replies that he thought his son's disappointment at not passing his examinations had affected him, together with the general "pace of living", and being unemployed. When the deceased had passed his 'O' levels two years' earlier, everything seemed fine: but "the world isn't like that": it isn't fine. The coroner concludes by checking details of identification with the witness and by showing him the note left by his son: the father confirms that it is his son's handwriting. (There are no questions).

D5. The coroner sums up. He very briefly gives a verbal summary of the post-mortem report to the father (who says that he was pleased to have missed the pathologist's evidence). The coroner

then mentions the note left by the deceased, adding that he does not intend to read it out but can confirm the personal nature of the note and the warm feelings expressed toward Mr. Grant senior in the letter. The coroner also says that the note gives an indication of the deceased's state of mind. The cause of death - asphyxia due to carbon monoxide poisoning - is restated by the coroner, and he then returns and records a verdict that Mr. Grant killed himself while the balance of his mind was disturbed. Mr. Grant senior asks if he may retain the note. 'All rise'. Inquest D lasted for twenty-five minutes.

Having presented four separate inquests, we are now in a position to, firstly, discuss the structure of Inquests C and D resulting, as they did, in the same verdict; secondly, briefly consider the newspaper report of Inquest D; thirdly,compare provisional conclusions about Inquests C and D with the comments made above about the first two inquests; fourthly, briefly consider the discussion of Inquest C held afterwards with the coroner.

The verdicts returned at Inquest C and D were that the deceased "killed him/herself while the balance of his/her mind was disturbed." It can be noted, first of all, that the word suicide was nowhere used at either inquest. It can also be noted, of course, that the coroner chooses to add a reference to "balance of mind" in returning his verdict, although this has no legal significance. It is known from the interview programme that this particular coroner invariably uses the phrase. It can therefore be assumed that the reference to balance of mind has nothing to do with individual assessment of the mental health of the subjects of Inquest C and D: it is a general phrase, always used by this coroner.

At Inquest C, the coroner's initial questioning immediately refers to events more than thirty years earlier (C2). The written statement of the witness has already pointed the coroner in this direction and thus, at the inquest, he is able to make the first substantive step in the construction of the true story by referring to historical factors. Also contained within this historical reference is the first element of explanation and of a possible verdict of suicide: at an inquest concerned with an emerging 'misadventure' verdict, the coroner would not concern himself with events so long ago. So at Inquest C a probable true story begins to emerge almost immediately. The questioning of the next witness (C3) similarly refers to the events of thirty years ago, and the coroner's reference to their "lasting effect" is to be noted. It might also be noted that at Inquest C the husband of the deceased was not called to give evidence. (The coroner and coroner's officer had decided not to call the husband to give evidence before the inquest started, and throughout the inquest he appeared, seemingly through age and ill-health, oblivious of the proceedings). Inquest C is a self-contained, brief, resume of some of the evidence surrounding the death, where one factor is established at the beginning of the proceedings as the basic explanation for all that followed, reinforced by subsidiary elements such as ill-health. The causal factor in the true story was - in terms of the inquest's public portrayal of the facts-of-the-matter - quite clear.

Inquest D was also about suicide. It was more disjointed than Inquest C, through capricious circumstances and the hasty re-arrangement of the planned sequence of witnesses, and concentrated almost exclusively upon the evidence of one witness, the father of the deceased (D4). Within the evidence of this sole

witness lie all the elements of the coroner's explanation/ verdict: marital separation; academic failure; social isolation; unfavourable comparison not only with a sibling but with a twin; the occasion of the father's birthday; unemployment; withdrawal; the existence (as in Inquest C) of a note. Inquest D contains so many of the factors which a coroner will use in the assembly of a suicide verdict that, once more, the verdict is clearly implicit at a very early stage of the inquest and, as at Inquest C, evidence is assembled in a structured manner, consistent with the projected categorisation. It might be noted that witnesses' comments (D4) sometimes did not reinforce the developing account: e.g. lots of people like to be alone; most firms don't bother replying to applicants for jobs; and the general "pace of living" for everyone. More subtle, or more general, points of this kind tend, however, to be not included in a summing-up, where a uniformity of evidence is summarised.*

No newspaper account of Inquest C is available as no reporter was in attendance. It might, in passing, be of interest to speculate on the basis for selecting which inquests should be attended: at Inquest C the card (detailing name and address of the deceased and all witnesses) made available for the Press remained on the table in front of an empty chair. Leaving this aside, a newspaper report of Inquest D is available, and this may usefully be examined.

The report of Inquest D is headed: "City Twin Was Found Dead in Car." Like the reports of Inquest A and B, this newspaper report is only single-column width, but it is rather longer

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* Except at an open verdict, where there may be an explicit emphasis in the coroner's summing-up on an unresolved set of circumstances, a balanced or inconclusive assortment of potential true stories.

(eleven paragraphs) than the two reports already discussed. The report opens by stating that the deceased ".....became quiet and withdrawn after failing his A-Levels and finding himself unable to get a job." So here, on one level, is a descriptive account of what might be seen as salient parts of the evidence, or, on another level, an explanatory, causal, theory: exam failure and unemployment together caused this condition of being "quiet and withdrawn." The second paragraph adds to this (already 'explained') condition of withdrawal the fact of death, and the third paragraph completes the explanation by reporting the cause of death and the coroner's verdict.

The remainder of the report serves to embellish the essentially 'complete' account given in the first three paragraphs. Paragraphs four to six condense the evidence of P.C. 9026 (D3). Paragraphs seven to eleven summarise the evidence of the deceased's father (D4), amplifying the opening themes of exam failure and unemployment. The newspaper report of Inquest D rather resembles that of Inquest B: there are no rough edges, the facts-of-the-matter are clear, and the explanation in both cases is presented as simple and straightforward. At Inquest D, the twin factors of exam failure and unemployment are all-important; at Inquest B, the single factor of alcohol is all-important. The only substantial difference is that the Inquest D report is given rather more space to illustrate and adorn its characterisation of the inquest proceedings. In neither case is there any of the mystery of the Inquest A report.

It will be recalled that Inquest A and B concluded with verdicts of misadventure.Inquest C and D concluded with verdicts of suicide.* It may now be suggested that the particular verdict

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* It might be objected that in Chapter Three, some importance was given to the terminology of the verdict, yet here 'killed

of suicide or misadventure is not centrally important in examining the structure of evidence at the inquest: the typical methods of constructing a true story tend to obtain, in a systematic form, at the coroner's inquest, whether the verdict is suicide or misadventure, and whether or not a jury is present.

At all inquests attended, police evidence and pathological evidence was given in a standard form, taking its place within the accumulating structure of evidence and the projected verdict. This projected verdict was clear,so far as the coroner and his staff were concerned, at the beginning of the proceedings. There tended to be a normal sequence for the giving of evidence by the various witnesses, except when capricious circumstances (as at Inquest D)intervened. A relative tended to give a general biographical account of the deceased, the coroner asking about specific aspects (in all cases health; in some cases, a specific incident in the past). Other witnesses (such as eyewitnesses otherwise uninvolved, or witnesses who had been with the deceased prior to, or at, the time of death) were asked for general scene-setting accounts. The coroner's summing up can also be seen to have a structured nature, generally applicable. The degree of formality at an inquest where jurors have been summoned is considerably greater than at inquests without jury, and the projected verdict of misadventure or suicide certainly involves a particular emphasis in the coroner's questions to witnesses: but the prevailing method of constructing the true story is constant, whether the verdict is suicide or misadventure, and whether or not a jury is present.

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himself/herself' is casually being substituted by 'suicide'. The point here, however, is that a comparison is being made between inquests resulting in different verdicts. The practice of this coroner in not using the word 'suicide' is beside the point: or, more accurately, it is beside this particular point.

The period of systematic observation of fifty inquests, upon which the present part of the discussion is based, included attendance at three inquests in which open verdicts were returned. The open verdict explicitly leaves the matter unresolved and it might initially be thought that here at least there must be no obvious true story and no structured organisation of evidence toward a projected verdict. To examine these issues, it will therefore be appropriate to consider Inquest E, an open verdict.

Before doing so, it may be useful to discuss the post-inquest interview held with the coroner after Inquest C above, for in this case there was a considerable divergence between public and private accounts.

It will be recalled that Inquest C concerned the death of Mrs. Hart, aged 80. The coroner returned a verdict that the deceased killed herself while the balance of her mind was disturbed. In his summing-up, the coroner accounted for (explained, gave meaning to) the death by referring to the death of the deceased's daughter thirty years previously and pain caused by physical illness. Publicly, then, this was the complete account.

Discussing Inquest C with the coroner, and examining the note left by the deceased, indicated interpersonal relations within the family to be quite unlike those presented at the inquest. The note refers to disposal of money and expresses feelings not included as relevant at the inquest. No further details need to be elaborated, as our point is not about the particular circumstances or apparent emotional background in a specific case: nor are additional details introduced here to suggest that the coroner's true story can or should be replaced by a "truer" story. The point is that the coroner's account and the accounts presented at this inquest by witnesses are highly <u>partial</u>.

Partial is not contrasted here to impartial: partial is to be contrasted to complete. A number of important issues are raised by this in terms of the nature of the accounts presented at the inquest.

No description or account can be complete (see Chapter One). It may, however, be adequate, and 'adequacy' may be evaluated in terms of the purpose of the account. So, is the account produced at Inquest C adequate: and, if so, adequate for what purposes? In absolute terms, of course, the account produced was neither complete nor adequate, because known details were excluded from the proceedings, perhaps on apparently ethical grounds. However, adequacy is not judged absolutely. It may be suggested:firstly, that the inquest, both in law and in the context of the practical task of producing a verdict, is not required to construct a complete account; and, secondly, that in order to assume the status of an adequate account, both in law and in the context of the practical task, of recording a verdict, the inquest may cover very little of the available stock of potential facts-of-the-matter.

In short, the scope of the inquest is far from being extensive: yet it may be quite adequate for the practical purpose of providing a true story (verdict/explanation).

Examination of inquests selected from the period of systematic observation is concluded by considering an inquest where an open verdict was returned. Thus an example of all three verdicts recorded at inquests during the observation period has been considered.

Inquest E.

E1. The setting, once more, is the coroner's office. There is no jury.

E2. The first witness in this case is Dr. French, pathologist at City hospital, by now a familiar figure at City coroner's court. Dr. French reads his prepared report to the court. The deceased, Mr. Bacon, was aged 75. Upon admission to City hospital, he was found to be bleeding profusely, and Dr. French estimated that Mr. Bacon had fallen from a height of approximately twenty feet. The pathologist continues by reporting details of the deceased's abrasions, fractured ribs, and enlarged heart. Dr. French states - "in my opinion" - that death was due to cerebral haemhorrage and laceration, caused by fractures of the skull, contributed to by fractures of the ribs. There are no questions.

E3. Mr. Bacon's son gives evidence, very briefly. The only question from the coroner refers to identification of the body.

E4. The third witness is another son of Mr. Bacon. His evidence is much more extensive. He indicates that Mr. Bacon senior lived with the witness and his wife. The coroner's first question concerns the deceased's <u>health</u>. The witness describes this as "deteriorating", as it had been for the preceding few years. (Details of surgical operations and specific illness are given). The witness then reports that he and the rest of the family - excluding his father - had been told by a doctor that the deceased had cancer. (At this point, the coroner reads from the pathologist's report, where there was no indication of cancer). The coroner's next question concerns the deceased's <u>personality</u>. The witness replies that Mr. Bacon hardly ever spoke, "you could see that he was suffering." Mr. Bacon went for a daily walk, but little more. On one occasion, Mr. Bacon complained of "not getting his breath." His son offered to call an ambulance, but Mr. Bacon said not to bother, he would "do himself in". He did subsequently go to hospital, and returned home in due course. The witness

continues that on the morning of the death, Mr. Bacon had arisen very early, made his son a cup of tea, and then gone out: his son assumed it was simply a visit to the local shop. Shortly afterwards, Mr. Bacon was found at the bottom of a disused railway embankment. The coroner asks whether Mr. Bacon went to the embankment often. (Yes: sometimes to watch the children fishing). The witness then suggests that his father may have had a "dizzy spell". The hour of the day (7 a.m.) was then commented upon by the coroner, together with the frequency ("occasional") of Mr. Bacon's visits to the embankment.

E5. The fourth witness is Mr. Dent. He was driving along Pool Street when he saw "something fall" from the gap across the road where the railway bridge used to be. He stopped the car, briefly looked at Mr. Bacon, then drove to a nearby filling station where he called an ambulance. He went back to Mr. Bacon, and found him to be bleeding. He rolled him over, (explaining to the court that his wife is a nurse) and the police and ambulance staff then arrived. The coroner asks about the weather: it was very good that day. The coroner then returns to a specific point: did Mr. Dent see the deceased start to fall? No: he only saw him in the process of falling.

E6. The final witness is City police officer 4242 who attended the scene. An account is given of the physical setting: the bridge which formerly linked the two sides of the railway embankment had been demolished, leaving a twenty-five-feet sheer drop at either side of the road. P.C. 4242 then continues by detailing the journey by ambulance to hospital.

E7. The coroner sums up. Factors initially mentioned by the coroner are the age of the deceased; his medical history and, in particular, surgical history; and the general deterioration

of physical health. The coroner characterises the key question as: why did he fall? "Was he pushed, did he have a dizzy attack .... or had he done it deliberately?" The coroner continues that, because "no-one is certain", the "only verdict" is an open verdict. The coroner seeks assent from the police chief present that the verdict is appropriate, and this is given. An open verdict is returned and recorded. 'All rise'. The inquest was thirty-five minutes in duration.

Superficially, it might appear that Inquest E was different from the other inquests discussed above, as the proceedings concluded with an open verdict, and thus the matter was, formally, unresolved. Alternatively, but equally superficially, it might be said that Inquest E resembled other non-jury inquests- there were no obvious procedural differences - and the verdict is therefore irrelevant. Let us consider this problem a little further.

Inquest E opened with the pathologist's report, and his view (" in my opinion .....") of the cause of death (E2). This element of the total evidence was no more, or less, precise than any other inquests already discussed. Identification details are given, as normal, by a relative (E3). The third witness provides the coroner with the opportunity to create a true story, as the coroner goes through a list of factors, familiar from inquests considered above: health ("deteriorating"); personality; a previous suicide threat; dizziness; the general events-of-the-day account (E4). The coroner asked whether the deceased went to the place of death often. As the answer was 'yes', it became established that it was unsurprising for the deceased to be found there. It is clear that a "balancing" account is being drawn out by the coroner: a true story is being constructed, in terms of the opposition between different strands of evidence. An open

verdict is emerging from this in precisely the same way as a "definite" verdict(of misadventure or suicide) emerged from the other inquests through the structuring of different strands of evidence. The process is the same.

The balanced, self-evidently-inconclusive, nature of the construction is reinforced by the handling of the chance witness (E5) where the coroner places emphasis on the witness seeing the deceased in the process of falling only: he did not see the deceased begin to fall, and hence the key causal factor is rendered unknown and, indeed, unknowable.

As in the other inquests considered, the verdict in the case of Inquest E is, in practical terms, known at the commencement of the proceedings. Evidence is built up consistent with the emergent verdict. In the case of the open verdict, this <u>consistency</u> (between projected verdict and evidence) is built upon the opposition, or seeming <u>inconsistency</u>, of particular pieces of evidence. Elements routinely consistent with a projected suicide verdict (a previous threat; some withdrawal; physical pain) are opposed to elements routinely consistent with a projected misadventure/accident verdict (dizziness; the steep slope; the normal nature of the deceased being at the place of death). "No-one is certain", said the coroner, hence the "only verdict" is an open verdict (E7).

Inquest E did not resemble the other inquests in every respect. It was, for instance, interesting to note that the coroner, at Inquest E, sought the assent of the police chief before recording the verdict. Indeed, it might be remembered (see Chapter Three) that an open verdict leaves the matter "open", potentially, for further police investigation. The open verdict also leaves the matter "open" in a <u>formal</u> sense, because in law,

and in the coroner's annual returns to the Home Office, it is signified that the evidence has not fully disclosed the facts-of-the- matter. Yet in practical terms; in terms of effectively concluding the matter by constructing a true story; in terms of creating an adequate level of order from the unorganised, potential, facts-of-the-matter, the open verdict stands as a normal, typical, conclusion to some inquests. It is produced in the same way as any other verdict. In sociological terms, it stands as a 'definite' verdict like any other, in spite of its formerly unresolved nature. It might also be remembered (see Chapter Three) that some coroners use the open verdict to accomodate different, specific, sorts-of-death.

So it can be concluded that, for all practical purposes, and for sociological purposes, that the open verdict can be examined in precisely the same way as any other verdict, and that the essential processes of construction at the inquest operate irrespective of verdict.

A newspaper reporter was present at Inquest E. The report, again from the City evening newspaper, was eleven paragraphs long, occupying single column width. It was headed: "DEATH FALL FROM BANK". The result of the inquest is made clear at the very beginning of the report, which opens with the following paragraph:

> "AN OPEN VERDICT was recorded at a City inquest on a 75-year-old man who fell from an old railway embankment in Pool Street."

The report continues by saying that the coroner suggested "..... there were a number of possibilities" concerning the death but "a lack of evidence to show what had actually happened." (The quotations are from the newspaper report, not from the coroner). The next two paragraphs are devoted to a condensed

summary of the pathologist's evidence. The next three paragraphs report the evidence of the deceased's son, making three separate points: the deceased's poor health; the normal events of the day of the death; and the normal visits the deceased made to the railway embankment where "it was quite possible" he had a "dizzy spell". The next three paragraphs concern the evidence of Mr. Dent, the car driver. The final paragraph is as follows:

> Coroner A.B. said that Mr. Dent should be publicly complimented and thanked for the action he had taken.

This press report has some similarities and some differences in comparison to the press reports examined above. It is not simply a condensed account of the coroner's account, as the balancing process present at Inquest E, the reconciliation between opposing factors into an open verdict, is not presented: all the evidence summarised in the newspaper report would have been quite consistent with a verdict of misadventure/accident, rather than an open verdict. There is no indication of why an open verdict might in this case have been recorded, other than in the passing reference to a lack of evidence. Also of interest in this report is that the verdict is stated in the first three words of the first paragraph. Unlike other inquest reports considered, there is no emphasis on the key "explanatory" factors and, perhaps more surprisingly, there is no emphasis on mystery or the unresolved nature of events. The style of the report of Inquest E is considerably 'flatter' - one piece of information after another - than other reports. Similarities between all the newspaper reports considered lie in the overall form, location within the newspaper itself, and in the characteristics of composition which denote that they are indeed newspaper reports. It seems reasonable to conclude, however, that there is no

single uniform newspaper-report-of-an-inquest: the angle from which the inquest is approached by the reporter and sub-editor varies according to the particular inquest under consideration.

General conclusions, based upon the period of observation at coroners' inquest, are presented below in section 4(4). To conclude the main section of the current discussion, an account is presented of a case from outside the programme of observation. During formal interview with the coroner from another area, he was called out to the scene of a road-traffic incident. It was possible on this unique occasion to accompany the coroner on his visit to the scene, and the formal interview was concluded on another date. Some time later, it was also possible to attend the inquest held as a result of the road-traffic incident. Thus, outside the planned research programme of interviews with coroners, systematic attendance at inquests, and statistical searches, the opportunity arose to follow one example of coroners' work from beginning to end: from the time of the incident, to eventual formal categorisation.

The account can begin at the point where formal interview with a full-time coroner, serving an urban and rural area some seventy miles from City, was interrupted by a call from the coroner's secretary that a coach had overturned on a moorland road. The scene of the incident was visited immediately.

The coroner had an expectation of a serious case, as three years earlier thirty people had died in apparently similar circumstances on the same stretch of road. On arrival at the scene of the present incident, all the injured had already been taken to hospital. Two people had died. The police presence was both numerous and senior, including a chief superintendant and the deputy chief constable. The coroner said that the police would start taking statements from the injured as soon as they could

be interviewed. At this time - thirty minutes after 'the event' - the coach driver had already been interviewed. It was suggested that a car had forced the coach off the road. The road was narrow, and although the coach had overturned, it had not rolled all the way down a long, and steep, hillside. Police consensus was that it could "all have been much worse".

Police vehicle-inspectors were busy atop the upturned coach. Comparisons were being drawn with the superficially similar case three years before, when brakes had been found to be defective. The mechanics were saying, however, that this particular coach seemed to be "brand new", that nothing seemed to be "wrong" with it. Police photographers and numerous newspaper reporters were also very busy.

The roof of the coach had been crushed. No doubt, said the coroner and police, this would lead to renewed demands for design modifications, as happened "last time".

The coroner and a senior police officer inspected the interior of the coach through the broken windows. They exchanged comments. A reporter asked for a photograph of them "just looking inside".

Clearly the investigation was already very much in progress when the coroner arrived. The police were busy and the coroner gave no instructions. The question arises of why the coroner visits the scene of the incident at all. The coroner replied that he is responsible for leading the investigation, that the evidence presented at the inquest will now make more sense, and that he is required to view the bodies in hospital.

In addition to inspecting the coach, the coroner inspected the road. Police pointed out tyre marks where the coach had travelled on the edge of the road before leaving it altogether.

The coach driver's account of what-happened was already being put together in a preliminary way, and evaluated in the context of physical features, the position of the coach, and so on. Details of where the coach had come from, and its destination, were discussed.

The coroner's stated reason for visiting the scene is of interest. In law the coroner indeed leads the investigation when death has occurred, and any police personnel, of whatever rank, are subject to his authority. It is also of interest to note the coroner's comment that the evidence presented at the inquest will make more sense as a result of visiting the scene of death. The meaning of events is already being constructed thirty minutes after they occurred. Accounts are already being constructed. Some versions of the reality of what-happened such a short time ago are being rejected, and others are being assimilated into the emerging, overall, account.

The coroner left for the local hospital to view the bodies and to discuss the case with the pathologist. An invitation to accompany the coroner on this stage of his investigation was declined.*

Several points can be made about the visit to the scene of death in this case. Accounts are already emerging, meanings are being ascribed to events. The present event is being evaluated by the reference-point of an apparently similar event in the past.

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* The possible moral implications of attending inquests have already been discussed. Visiting the scene of death did not present any moral problems, as all passengers were already at the hospital, no relatives were present, and numerous personnel were already on site. An invitation to visit the hospital, however, seemed to be of limited value in terms of a sociological study of the work of coroners and, moreover, of questionable moral status, as both the injured and their families would have been present.

The reasons for the coroners' presence are of interest in terms of authority relations, and 'making sense' at the subsequent inquest. Additionally, it is instructive to see police photographers, vehicle inspectors and other personnel in the act of creating the photographs, plans and technical details which are such familiar features of a road-traffic inquest. The extent of police activity at the scene of this incident was very considerable: police photographers, vehicle inspectors, senior staff, patrol officers. The immediate investigation is for all practical purposes a police investigation, an aspect of police work, notwithstanding the coroner's ultimate authority and personal visit.

A more general issue is raised by attending, in this case, the scene of death, as well as by attending the inquests discussed above. It has become, by this stage, quite clear that sociologists who define their interest in the rate-producing process purely in terms of <u>suicide</u> verdicts, and the coroner's role in producing <u>suicide rates</u>, may fail to notice that coroners' work <u>in general</u> and inquest verdicts in general are very rich areas for the sociologist to explore. There is no sociological work on coroners' constructions of a 'misadventure' or an 'open verdict': except in so far as these verdicts are to be differentiated from suicide. There is no sociological work on coroners' work <u>per se</u>. The opportunity presented to visit the scene of death, and to follow this through by subsequently attending the inquest, reinforced the central concern of this study with the totality of coroners' work.

Following the incident in which the coach left the moorland road, leading to two deaths, the coroner within a few days formally opened, and then immediately adjourned, the inquest. The resumed inquest, that is to say, the 'inquest proper',

followed three months after the original incident. It was possible to attend this inquest, and detailed fieldnotes were taken. It should be noted that this inquest occurred after the period of 'systematic observation' from which Inquests A to E above were drawn. The Criminal Law Act 1977 had now come into force. Thus, although the coroner is considering a road-traffic incident, a jury is no longer required by law. This is to be contrasted with Inquest A.

Inquest F

F1. This single inquest is concerned with two deaths. Approximately thirty-five people are present. There is no jury. The jurors' box is occupied by County Council observers, representatives from traffic authorities, and others. Solicitors, newspaper reporters, police, the pathologist and a Department of Transport vehicle inspector are also present.

F2. 'All stand'. There is an opening address by the coroner, who points out that evidence of identification was taken at the previous, adjourned, session. No "conflict of evidence" is expected. The coroner places explicit emphasis on making "recommendations" at today's inquest. Attention is drawn to a map, on display, and to two alternative routes which would have been available to the coach driver. The coroner notes that these alternative routes are of importance to today's proceedings. The coroner states that a single inquest is being held on two deaths as he is satisfied they had a common origin.

F3. The first witness is called by the coroner himself - not by the coroner's officer. This witness, a pathologist, takes the oath. The coroner asks: "are you Doctor Brown?"; "did you perform a post-mortem examination at my request on (name of first

deceased)?" The pathologist gives his opinion of cause of death. The coroner refers to photograph No.1, from a sheaf of photographs in the possession of all solicitors and police officers present. The coroner asks whether the injuries received by the deceased are consistent with having been involved in (points to photograph of overturned coach). "Yes". The same procedure and structure of questioning is followed by the coroner for the second deceased. The pathologist then leaves the courtroom.

F4. The second witness is an elderly male, the driver of a car travelling along the same road as the coach, but in the opposite direction, shortly before it left the road. The coroner refers to photograph No.10. "was this coach coming toward you?": yes. The coroner then asks the witness, "in your own words", to describe what happened. The witness replies that he saw the coach "looming up" toward him: "a strange place to find a coach". The coroner asks why. "Such a narrow road". The witness, who used the road "very often", knew the vehicles could not pass. The coroner asks the witness whether he was satisfied there was insufficient room to pass. "Yes". After the two vehicles nevertheless edged past, the witness' wife saw the coach "about to topple". They drove to summon an ambulance. The coroner refers to photograph No.12. The positions of the vehicles' wheels are discussed. Both vehicles were said to be travelling at walking-pace. Questions from a solicitor.

F5. The third witness was parked in a lay-by on the road in question, having a picnic. (The moorland area concerned is of historic/tourist interest). He turned his head to look at the back of the coach, to see where it had come from. He then saw it fall, and went to give assistance. He considered the coach had

been entirely on the road until it fell. He had only ever seen two coaches using the road in the past.

F6. Fourth witness: an elderly female passenger on the coach. She was sitting on the front seat. She could not remember whether she had ever travelled along the stretch of road before. She thought the coach was on the road (not the grass verge) until it fell. She could not recall any "trouble" with the coach until the point where it left the road. She mentioned the "good, sensible driver".

F7. Fifth witness: another elderly female passenger. She could not add to the evidence already given, except to comment on the steep hill, as well as the narrowness of the road. It was a "steep pull".

F8. The sixth witness is an elderly male passenger. He was sitting, with his wife, behind the coach driver. He saw the car coming in the opposite direction, down the hill, as the coach was climbing. He thought the car would stop, but it did not. A solicitor asks why the witness expected the car to stop. "Well, always if there's a big vehicle coming up hill, you give way, don't you?"

F9. The seventh witness: police constable. He gives details of the width of the road and of the two vehicles. (He has also been pointing out details on the map throughout the inquest so far). The coroner asks him, summing up at the same time: "For all practical purposes, if both vehicles remained on the metalled surface [of the road] there simply wasn't room to pass?" Yes, replies the P.C., that is so.

F10. Another police officer, who attended the scene and interviewed "someone who identified himself as the driver of the coach".

The driver made a statement under caution, which the P.C. now reads to the coroner and the court. In his statement, the driver indicated that he was not driving his usual coach but another, brand-new, vehicle. He also indicated that, before leaving the road, he realised his nearside front wheel was on the verge. He braked but could not avert continuing movement to the left. Detailed interchanges follow between the coroner and the P.C. on the relative position of the two vehicles. A solicitor asks about signposting of roads in the area.

F11. The ninth witness is the coach driver. He is told by the coroner that he need not answer incriminating questions, but is not excused from questioning altogether. The coroner asks the coach driver about the exact position of his vehicle: the coach driver's solicitor gives <u>his</u> permission for the witness to answer the coroner's question.

F12. The tenth witness is a police vehicle inspector. No fault found with the coach. The car was undamaged. The coach became "irretrievable" once it touched the grass verge.

F13. Department of Transport vehicle inspector. Further details are given of mechanical examination of the coach.

F14. Adjournment: twenty minutes. This adjournment appears to serve the purpose only of refreshment: there do not seem to be any unexpected developments or new evidence to consider. Witnesses, police, technical 'expert' witnesses alike retreat to a canteen in the same building. Passengers from the coach talk amongst themselves ("and I tell you something else that was wrong ....."). The coach driver chats to his employer and a fellow-driver. The police sit together. Back in the courtroom, solicitors discuss various possible outcomes of today's pro-

ceedings. A female newspaper reporter charmingly elicits information from the solicitors which is "not for publication".

F15. The eleventh witness (the government vehicle inspector) returns to discuss, in general terms, research work into ways of strengthening coaches, particularly the roof. The coroner refers to the "increasing" number of incidents involving coaches turning over, and alludes, without naming it, to the "similar incident" so much on the minds of those who attended the scene of death (see above). A general discussion follows. It is suggested that if the roof of the coach in question had indeed been strengthened, more deaths could have resulted, as the coach would have been heavier. If the roof had not been crushed, the coach would have rolled for eighty-feet down a steep hill, instead of coming to rest. The loss of life could then have been considerable. The coroner suggests that the collapse of the roof in the case in question may indeed have saved lives: so it is not a matter of "strengthening everything in sight". (Anticipated commonsense reasoning is thus dismissed).

F16. The twelfth witness is the owner of the coach and the employer of the driver. He "usually" specifies the route to be followed by his drivers, but not in this case. He only specified the destination. He adds that the coach was only being used to assist a fellow coach-operator who would otherwise have been without a vehicle.

F17. The "fellow coach operator" gives evidence. He reports that the two coach owners often assist each other when one of their vehicles is off the road. He specified a route as far as Milltown, but says that he was unaware the coach would go on to Moor Bridge, and thence along the narrow moorland road.

F18. The fourteenth witness is the driver of another coach, forming one half of the two coachloads of predominantly elderly people on the day's excursion. His vehicle was travelling a "few hundred yards ahead" of the coach involved in the incident. He did not turn off along the narrow moorland road, however. He continued along the main road, to reach the destination "as I normally go in". This witness had never driven along the road in question. Detailed questions follow from the solicitors present. The questions focus upon the divergent routes taken by the coaches. The witness avoids any suggestion that the moorland road may have been known to be unsuitable.

F19. The fifteenth witness is the County Council's highways spokesman. He visited the site and prepared a report on the road itself, which he reported to be an unclassified road, twelve feet and ten inches wide. The coroner asks "Clearly not suitable for a coach?" The witness replies that "it would be difficult with any wide vehicle." The lay-byes on the road are said to be designed for sightsee-ers, and are not meant to be passing places for vehicles. (Any implication that the third witness - see F5 - was improperly parked is thus removed from further consideration). The witness describes the road as a "typical moorland narrow road". The coroner then asks: "Can I make any recommendations which could help?" The witness replies that the road could be signposted, but that it is not possible to signpost every such road to warn drivers of large or heavy vehicles.
A general, informal, discussion follows, the coroner asking, rhetorically, if anything can be done about cases such as the present one, or whether incidents of this kind are inevitable.
A solicitor argues that any driver could make the mistake of turning down this particular road. Both the coroner and the witness

remain sceptical: the unsuitability of the road is taken to be self-evident.

F20. The final witness is the clerk to the local traffic commissioners. He is responsible for licencing vehicles which carry passengers. He indicates that the commissioners do not specify routes for coach operators: it is the responsibility of owners to check the suitability of roads used.

F21. The coroner sums up. This occurs in an informal manner. The coroner rhetorically asks whether some cases of this sort are an inevitable feature of coach tours of "beauty spots", as such places of natural beauty tend to be served by old, narrow, unsuitable roads. The coroner then restates the names of the two deceased, adding that he is satisfied with details of identification, satisifed that the cause of death was as given by the pathologist, and satisfied that death occurred as a result of the coach leaving the road and overturning. "To deal with formal matters first, I shall record that these ladies died as a result of misadventure." The coroner then details the circumstances in which the coach driver lost control, before again discussing in general terms current research into coach construction, and the advantages and disadvantages of strengthening the coach's bodywork and roof. He then reflects that there are considerable practical difficulties in excluding coaches altogether from certain roads.

No specific recommendations are made by the coroner. He concldues:

> Though the driver might have had an error of judgement - and this may be decided by another court - he exercised very great care. The road was simply not wide enough.

Perhaps, adds the coroner, the Press can help to give other drivers a warning of the dangers discussed today. 'All stand'.

Inquest F concludes our detailed consideration of inquest proceedings. It will be recalled that Inquest F was not part of the systematic inquest-observation programme. It has been included here, firstly, because it offered a unique opportunity to consider a coroner's categorisation of a sudden death from the point of death through to eventual formal disposal and, secondly, because, unlike any of the inquests otherwise attended, this particular case was perceived as a major "public safety" issue. The latter point has several implications.

It can be noted, first of all, that the verdict itself at Inquest F is <u>almost incidental</u>. The coroner (F21) refers to dealing with the "formal matter" of the verdict, before he goes on to consider other and, by implication, over-riding, public-safety matters. It may also be noted that the characteristics and details of the two deceased were barely referred to at any point throughout the inquest. Only in the pathologist's evidence (F3) and the coroner's summing-up (F21) were the deceased mentioned at all. The verdict itself was wholly unproblematic. This emphasis at the inquest can be accounted for in terms of its concern with <u>general</u> issues, such as the construction of vehicles and the suitability of roads.

In this particular case, the coroner had shifted the primary function of the inquest to that of a <u>de facto public inquiry</u>. Expert witnesses and photographic/diagrammatic evidence were a major feature of the proceedings. At the start of the inquest, the coroner makes explicit reference to making general recommendations (F2). The coroner later <u>offers</u> his authority to one of the witnesses to make a public recommendation (F19).

The issue of authority is indeed highly relevant to an understanding of Inquest F. It will be recalled that the coroner's

authority over the overall investigation was one of his stated reasons for attending the scene of death. At the subsequent inquest, the coroner's authority is used only incidentally to examine the cause and circumstances of two specific deaths or to record a verdict: the coroner's principal role at Inquest F was as an ultimate authority over all other participants, with the power to make public observations and recommendations, in the context of an inquest functioning as a public inquiry.

The provisional conclusions made above about Inquests A to E also apply to Inquest F. The coroner is still engaged in providing a structured account of what-really-happened at the time of death. The projected verdict is unproblematic, and evidence is structured toward a total account, a comprehensive explanation, of hitherto unsorted events. A true story "emerged", as it routinely does, from an initial identifiable point, through a structured construction, to final explanation and disposal. Inquest F was different from other inquests attended, however, in that the coroner placed the process of construction itself to one side, while a more general function was defined for this particular inquest.

It is now possible to draw together our discussion of the inquest-observed into the form of concluding comments.

4 (4) Conclusions

The preceding discussion of the coroner's inquest was conducted on the empirical base of observation at fifty inquests in the jurisdiction of a full-time coroner. Five inquests were selected for detailed analysis. Additionally, material was drawn from subsidiary informal observation, and from one case where it was possible to observe the entire process from the coroner's

visit to the scene of death through to the ultimate inquest.

Overall conclusions can now be outlined in summary form:

1) Taylor has restated that what laymen or sociologists might see as problematic in coroners' work may not, to coroners themselves, be problematic at all (1982, 71). Taylor was referring specifically to the imputing of suicidal intent, but the point has a general applicability. Coroners routinely perceive their work as unproblematic. The progress of any particular inquest follows a predictable course.

2) The inquest verdict tends to be "recognised" within the strands of evidence: it tends to be "known" from the start of the proceedings. This need not imply a deliberate conspiracy to prejudge the results. The point, simply, is that by considering, for example, Inquest A above, an explicit example is provided of a typical feature of inquests. The projected true story appears at an early point in the structuring of evidence and the coroner's questions. The verdict itself is unsurprising.

3) The sequence in which evidence is presented at the inquest tends to fall into a recognisable pattern. Accounts of the deceased's health; recent general history; age; worries and troubles; and the "scene-setting" account of the day in question are arranged in a predictable form, within a structure. Particular factors may be accentuated or underplayed in the light of the projected verdict: e.g., "worries" may be amplified in the case of a projected suicide verdict, while similar worries are minimised or denied in the case of a projected misadventure verdict. All evidence presented at the inquest already exists in the form of written statements. These permit pre-inquest construction of the projected true-

story.

4) The pattern of structured evidence includes certain key-documents. The clearest example of a key-document is the pathologist's report: it is invariably an important initial piece of evidence. The existence of a note in cases of suicide also stands as a key-document. The evidence of other witnesses - in the form of written statements - may also become key-documents. This may especially apply to expert witnesses. More generally, the transformation of witnesses' verbal accounts into tangible documents, and vice-versa, mediated by the coroner, is a topic of sociological interest.

5) The formality of the physical structure of the coroner's inquest, when compared to other courts of law, reveals certain parallels; and it is in any event interesting to consider the physical structure and ritual of the inquest. However, a comparison of the entrance of the coroner with Carlen's description of the entrance of the magistrate (1976, 31) takes us only so far: and there is no basis for drawing a conclusion about <u>overt</u> social control from the ritual aspects of the inquest. It is perhaps more productive to compare the relative formality of the setting to the informality of typical exchanges between the coroner and witnesses. There is a disjunction between setting and mood.

6) Juries at coroners' inquests tend to be inactive and passive elements in the structure.

7) There are no <u>substantive</u> differences between jury inquests and non-jury inquests: there may be lesser or greater degrees of surrounding ritual. The process of constructing a true story through an initial projected verdict and the structured

accumulation of evidence has a typical, general character, irrespective of the presence of a jury.

8) The particular verdict recorded at an inquest does not substantially affect such typical processes of construction. Such processes obtain generally, although emphasis will vary according to the projected verdict.

9) Verdicts are ways of giving meaning and explaining. Causal factors are sought. Theories are used (Inquest D). A large leap may be made in the direction of a single, key, causal factor (Inquest C): more usually, the process is piecemeal, although systematic.

10) The inquest may have a role, a "reason", other than its formal purpose of recording the identity of the deceased and the cause and circumstances of death. Such an additional role may be to allay suspicion, gossip, or controversy. A common additional role is to perform a "public safety" function. This was the case at Inquest B. The process went further at Inquest F, where the "additional" public-safety role became its principal role, and the formal function was regarded as subsidiary.

11) An open verdict may have the practical status of a definite verdict, despite its formally unresolved character. As noted above, the inquest is characterised by typical processes of construction, irrespective of verdict. The true story in the case of an open verdict emerges either through the balanced opposition of contrary strands of evidence, or through the absence of an immediate causal explanation which itself is recognised as a typical open verdict.

12) The attribution of meaning and the creation of a projected verdict begins, as noted above, before the start of inquest proceedings. Inquest F indicates that this process may indeed begin at the scene of death where potential true stories are immediately sought. Inquest F's pre-organisation at the scene of death also reveals the process of evaluation in terms of past events.

13) The coroner does not attempt to produce a complete account. This is not because of the impossibility of a complete account (that is relevant to the sociologist, not the coroner): it is because the coroner is <u>not required</u> to produce a complete account. The coroner is required to produce an adequate account: adequate for the practical purposes for which he was appointed and for which he holds inquests. An adequate account, for coroners' purposes, may be quite <u>limited</u>, in terms of the total stock of potential facts-of-the-matter.

14) Formally, the inquest is not concerned with blame or liability. Observation at inquests suggests this is indeed so. However, coroners typically refer to the <u>absence</u> of blame. While the inquest may no longer return <u>de facto</u> 'convictions', it does enable <u>de facto</u> 'acquittals'.

15) The police role: Cicourel's depiction of "..... their sense of social structure and memory of past events ....." in providing initial interpretations of what-really-happened might be recalled (1968, 328). In terms of manpower and day-to-day direction the coroner's investigation is a police investigation, notwithstanding the transfer of the coroner's officer's 'social work' role to civilian staff in some areas.

The explicit request for police assent for the verdict at Inquest E is not typical. However, the coroner's investigation in general and the emphasis placed on police evidence at particular inquests indicates a major police role in the process of construction.

16) The inquest ordinarily is no longer concerned with overt social control. (This is partly why analysis of the formal, ritual structure of the inquest should not be taken too far in drawing comparisons with other courts of law). The inquest, however, is concerned with social control insofar as it produces an officially-sanctioned, generally binding, account of reality. The question of social control and the inquest is appropriately examined on the level of knowledge-about-the-world.

17)a) Inquests which produce verdicts of suicide are similar to inquests which produce any other verdict. The question arises of why sociologists, insofar as they have considered coroners' inquests at all, have only been concerned with suicide verdicts (Douglas 1967; Atkinson 1978). As suicide verdicts are produced by the same processes as other verdicts, and as 'suicide' occupies so small a part of any coroner's time, it is not within coroner's work itself that the reason for the lack of sociological interest in coroners' work as a whole is to be found.

b) Although Douglas (1967) takes an interactionist position and Atkinson (1978) takes, eventually, an ethnomethodological position, their interest in suicide (as distinct from other inquest verdicts) arises from the same bases: firstly, that an established, although theoretically diverse, "sociology

of suicide" already exists; and, secondly, that they employ a commonsense notion of which "kinds of death" are "interesting". Atkinson does conclude by widening his focus, but this is toward Anyman's categorisations about anything-in-the-world, not towards coroners' categorisations irrespective of verdict (1978, 196). A very narrow interest gives way to a nebulous interest in all social life.

c) Taylor (1982), although centrally interested in suicide, does give some consideration, briefly, to coroners' procedure as a whole. He observed that two sources of evidence are used by coroners at any inquest: "immediate circumstances of death" and "biography of the deceased". (Taylor 1982, 76). The emphasis then returns to suicide in particular. In part, Taylor's project was to examine the <u>quality</u> of suicide rates. He took this direction because both Douglas - in his "hard thesis" (Taylor 1982, 55) - and Atkinson, in rejecting any evaluation of the <u>reliability</u> of suicide rates, are quite unlikely to affect the course of traditionalist (positivist) studies. Therefore, Taylor, as it were, adopts the mantle of the positivist in order to tackle the question of the reliability of suicide rates in studies such as those of Gibbs and Martin (1964). This is a logically coherent position to take, but it is taking us some way from our current concern with coroners' categorisations in general. Taylor's approach will therefore be considered in more detail in the concluding chapter below.

d) The central questions about official statistics are what they are <u>conceived as</u> and what they are <u>used for</u>. Taylor saw those ethnomethodologists who took a "rejectionist" view of

official (suicide) statistics as precluding the possibility "..... of any rational knowledge of the world." (Taylor 1982, 56). This is reminiscent of Hindess' argument (1973). To restate the position adopted in the present study: coroners' statistics (including suicide statistics) are seen as wholly reliable records of what coroners do and the verdicts they record. Difficulties with official statistics arise from arguable notions of their supposed (reliable or unreliable) relation to events-in-the-world. Official statistics are treated below as reliable records of coroners' categorisations: the preceding discussion, based on observation at inquests, has considered how coroners make such categorisations.

18) Newspaper reports of coroners' inquests tend to be characterised by a further compression of the categorisation produced by the coroner. However, there is no typical newspaper report of an inquest. The reports of inquests attended yield, variously, a simplified account based on one or two key causal factors in the form of a short, self-contained explanation; a concern with mystery and continuing non-resolution; a bland summation of pieces of evidence. It may be that study of a sufficient number of newspaper reports of inquests would lead to the emergence of identifiable 'types of report'. However, the value of such an exercise, in terms of understanding coroners' work, is limited.

19) The coroner's considerable formal authority is of relevance in understanding the inquest and the production of the true-story. It was concluded in Chapter Three above that authority is appropriately seen in the context of historical factors, discretion, and the officially-produced version of what-really-happened. Coroners' authority is also part of

the formal physical structure of the inquest, the structuring of evidence around the projected verdict, and is of importance in considering the police and medical roles at the inquest. The most senior police officer involved in an investigation remains subject to the coroner's authority.

20) The composition of juries was not considered in detail during observation of inquests. There appear to be no studies of coroners' juries. Baldwin and McConville (1979; 1980) have examined the composition of other juries, concluding that "..... the jury is broadly representative of the community in terms of age and social class, but unrepresentative in terms of sex and race." (1979, 126). The material does not exist for drawing conclusions about the composition of coroners' juries. Historically, the rules governing selection of inquest juries have certainly been more casual than the rules governing selection of other juries. The position, however, is subject to change.*

21) It has been said above that the true story presented at the inquest may, while fulfilling the grounds of "adequacy" so far as the coroner is concerned, remain limited. The evidence (potential strands of the true story) which is <u>excluded</u> from the inquest may be quite considerable. Perhaps more needs to be said of this. Inquest C resulted in a specific verdict, and involved the construction of a coherent true story of events. Yet a separate discussion with the coroner, and a brief consideration of documentary material, revealed not

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* The Coroners' Juries Act 1983, together with changes embodied in the Coroners' (Amendment) Rules 1983 (S1 83/1539) which became operational in January 1984, codify practice relating to the summoning of jurors to an inquest, and lay down reasons for being excused service.

only <u>additional</u> elements, but strands of "explanation" quite different from those which were made public at the inquest. One may need to consider the possibility that there exists an "undercover" true story (known to the coroner, his staff, and the family) at odds with the "official" true story. In this particular case, it might be said that the verdict would not have been materially affected. The point is, however, that there may be an unwritten understanding that if no <u>purpose</u> is perceived to be served by the revelation of known strands of evidence, then such evidence, considerable though it may be, is not made public. This has implications for what is meant by a public inquest and also brings us back to the <u>limited</u> nature of an "adequate" inquest account.

22) To sum up, typical methods of constructing a true story obtain at inquests, in a systematic form, irrespective of whether a jury is in attendance, and irrespective of verdict. The initial point of the process of construction may be as early as the first police visit to the scene of death. At the start of the inquest itself, the projected verdict is, for the coroner's purposes of an adequate account, already "straightforward", already "known". <u>The verdict is immanent in the unfolding account</u>. Evidence is structured according to the projected verdict, and typical features of the "kind of death" under consideration are recognised. In general terms of course, examination of the inquest is examination of only a part of the coroner's total work. It is now clear that even consideration of a particular inquest is consideration of only a part of the total process of categorising that particular death.

Through the processes described above, formal tangible records are produced. These comprise coroners' annual statistical returns

to the Home Office. Parts of such statistics are published, to become the available "facts". Parts remain unpublished. The next part of the study considers, in a number of different ways, the statistics of coroners' work.

CHAPTER FIVE: CORONERS' ACCOUNTS: A CONSIDERATION OF STATISTICAL RECORDS

5(1) Introduction

This final section of Part Two consists of a discussion of the statistical records produced by coroners. The statistical product of coroners' work will be approached from more than one direction, building upon the empirical material collected and discussed so far. It might be recalled that Chapter Three considered the perceptions of different coroners, yielding comparative material about both the particularities of individual coroner's activities and possible generalities within coroners' work as a whole and that the information thus collected at interview was evaluated partly in terms of the preceding historical discussion. Chapter Four considered in detail the systematic methods used at a coroner's inquest to generate categorisations, or true-stories, relating to the death at hand. The formal product of the processes discussed above is the statistical record.

The first area of contention concerns the status or nature of such statistical records. For the layman, journalist or epidemiologist, coroners' statistics are records of types of deaths and numbers of deaths occurring, perhaps in absolute terms or, more usually, expressed in relation to population or some other factor. Whether sociologist or not, the epidemiologist will tend to see an 'increasing' or 'decreasing' rate of suicide, for instance, as a direct indication of changed events out-there in the world, and might proceed, from this point, to seek explanations. Such a researcher might also be more interested in inquest verdicts than in coroners' work as a whole.

In the present section of the study, statistical aspects of the totality of coroners' work are considered. The statistics of coroners' work are not treated as evidence of types-of-death-occurring. (The overall theoretical orientation of the study and the nature of official statistics were discussed in Chapter One above). The statistic is seen as the point at which the true-story or coroners' categorisation becomes the binding 'fact of the matter'. Thus, statistics are treated in the following discussion as (accurate) records of what coroners do: as the tangible <u>products of coroners' activities.</u>

Statistics, then, are to be used in an essentially descriptive manner, or, to put it another way, quantitative material is to be used qualitatively. Adoption of a different theoretical stance might, of course, involve an objection that 'mere' description limits the uses to which a substantial quantity of statistical material might be put. However, the position taken in the present study, as outlined already, is that sociological description is in itself an aim of central importance. If the descriptive significance of coroners' statistics is elucidated - not, of course, in isolation from material presented elsewhere in the study - then the bases for understanding coroners' work may be provided.

Notwithstanding this specific <u>attitude</u> toward coroners' statistics, some difficulties may remain. Firstly, it remains easy to lapse into a view of statistics as evidence about deaths-out-there, and the usage is so common that the very presentation of statistical material is routinely perceived as presentation of facts-about-deaths-occurring. It is to be emphasised that judgement about this is suspended. Secondly, familiar difficulties in discussing 'absolute numbers' and 'rates' cannot be avoided.

A simple example of the latter point is in contemplating a simultaneously increasing number and decreasing rate. For instance, 'parasuicide' in Edinburgh has been conventionally measured during the late 1970s and early 1980s as increasing amongst the 'young unemployed'. Over the same period, the 'rate of parasuicide' amongst the 'young unemployed' has continued to fall, simply because the total number in the group 'young unemployed' has increased so much more than the numbers in the group 'parasuicide' (Platt 1983).

The approach toward coroners' statistics adopted below is not, then, totally unproblematic. It is, however, an approach consistent with the overall aims of the study and with the chosen theoretical and methodological position. The well-rehearsed debates within sociology about the uses of official statistics (Chapter One above) may perhaps now be reduced to the questions of what official statistics are used as and what official statistics are used for. Their use below may be evaluated in terms of the choices made about the sociological use of official statistics in general.

Firstly, the national statistics of coroners' work over the period 1926 to 1975 will be discussed. (Throughout this chapter, 'national' denotes England and Wales, not the United Kingdom). Consideration of this fifty-year period allows discussion of the changing patterns of coroners' work as a whole, changes in specific categorisations represented by the coroner's verdict, and the significance of the many legal changes instituted during this time. The focus is upon the changing facts of sudden death, studied comparatively over a period of fifty-years.

Secondly, the national statistics for the year 1975 are considered in rather more detail. A geographically comparative

element is introduced. The differences between individual coroners' verdicts and the use of, for instance, the post-mortem examination may suggest different routes to a true story. The perceptions and attitudes of the interview sample of coroners (Chapter Three above) and their varying approaches to coroners' work might usefully be recalled.

Thirdly, the statistics produced in one coroner's jurisdiction - 'City' - over the period 1926 to 1975 are discussed. Consideration may thus be given to any relevant changes in the pattern of categorisations in this particular area. Statistical totals are supplemented by reference to comments and notes found in the City coroner's registers.

The three complementary approaches to the statistics of coroners' work are designed to yield descriptive and qualitative material about what coroners do. The necessary expression of statistical material in quantitative form does not alter this emphasis, nor introduce matters which detract from this emphasis, such as general age or sex breakdowns of those upon whom a particular verdict has been pronounced. In short, the biographical characteristics of the deceased are not seen as relevant. The emphasis is upon the use of statistical material insofar as it assists in the task of understanding the work of the coroner. It is to be considered alongside the conclusions drawn from the interview and observation elements of field research.

The choice of the year 1975 as the end-point of the national and local statistical surveys, and the focus of the single-year study of individual jurisdictions, was made for a number of reasons: the availability of statistical information; the wish to apply the local and national statistical surveys to

the same period; the timing of the different parts of the field research (see Appendix I); and because it reflected a full-year of operation of the revised coroners' boundaries following local government re-organisation. Some further statistics, covering the period from 1976, are appended to the study (see Appendix II).

The final part of the consideration of coroners' statistics briefly examines one verdict - suicide - up to the year 1980. Apparent changes in the numbers of suicides occurring during the 1970s have to some degree been a subject of public debate. In terms of this study's interest in coroners' categorisations, the question of whether anything can be said about 'trends in suicide' over recent years will be considered. The issue again arises of whether suicide is simply one verdict amongst many, so far as coroners' processes of construction are concerned, or whether it is in some sense a 'special case'.

The comment of a coroner during the interview programme that a verdict is essentially "a categorisation of the slot the death fits into" might be kept in mind during this discussion of the statistical products of coroners' activity.

5(2) Fifty Years: the Statistics of Coroners' Work in England and Wales 1926-75.

Coroners' verdicts are only one part of the statistical pattern of coroners' work as a whole. It is helpful to examine inquest verdicts in relation to the total number of deaths reported to coroners, the number of inquests held, and so on. Table 5(2)1 illustrates broad changes in coroners' work over the fifty-year period 1926 to 1975.

Between 1926 and 1975, it can readily be seen that the total number of deaths in England and Wales has steadily increased from approximately 450,000 in the early 1920s to approximately 500,000 in the late 1930s and 1940s, continuing to increase during the 1950s until the figure reaches approximately 550,000 in 1965. The total number has again risen during the period 1965-75. Table 5(2)1 indicates the precise details of this generally continuing increase in total numbers of deaths. It is not remarkable that the number of deaths has risen over the fifty-year period in question: total population has also risen. However, it is of interest to note (Table 5(2)1, column three) that the proportion of deaths <u>reported to coroners</u> has risen dramatically. In 1926, 11.9% of total deaths were reported to coroners; in 1936, 14% of deaths were reported; in 1946, 14.8% were reported; in 1956, 18.6% were reported; in 1966, 20.8% were reported. By 1975, 26.3% of all deaths in England and Wales were reported to coroners. There are legal and procedural factors which might help to account for this increase, and the historical discussion in Chapter Two above might usefully be consulted. The salient point, however, is that over the fifty-year period coroners' work has moved from the position of an activity concerned with a relatively small proportion of deaths to that of an activity concerned with well over one quarter of all deaths. <u>Coroners' work has become an increasing feature of the system for dealing with death in general.</u>

The content and boundaries of what constitutes "coroners' work" have also changed between 1926-75. In 1926, a coroners' investigation typically meant an inquest. In 1975, a coroners' investigation typically meant a form 'B' procedure i.e. post

TABLE 5(2)1: CORONERS' WORK 1926-75: PART ONE*

YEAR	TOTAL NO. DEATHS, ENGLAND AND WALES	TOTAL NO. DEATHS REPORTED TO CORONERS	TOTAL NO. CORONERS' INQUIRIES NOT FOLLOWED BY INQUEST	TOTAL NO. POST-MORTEM EXAMINATIONS ORDERED BY CORONERS	
				INQUEST CASES	NON-INQUEST CASES
(col.1)	(col.2)	(col.3)	(col.4)	(col.5)	(col.6)
1926	453,804	54,177	14,506	14,463	
1927	484,609	60,511	20,808	12,904	3,616
1928	460,389	62,501	23,542	11,127	6,791
1929	532,492	67,259	26,581	11,468	7,906
1930	455,427	63,238	24,983	11,306	7,875
1931	491,630	65,082	27,358	11,069	8,458
1932	484,129	65,979	28,455	10,796	8,873
1933	496,465	67,458	29,277	11,561	9,647
1934	476,810	67,044	29,175	12,054	10,745
1935	477,401	67,646	30,178	11,728	11,058
1936	495,764	69,687	31,828	11,972	12,269
1937	509,574	71,628	33,069	12,771	13,212
1938	478,996	70,635	32,381	13,180	13,764
1939	**				
1940					
1941					
1942					
1943					
1944					
1945			PINK FORM A		
1946	492,090	72,664	23,219	13,655	22,895
1947	517,615	81,316	25,426	14,854	27,881
1948	469,898	n.a.	n.a.	n.a.	n.a.
1949	510,736	75,844	22,538	13,897	28,865
1950	510,301	83,571	n.a.	n.a.	n.a.
1951	549,380	89,587	n.a.	n.a.	n.a.
1952	497,484	85,929	n.a.	n.a.	n.a.
1953	503,529	88,128	n.a.	n.a.	n.a.
1954	501,896	90,797	23,250	17,304***	41,564

TABLE 5(2)1 Continued

(col.1)	(col.2)	(col.3)	(col.4)	(col.5)	(col.6)
1955	518,864	94,914	24,761	17,442	44,042
1956	521,331	96,977	31,388	15,086	39,399
1957	514,870	n.a.	28,654	18,902	50,665
1958	526,843	100,901	21,934	19,759	53,031
1959	527,651	102,182	21,012	20,982	54,788
1960	526,268	101,079	16,933	21,496	57,841
1961	551,752	101,667	13,162	22,229	62,329
1962	557,836	106,786	13,314	23,417	66,589
1963	572,868	113,001	13,245	24,179	72,443
1964	534,737	109,844	11,924	24,639	70,826
1965	549,379	116,267	12,639	24,914	76,604
1966	563,624	117,438	12,754	24,893	77,826
1967	542,519	117,935	12,964	23,918	79,364
1968	576,754	124,420	13,927	23,407	85,870
1969	579,378	131,639	14,506	24,101	92,003
1970	575,194	133,356	15,053	23,959	93,433
1971	567,262	134,405	16,220	23,748	93,295
1972	591,889	143,983	16,506	23,621	103,175
1973	587,478	145,658	17,104	23,971	103,959
1974	585,292	149,309	18,055	23,228	107,363
1975	582,700	153,366	19,526	23,014	110,385

* Source: Brodrick Report (1971, 370-373), years 1926-1969;
Unpublished Home Office statistics, years 1970-1975.

** Wartime figures are unavailable. From 1946, column 4 (inquiries not followed by inquest) is re-titled 'Pink Form A'

***The figures in columns 5 and 6, years 1954 to 1958 inclusive, are estimates from the Coroners' Society: see Brodrick Report (1971, 365-369) for details of this and other irregularities in tables 5(2)1 and 5(2)2.

mortem examination and no inquest. This can be presented in more precise terms. In 1926, it can be seen (column 4, table 5(2)1) that 14,506 deaths reported to coroners did not involve an inquest i.e. 26.8% of all deaths reported to coroners. By 1946, 23,219 deaths were being dealt with by the 'form A' procedure (no inquest, no post-mortem) but another 22,895 deaths were now being disposed of by the 'form B' procedure (post-mortem, no inquest) i.e. 63.5% of deaths reported to coroners in 1946 did not involve in inquest. The trend has continued, and by 1975 it can be seen that 19,526 deaths were being dealt with via 'form A', and another 110,385 deaths via 'form B': thus in 1975 almost 85% of deaths reported to coroners did not involve an inquest.

It has already been suggested above that the inquest is a relatively minor part of the day-to-day work of the modern coroner. The descriptive statistics presented in table 5(2)1 reinforce this view. It can now be suggested that, alongside coroners' work as a whole becoming an increasing feature of the social/bureaucratic system for dealing with death in British society, (i.e. ever-more deaths are being reported to coroners), there has been an important change in the coroner's typical manner of disposing of the deaths reported to him, i.e. the post-mortem, not the inquest, is the typical 'instrument' of the coroner.

Before proceeding further, attention might briefly be drawn to some of the irregularities within table 5(2)1. The Brodrick Report (1971, 365-369), accounts for some apparent inconsistencies. It will be seen, for instance, that columns 4, 5 and 6 of table 5(2)1 do not correspond, in total, to column 3 ("total number deaths reported to coroners"). This is because

in a small number of cases inquests are held without first conducting a post-mortem examination, and these are not included at table 5(2)1. It will also become clear that the total annual verdicts returned is less than the total number of inquests held, because some inquests are opened and never completed (S.20, Coroners (Amendment) Act 1926), or not completed until the next calendar year. When the discussion below comes to focus upon the year 1975 in detail, for instance, it will be seen that 22,352 verdicts were returned; 23,411 inquests were 'held' i.e. completed; but 23,455 deaths were reported upon which inquests were opened. Clearly, caution is necessary in drawing out conclusions. Nevertheless, on the basis of the material presented in table 5(2)1, there appears to have been a considerable change between 1926 and 1975 in both the quantity of coroners' work and the typical manner in which that work is performed.

Table 5(2)2 completes the initial profile of coroners' work as a whole over a fifty-year period. For ease of reference and clarity, columns 2 and 3 are reproduced from the previous table. It can be seen that the total number of inquests, as a proportion of total deaths reported to coroners, has continually fallen during the relevant period: in 1926 60.8% of deaths reported to coroners involved an inquest; in 1946, 36.5%; in 1975, 15.3%. Of course, this is only to express in another form one of the conclusions drawn from the previous table. What might also be noted, however, is that table 5(2)2 indicates that during the fifty-year period the total number of verdicts began to diverge from the total number of inquests. From 1926 to 1928, the number of inquests and the number of verdicts are identical. From 1930 through to 1975, however, the annual number of verdicts

TABLE 5(2)2 CORONERS' WORK 1926-75: PART TWO*

YEAR	TOTAL NO. DEATHS ENGLAND AND WALES	TOTAL NO. DEATHS REPORTED TO CORONERS	TOTAL NO. INQUESTS	TOTAL NO. VERDICTS RETURNED	TOTAL NO. CORONERS' JURISDICTIONS
(col.1)	(col.2)	(col.3)	(col.4)	(col.5)	(col.6)
1926	453,804	54,177	32,924	32,924	363
1927	484,609	60,511	32,438	32,438	
1928	460,389	62,501	31,553	31,553	
1929	532,492	67,259	32,612	32,610	
1930	455,427	63,238	31,659	31,521	
1931	491,630	65,082	30,801	30,638	
1932	484,129	65,979	30,512	30,357	
1933	496,465	67,458	31,669	31,476	
1934	476,810	67,044	31,562	31,374	
1935	477,401	67,646	31,032	30,850	
1936	495,764	69,687	30,963	30,737	353
1937	509,574	71,628	31,575	31,358	348
1938	478,996	70,635	31,505	31,292	345
1939	**				
1940					
1941					
1942					
1943					
1944					
1945					
1946	492,090	72,664	26,550	***	333
1947	517,615	81,316	28,009		332
1948	469,898	n.a.	n.a.		331
1949	510,736	75,844	24,441		330
1950	510,301	83,571	25,784		329
1951	549,380	89,587	27,256		327
1952	497,484	85,929	25,361		324
1953	503,529	88,128	25,521		321
1954	501,896	90,797	25,983		316
1955	518,864	94,914	26,111		313
1956	521,331	96,977	26,240		310

TABLE 5(2)2 Continued

(col.1)	(col.2)	(col.3)	(col.4)	(col.5)	(col.6)
1957	514,870	n.a.	25,752	25,294	309
1958	526,843	100,901	25,936	25,499	304
1959	527,651	102,182	26,382	26,005	303
1960	526,268	101,079	26,305	25,785	300
1961	551,752	101,667	26,176	25,620	300
1962	557,836	106,786	26,883	****	297
1963	572,868	113,001	27,313	26,627	299
1964	534,737	109,844	27,094	26,425	291
1965	549,379	116,267	27,024	26,053	286
1966	563,624	117,438	26,858	25,940	282
1967	542,519	117,935	25,607	24,680	270
1968	576,754	124,420	24,623	23,759	270
1969	579,378	131,639	25,130	24,172	264
1970	575,194	133,356	24,870	23,900	262
1971	567,262	134,405	24,890	23,777	256
1972	591,889	143,983	24,302	23,053	255
1973	587,478	145,658	24,595	23,412	255
1974	585,292	149,309	23,891	22,663	251/186*****
1975	582,700	153,366	23,455	22,352	183

* Source: Brodrick Report (1971, 370-373) and (386-387), years 1926-1969. Unpublished Home Office statistics, years 1970-1975.

** See Note table 5(2)1

*** Total number verdicts returned not available 1946-56.

**** This figure, given as 16,347 (Brodrick Report, 1971, 386) apparently erroneous.

***** Denotes local government re-organisation

is invariably smaller than the annual number of inquests: by 1975, the difference in the two figures is more than 100. This divergence in total numbers between inquests and verdicts is an example of a legal change, i.e., Section 20 of the Coroners' (Amendment) Act 1926, altering the profile of what-it-is that coroners are doing. The 1926 Act required that coroners hence-forth adjourn inquests where proceedings are to be taken in another court for homicide: the Act represented one of a series of measures designed to limit the coroner's powers in matters of criminal law. The 1926 Act, as we noted in Chapter Two,was by virtue of this particular section, aimed at preventing the inquest becoming, de facto, a court of trial in cases of murder or manslaughter. From 1956, adjournments were also required where an individual faced a charge, in another court, of causing death by dangerous driving.

Table 5(2)2 indicates that between 1926 and 1975 the number of inquests, in absolute terms, fell from 32,924 to 23,455. The number of inquests as a proportion of all deaths in England and Wales fell from 7.25% in 1926 to 4% in 1975. Both figures are less striking than the fall in inquests as a proportion of deaths reported to coroners. To put it another way, it is the increased number of deaths reported to coroners and the decreasing use of the inquest by coroners on such deaths that are of sociological interest. The first phenomenon tell us something of the more central role being occupied by coroners' work within the societal framework for dealing with death; the second phenomenon tell us something of the less central role being occupied by the inquest within coroners' work.

The final point of interest to be drawn from table 5(2)2 is that the number of coroners' jurisdictions in England and

Wales has steadily fallen. In 1926, there were 363 jurisdictions; by 1946, 333 jurisdictions; by 1960, 300 jurisdictions; and in 1973, 255 jurisdictions. At the time of local government reorganisation in 1974, coroners' jurisdictions were further enlarged (and therefore reduced in number) to correspond to the new county boundaries. Thus in 1974 there were initially 251 jurisdictions; in April 1974 there were 186 jurisdictions; and in 1975 the total number fell further to 183. Quite clearly, the change from 363 jurisdictions in 1926 to 183 jurisdictions in 1975 indicates that coroners' areas have tended to become ever larger. It would not be possible, however, to draw conclusions about the concentration of coroners' authority in fewer hands until analysis was also made of the total numbers of coroners, deputies and assistants, and the relative numbers of full-time and part-time coroners. What can be said is that coroners' areas have become more uniform, and more consistent with the boundaries of other vehicles of classification and State involvement, e.g. health, social services, education. Coroners' jurisdictions have increasingly corresponded to the bureaucratic framework of a modern industrial society. For the sake of completeness, it should finally be noted that there are invariably fewer coroners than there are coroners' jurisdictions, as some coroners cover more than one area, even on a temporary basis (Brodrick Report, 1971, 368).

Table 5(2)3 is an illustrative table, covering the period 1969 - 1975 only. It has already been noted that the total number of inquests has continued to decrease. It is of interest here to note that inquests being held where a post-mortem examination has not first been conducted are, by 1975, few in number: the 441 inquests-without-post mortem held in 1975

TABLE 5(2)3: DEATHS ON WHICH INQUESTS WERE HELD
1969-75: USE OF THE POST-MORTEM EXAMINATION*

	1969	1970	1971	1972	1973	1974	1975
Inquest Held/ Post-Mortem Performed	24,101	23,959	23,748	23,621	23,971	23,228	23,014
Inquest Held/ Post-Mortem Not Performed	1,029	911	1,142	681	624	663	441
TOTAL NO. INQUESTS	25,130	24,870	24,890	24,302	24,595	23,891	23,455

* Source: Unpublished Home Office statistics derived from coroners' returns

represent less than 0.3% of all deaths reported to coroners in that year. The centrality of the post-mortem examination (and its concomitant "key document", the post-mortem report) is again evident.

Table 5(2)4 provides a descriptive statistical summary of all inquest verdicts over the fifty year period where statistics are available: unfortunately, figures for the years 1939 to 1956 are not included in the published source (Brodrick Report 1971, 386-387). Despite this gap, table 5(2)4 provides the basis for a descriptive overview of the products of coroners' activity, and permits some tentative interpretations of developments.

The verdicts of murder, manslaughter and infanticide can be seen to have steadily been recorded less often, with the partial exception of manslaughter verdicts which numbered 30 in 1974 and 49 in 1975. Of course, a decreased number of a particular verdict would be initially unsurprising, given that the total number of all verdicts fell during the fifty-year period. Nevertheless, the decrease in these three verdicts is proportionally greater than the general decrease in total verdicts recorded. Since the implementation of the Criminal Law Act 1977, the verdicts of murder, manslaughter and infanticide have been replaced (as verdicts available to the coroner or jury) by the single verdict of "unlawful killing". Thus, matters which were once the province of the coroner's inquest have passed, again, to the criminal courts, although it is perhaps interesting that a finding of unlawful killing still falls within the jurisdiction of an inquisitorial court.

Table 5(2)4 indicates that verdicts of justifiable or excusable homicide have been, numerically, a very small element

TABLE 5(2)4: CORONERS' VERDICTS 1926-1975*

VERDICT	YEAR 1926	1927	1928	1929	1930	1931	1932	1933
(1) Murder**	164	121	76	81	84	71	76	73
(2) Manslaughter**	88	42	66	47	46	31	40	39
(3) Infanticide**	20	7	7	5	6	4	4	3
(4) Justifiable Homicide***	4	1	1	2	-	-	-	1
(5) Execution of Death Sentence	17	8	21	8	3	10	9	9
(6) Suicide: While Insane****	4,330	4,770	4,758	4,844	4,886	4,987	5,587	5,472
(7) Suicide: Felo-De-Se ****	78	93	88	65	86	105	70	71
(8) Attempted/Self-Induced Abortion	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	29	42
(9) Lack of Care/Self-Neglect +	126	127	112	165	115	109	68	85
(10) Excessive Drinking ++	86	91	84	160	133	119	127	115
(11) Addiction to Drugs	n.a.	n.a.	n.a.	12	8	6	9	12
(12) Want of Attention at Birth	295	231	217	189	189	182	199	145
(13) Industrial Diseases	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
(14) Accident/Misadventure	13,851	15,135	16,485	17,452	17,532	16,711	16,120	17,136
(15) Natural Causes	12,117	9,998	7,783	7,825	6,736	6,660	6,308	6,618
(16) Still-Born	262	210	207	154	160	153	153	121
(17) Open Verdict +++	1,486	1,514	1,499	1,453	1,537	1,491	1,558	1,529
(18) Adjourned S.20 Coroners (Amendment) Act 1926 ++++	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

TABLE 5(2)4 Continued

VERDICT	YEAR 1934	1935	1936	1937	1938	1939-1956
(1) Murder	83	75	71	53	55	Not available
(2) Manslaughter	48	53	36	32	50	
(3) Infanticide	3	1	3	1	3	
(4) Justifiable Homicide	-	2	-	2	5	
(5) Execution of Death Sentence	9	11	7	9	5	
(6) Suicide: While Insane	5,431	5,090	4,920	5,061	5,210	
(7) Suicide: Felo De Se	55	66	87	44	53	
(8) Attempted/Self-Induced Abortion	46	36	43	45	35	
(9) Lack of Care/Self-Neglect	70	62	74	77	71	
(10) Excessive Drinking	112	120	142	182	166	
(11) Addiction to Drugs	12	10	5	6	12	
(12) Want of Attention at Birth	179	160	117	149	154	
(13) Industrial Diseases	n.a.	n.a.	n.a.	n.a.	n.a.	
(14) Accident/Misadventure	17,345	17,024	17,365	17,804	17,415	
(15) Natural Causes	6,360	6,431	6,162	6,147	6,066	
(16) Still-Born	121	104	104	144	*+	
(17) Open Verdict	1,500	1,625	1,601	1,602	1,892	
(18) Adjourned S.20 Coroners (Amendment) Act 1926	n.a.	n.a.	n.a.	n.a.	n.a.	

TABLE 5(2)4 Continued

VERDICT	YEAR 1957	1958	1959	1960	1961	1962	1963	1964
(1) Murder	76	58	71	50	53	66	60	62
(2) Manslaughter	17	17	21	23	27	19	25	21
(3) Infanticide	4	2	4	2	3	1	2	3
(4) Justifiable Homicide	1	-	1	-	-	2	2	2
(5) Execution of Death Sentence	2	4	6	10	7	3	2	2
(6)(7) Suicide	5,313	5,237	5,206	5,119	5,212	5,583	5,727	5,565
(8) Attempted/Self-Induced Abortion	15	12	7	12	15	17	13	8
(9) Lack of Care/Self-Neglect	40	54	66	46	39	52	67	53
(10) Excessive Drinking/Chronic Alcoholism	70	63	90	89	79	85	74	83
(11) Addiction to Drugs	4	5	4	2	1	4	5	8
(12) Want of Attention at Birth	42	41	40	24	35	23	39	26
(13) Industrial Diseases	874	757	737	784	954	914	1,012	853
(14) Accident/Misadventure	15, 088	15,581	16,042	16,201	16,878	16,298	16,522	16,651
(15) Natural Causes	2,440	2,367	2,279	2,039	1,860	1,853	1,501	1,575
(16) Still-Born	21	30	36	21	19	34	40	22
(17) Open Verdict	1,290	1,261	1,365	1,363	1,392	1,393	1,490	1,507
(18) Adjourned S.20 Coroners (Amendment) Act 1926	497	560	596	596	688	619	n.a.	707

TABLE 5(2)4 Continued

VERDICT	YEAR 1965	1966	1967	1968	1969	1970	1971	1972
(1) Murder	65	55	58	59	42	30	70	35
(2) Manslaughter	28	26	24	28	26	18	28	26
(3) Infanticide	4	3	3	1	2	4	3	3
(4) Justifiable Homicide	-	-	1	-	-	2	1	1
(5) Execution of Death Sentence	-	-	-	-	-	-	-	-
(6)(7) Suicide	5,187	5,013	4,735	4,569	4,369	3,964	4,005	3,807
(8) Attempted/Self-Induced Abortion	16	8	7	9	3	1	4	1
(9) Lack of Care/Self-Neglect	53	75	37	47	55	43	49	49
(10) Excessive Drinking/Chronic Alcoholism	131	109	122	126	123	106	170	165
(11) Addiction to Drugs	12	11	16	19	37	26	42	64
(12) Want of Attention at Birth	47	31	31	29	15	23	17	20
(13) Industrial Diseases	934	882	747	771	783	827	818	862
(14) Accident/Misadventure	16,596	16,670	15,843	15,111	15,520	15,479	15,288	14,571
(15) Natural Causes	1,519	1,541	1,566	1,517	1,563	1,744	1,647	1,744
(16) Still-Born	27	25	36	23	32	7	19	10
(17) Open Verdict	1,447	1,491	1,454	1,450	1,602	1,626	1,616	1,695
(18) Adjourned S.20 Coroners (Amendment) Act 1926	871	933	933	998	860	n.a.	n.a.	n.a.

TABLE 5(2)4 Continued

VERDICT	1973	YEAR 1974	1975
(1) Murder	46	69	65
(2) Manslaughter	43	30	49
(3) Infanticide	2	3	2
(4) Justifiable Homicide	4	3	1
(5) Execution of Death Sentence	-	-	-
(6)(7) Suicide	3,864	3,931	3,717
(8) Attempted/Self-Induced Abortion	2	1	-
(9) Lack of Care/Self-Neglect	56	62	72
(10) Excessive Drinking/Chronic Alcoholism.	246	334	371
(11) Addiction to Drugs	55	50	63
(12) Want of Attention at Birth	17	12	25
(13) Industrial Diseases	818	776	823
(14) Accident/Misadventure	14,684	13,978	13,644
(15) Natural Causes	1,853	1,701	1,651
(16) Still-Born	12	14	8
(17) Open Verdict	1,710	1,699	1,861
(18) Adjourned S.20 Coroners (Amendment) Act 1926	n.a.	n.a.	1,059

Notes, Table 5(2)4

* Source: Brodrick Report (1971, 386-387); Unpublished Home Office Statistics.

** The verdicts of murder, manslaughter and infanticide were replaced by the single verdict of "unlawful killing" with the passage of the Criminal Law Act 1977.

*** The verdict of justifiable or excusable homicide was replaced by the verdict of "lawful killing" under the provisions of the Coroners' Rules 1980.

**** Two separate verdicts of 'suicide while insane' and 'felo de se' appear until 1938. When statistics resume, there is a single verdict of killed himself/herself only.

\+ "Lack of care" and "want, exposure, etc." are listed separately until 1938 - but are totalled here throughout.

++ "Excessive drinking" became "chronic alcoholism" when the published statistics resume in 1957.

Notes, Table 5(2)4 Continued

+++ Open verdicts are further subdivided until 1938 according to cause of death, but are totalled here throughout.

++++ Such adjourned inquests are not resumed. From 1956, they apply to death through "dangerous driving" as well as to suspected cases of homicide.

*+ The number stated here (Brodrick Report, 1971, 387), i.e. 500, appears to be erroneous.

of coroners' inquest work over the fifty-year period, the highest annual total being 5 in 1938. Despite small numbers, the verdict of justifiable homicide implied questions (akin to those previously relating to inquest verdicts of murder, manslaughter and infanticide) about the boundaries of coroners' categorisations and the relation to criminal law: matters which have characterised coroners' work over the centuries. During the 1970s, the verdict of justifiable homicide also raised social and quasi-political issues within the realms of public debate, and in 1980 an amendment to the Coroners' Rules replaced justifiable homicide by the verdict of "lawful killing". Thus, the first four verdicts listed in table 5(2)4 no longer exist as formal or legal categorisations available to the coroner at an inquest. The fifth verdict listed - execution of sentence of death - has de facto been abolished by the removal of the death penalty.

The verdict of suicide was, in 1926, available in two forms. It can be seen from table 5(2)4 that in the overwhelming number of cases suicide "while insane" was recorded, but in a residual number of cases prior to the Second World War, "felo-de-se", or "self-murder", was recorded. The practice of some coroners today in adding the phrase "while the balance of mind was disturbed" to suicide verdicts without doubt originates from a period when the phrase had legal meaning, setting the deceased aside from those who committed acts of "self-murder". The dual verdicts of suicide are interesting on a conceptual level, and indeed had a practical significance for surviving relatives in matters such as life insurance, religious burial, and moral condemnation. The disappearance of "self-murder" is consistent with the disappearance of other formal categorisations open to

the coroner in earlier times but gradually perceived as outmoded: the framework within which the coroner can categorise is subject to change. The disappearance of "self-murder" is also consistent with the medicalisation of coroners' work: in this case, medicalisation in the sense of the emergent psychiatric ethos and ideology as an explanation of areas of human behaviour formerly considered evil. The twin processes of medicalisation and de-criminalisation are evident in an examination of coroners' verdicts over the fifty-year period.

More will be said of suicide in the final section of Chapter Five. Returning to table 5(2)4, the verdict of death through attempted or self-induced abortion can be seen to have had its greatest significance during the mid to late 1930s. In the post-war period, the verdict was recorded only 17 times in 1962, and thereafter was recorded even less often. There were only 9 verdicts of death through attempted/self-induced abortion, in total, during the period 1970 to 1975 inclusive. It is not unreasonable to make some association with abortion law reform. It is yet another example of events in the legal/normative/moral areas 'leaving behind' the available formal framework within which coroners make their categorisations: until such time as the formal structure 'catches up' via such statutes as the Criminal Law Act 1977 or the periodic revisions to the Coroners' Rules.

The verdict of death through lack of care or self-neglect has gradually diminished in frequency over the fifty-year period. It might be noted that separate statistics within this category were recorded until 1938, distinguishing "lack of care" from "want, exposure etc": the two, however, are totalled on table 5(2)4. The verdict of death through "excessive drinking"

and, as it subsequently became, "chronic alcoholism" has been recorded progressively more often over the course of the relevant fifty-years: 86 such verdicts in 1926; 142 in 1936; 109 in 1966; 371 in 1975. Aside from the increasing number of such verdicts, it is of interest to consider the meaning of the change from "excessive drinking" to "chronic alcoholism". Firstly, the change in terminology reflects a clear medical-isation of the phenomenon it ostensibly describes, the emphasis shifting from personal excess to a distinct medical condition: just as the emphasis has shifted from sin to mental illness in the case of suicide verdicts. Secondly, the change in terminology indicates a difference of meaning: excessive drinking may be 'chosen' (invoking responsibility for behaviour) whereas alcoholism might denote a 'disease-state' (invoking the sick-role and a determinist explanation). The shift in meaning is clear when one considers that excessive drinking does not logically imply alcoholism at all. Verdicts of death through addiction to drugs have tended to be statistically of minor significance until the late 1960s and the 1970s. The issue of meaning is again relevant. The formal category of addiction to drugs existed, for instance, throughout the 1930s, when coroners made little use of it. The phenomenon of "addiction to drugs" changed its meaning in the 1960s when it became associated with a perceived sub-culture held to exist amongst young people. It is possible to speculate upon the manner in which the moral solidarity of a society or even, as in this case, a moral panic (Cohen, 1980) within society, may serve to influence the categorisations made by coroners.

The verdict of death through "want of attention at birth" decreased in frequency dramatically over the period 1926-1975.

295 such verdicts were recorded in 1926; 25 in 1975. This appears to be a case where, as an available categorisation, "want of attention at birth" is no longer adequate in the sense discussed in Chapter Four above. It is not-adequate insofar as it is unspecific. Increased medical knowledge, more frequent use of the post-mortem examination and more rigorous registration procedures are amongst the possible relevant background factors, but the salient point is that the criteria of adequacy, so far as coroners' categorisations are concerned, change over time.

There has been little change in the number of deaths categorised as due to industrial diseases since the figure appeared for the first time in 1957. The emergence of this verdict can reasonably be linked to the emergence of health and safety legislation, compensation regulations, and the increased perception of industrially-related illness. Viewed historically, it is also, of course, linked to the phenomenon of industrialisation itself.

Verdicts of death through accident or misadventure (the formal meanings are synonomous, although coroners may and do make a practical distinction) are, throughout the fifty-year period, recorded far more often than any other verdict. The number of accident/misadventure verdicts recorded in 1926 (13,851) is remarkably similar to the number recorded in 1975 (13,644). The total number of inquest verdicts (all verdicts) recorded during the fifty-year period, however, decreased, as we have noted above. Thus the 13,851 accident/misadventure verdicts in 1926 represented 42% of all inquest verdicts, whereas the 13,644 accident/misadventure verdicts in 1975 represented 61% of all inquest verdicts. This verdict, then, has not fallen into disuse, nor has its "adequacy" diminished:

indeed, it is being recorded more than ever before.

The continuing use of the accident/misadventure verdict can be accounted for on the level of meaning. Its meaning is sufficiently loose to accomodate changing mores and changing legal stipulations. The true story which constitutes a misadventure verdict can vary widely. It will be recalled from Chapter Four that a road traffic death was selected for consideration, and resulted in a misadventure verdict. Indeed, for coroners, road traffic deaths typically result in misadventure verdicts. This was not so in 1926: road traffic deaths were not then so significant. Events which are, commensically, "accidental" and events which, literally, involve mis-adventure are routine features of the constructed social world. Their typical form for coroners changes over time (as in the case of road traffic deaths) but the pool of unconstructed true stories which might, potentially, become verdicts of misadventure is large. By this wide sweep of meaning, the verdict (unlike some discussed above) continues to be in general and frequent use.

Verdicts of death by "natural causes", as may be seen at table 5(2)4, have declined in number from 12,117 in 1926 (second only to accident/misadventure verdicts in that year) to approximately 6,000 in 1938, falling further to approximately 1,500 in 1963 and continuing at approximately that level until 1975. The emergence of the form 'A' and 'B' procedures would seem to account for this striking drop in the numbers of inquest verdicts of natural causes. It may be that the total category of cases of "natural causes" has not fallen so dramatically, but simply that the bulk of such cases are now dealt with by non-inquest procedures. Hence, far fewer inquest verdicts of natural causes are recorded. Aside from the development of non-inquest

procedures, increasing medicalisation may be of relevance. "Natural causes" has perhaps increasingly become a matter for the referring doctor to categorise followed by the coroner's use of form A; or use of form B if a post-mortem is required; but rarely by use of the inquest. So categorisations of "natural causes" do not generally appear at inquests today, because the relevant deaths have already been disposed of at the form A or form B stage. A reminder of the growth in the number of deaths not involving an inquest can be found at table 5(2)1.

The verdict of still-born is perhaps unique. Let us note, first of all, that verdicts of still-born decreased in number from 262 in 1926 to 32 in 1969: table 5(2)4. The Brodrick Report ascribes this fall in the number of still-born verdicts to "..... a real drop in infant mortality" (1971, 385). Now, while one may wish to be sceptical about notions of a "real drop" in numbers in discussing other verdicts (for reasons made plain throughout this study), the verdict that a child was still-born is, conceptually, quite different. To declare a child still-born is, in its meaning, comparable to declaring that an adult has died: it contains per se no elements of explanation, reasoning or theorising. To refer to, and record, the fact of death at or before birth is to refer to a natural event-in-the-world not a construction. Even here reservations are necessary, as a verdict of still-born would become a construction (comparable conceptually to other coroners' verdicts) if it were to be the eventual true-story in a case of, for instance, hitherto suspected homicide. So it may be that verdicts of still-born can be described and understood in the same terms as all other verdicts. Equally, the verdict of still-born may refer to the fact of death, presented without explanation and containing no

theory, which is no more a construction than, for instance, the nineteenth-century coroner's verdict that a man was "found dead in bed" (see table 5(4)2). Thus it may be suggested that it is tenable in principle to posit a relation between verdicts of still-born and a real incidence of infant mortality. In practise, other accounts may need to be examined but, in principle, there need be no difficulties in accepting a link between this particular verdict and the real incidence of the fact-in-the-world to which it refers.

Insofar as the verdict of still-born is (in the senses outlined above) unique, it is a remnant of an earlier period of coroners' work when levels of adequacy were essentially different from today, i.e. when an elaborated causal theory or explanatory account was not necessarily contained in a verdict. Obsolete verdicts such as 'dead in bed' or simply 'found dead' might be considered. The 'still-born' verdict is perhaps the only coroners' verdict which today might be seen in such terms.

Open verdicts have been recorded with a degree of regularity over the years: 1,486 in 1926; 1,601 in 1936; 1,491 in 1966; 1,861 in 1975. As with accident/misadventure verdicts, this element of apparent continuity must be considered in the context of the total reduction in all inquest verdicts over the fifty-year period. In 1926, open verdicts represented 4.5% of all verdicts recorded: in 1975, however, open verdicts represented 8.3% of all inquest verdicts. The continuing use of the open verdict as a major element of coroners' work lies partly (as with accident/misadventure verdicts) on the level of meaning: many true-stories, varying between time or place and taking into consideration legal changes, may still continue to be accomodated

within the categorisation called 'open verdict'. It might also be recalled that in interviews with coroners (above) the open verdict was perceived as "useful", an adjective not normally applied to other verdicts.

Having considered the broad profile of inquest verdicts available to coroners during the period 1926 to 1975, it might finally be noted that table 5(2)4 records - for the years 1957 to 1969, plus 1975, only - the numbers of inquests where indefinite adjournments were made and where, of course, no verdict was recorded. The provision, indeed the requirement, to adjourn inquests was (like the later removal of the verdicts of murder, manslaughter, infanticide and justifiable homicide from the coroner's available stock of categorisations) a direct curtailment of the coroner's powers in matters of criminal law and liability, and a means of preventing the pre-empting of the decision of another court.

Originally confined to cases of suspected homicide, adjournments have become most frequently used in cases where an individual faces proceedings in a criminal court for causing death in circumstances involving a motor vehicle. (See also table 5(3)5 below). The power of the coroner (or inquest jury) to make any categorisation in such cases has thus been removed. It was a development consistent with many other changes over the years in the formal scope of coroners' work. Such changes have had the overall consequence of more closely circumscribing the formal authority of the coroner. However, as we have seen, in the very substantial number of cases where the coroner does retain the authority to produce the true-facts-of-the matter at the inquest, his powers remain considerable.

Having illustrated the pattern of inquest verdicts over a fifty-year period, the discussion of coroners' statistics

continues with a consideration of the detailed statistics for a single year - 1975 - throughout England and Wales.

5(3) One Year: Detailed Consideration of Coroners' Work in England and Wales in 1975

In this section of the discussion, the year 1975 is considered. It represents the most recent year of the fifty-year survey discussed above and also, importantly, reflects post-reorganisation coroners' areas.

Inquest verdicts recorded during 1975 have already been included in the final column of table 5(2)4 above. Little more need be said here about specific verdicts. It is useful, however, to consider in a little more detail the proportion of cases, in 1975, in which coroners were using the form A procedure, the form B procedure, and the inquest. Table 5(3)1 indicates that in 72% of all deaths reported to coroners in 1975,'form B' was used, that is, a post-mortem examination was conducted but no inquest was held. Ordering a post-mortem examination and then statistically disposing of the case is thus the typical procedure adopted in almost three-quarters of cases dealt with by coroners. It can also be seen from table 5(3)1 that in 12.7% of cases reported to coroners in 1975 form A was used and in 15.3% of cases an inquest was held. (Additionally, table 5(3)2 breaks down the figure of 'inquests held' by detailing the small number of cases in which an inquest is held without first conducting a post-mortem examination).

Throughout England and Wales in 1975, therefore, coroners' work comprised 72% 'form B'; 12.7% 'form A'; and 15.3% 'inquest'. It might be recalled from Chapter Three above that individual coroners may have rather different perceptions of and attitudes

TABLE 5(3)1: USE OF PROCEDURES 1975*

Total number, form A cases	19,526 (12.7%)
Total number, form B cases	110,385 (72.0%)
Total number, inquests held	23,455 (15.3%)
Total number, deaths, reported to coroners	153,366

* Source: unpublished Home Office statistics

TABLE 5(3)2: INQUESTS 1975*

Total number, inquests held after post-mortem	23,014 (98.1%)
Total number, inquests held without post-mortem	441 (1.9%)
Total number, inquests held	23,455
(Total number, inquest verdicts returned)	(22,352)

* Source: unpublished Home Office statistics

toward their work. It is interesting to examine how far statistics from individual coroner's jurisdictions depart from the average 1975 figures for form A, form B, and inquest, outlined above.

There were 183 coroners' jurisdictions in England and Wales in 1975.* (For reasons already given, this does not necessarily mean that there were 183 coroners). The size of coroners' areas and the number of deaths reported during the year in individual areas varied to a very considerable degree. During 1975, the smallest number of deaths reported was in the Meirionnydd district of Gwynedd and in the Sleaford district of Lincolnshire where, in both cases, only 55 deaths were reported during the year. (If the Scilly Isles are included in this consideration of 'England and Wales', an even smaller figure is apparent, as a mere 5 deaths were reported to the coroner in the Scilly Isles in 1975). The quantity of coroners' work in some city jurisdictions stands in contrast to the rural coroners' areas. The largest number of deaths reported in a single coroner's jurisdiction in 1975 was 4,795, in the Inner-South district of Greater London: this was followed by two other London districts with totals of 4,386 and 4,374, and the Birmingham district of West Midlands with 4,261 deaths reported during the year.

In considering the great differences in quantity of work between individual jurisdictions, it might be noted that the average number of deaths reported in a coroner's jurisdiction in 1975, i.e., 838, reveals very little about the scale of work in, say, the Isles of Scilly or Greater London. Nor is this only a matter of quantity. The proportion of form A, form B

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* The sources for this and following figures are unpublished Home Office statistics.

and inquest cases within coroners' work as a whole throughout England and Wales (table 5(3)1) may give no indication of the particular practices of individual coroners in their own areas. A coroner, for instance, might never use form A. It is of interest, then, to consider some totals and proportionate figures from selected jurisdictions, again referring to 1975. Breakdowns by jurisdiction are presented in table 5(3)3, together with a reminder of the national percentage breakdown for the different procedures.

The jurisdictions included at table 5(3)3 were selected for illustrative purposes: that is, the jurisdictions illustrate the actual use of different procedures in their widely varying proportions. Coroners' comments at interview suggested that they may perceive their work in rather different ways. A brief summary of statistics from selected jurisdictions 'describes' the actual use of different procedures by different coroners: it illustrates a developing theme of the study, that is, that the nature of 'coroners' work' is in some considerable part defined, in use, by the individual coroner.

The first jurisdiction listed at table 5(3)3, West Berkshire, indicates a use of form A, form B and inquest procedures broadly comparable to the overall national breakdown for 1975. The second jurisdiction, however, reveals quite a different profile of coroners' work, for in Mid Buckinghamshire form A was used in a substantial 46% of all cases reported to the coroner, form B was used less often (34% of cases reported) than form A, (and far less often than the national average for form B cases) and the inquest was used somewhat more often (19% of cases reported) than the national average for use of the inquest. It may be, of course, that (unknown) geographical

TABLE 5(3)3: CORONERS' WORK: SELECTED JURISDICTIONS 1975*+

JURISDICTION	FORM A	FORM B	INQUEST AFTER POST MORTEM	INQUEST WITHOUT POST MORTEM	TOTAL NUMBER DEATHS REPORTED
(TOTAL ENGLAND & WALES)	(12.7%)	(72%)	(15%)	(0.3%)	
(1) West Berks District of Berkshire	18 (10%)	131 (74%)	27 (15%)	- (-)	176
(2) Mid Bucks District of Buckinghamshire	186 (46%)	135 (34%)	78 (19%)	3 (1%)	402
(3) North Bucks District of Buckinghamshire	2 (1%)	128 (84%)	22 (14%)	- (-)	152
(4) Pembrokeshire District of Dyfed	80 (30%)	121 (45%)	64 (24%)	2 (1%)	267
(5) Furness District of Cumbria	12 (5%)	135 (56%)	65 (27%)	29 (12%)	241
(6) Manchester District of Greater Manchester	1,066 (33%)	1,901 (58%)	301 (9%)	- (-)	3,268
(7) Southampton District of Hampshire	- (-)	734 (88%)	97 (12%)	- (-)	831
(8) York District of North Yorkshire	- (-)	430 (74%)	150 (26%)	-(-)	580
(9) Grimsby District of Humberside	180 (43%)	193 (46%)	44 (11%)	1 (-)	418
(10) Liverpool District of Merseyside	718 (23%)	1,842 (59%)	540 (17%)	- (-)	3,100

* Source: Unpublished Home Office Statistics
\+ Note: All percentage figures have been adjusted to the nearest whole number for clarity

features or medical facilities for this particular jurisdiction are of relevance. The point is, however, that in this particular jurisdiction the constituent parts of 'coroners' work' are quite dissimilar from what would have been suggested by a national, average, statistical portrayal of coroners' work. The procedural routes to the true story are many and varied.

It is also of interest to note that the neighbouring jurisdiction of North Buckinghamshire suggests a use of procedures not only at variance from those of the adjacent area, but also at variance (in a different way) from the national averages. North Buckinghamshire reveals an exaggeration rather than a reversal of the total national average, for in this jurisdiction form A was used in only 1% of cases reported in 1975, form B was used in 84% of cases reported in that year, while the inquest was used marginally less often (14% of cases reported) than in average figures for England and Wales as a whole. The fourth jurisdiction listed at table 5(3)3, Pembrokeshire, indicates proportionally more form A cases (30%) and more inquests (24%) than in total national figures, together, of course, with fewer form B cases (45%). The <u>different</u> ways in which the procedural content of individual coroner's work varies from the national overall averages are clear in these illustrations.

The next jurisdiction listed at table 5(3)3, Furness, indicates further variations. It particularly reveals an employment of the inquest <u>without</u> post-mortem (12% of deaths reported) which, by the mid-1970s, was highly unusual in the total British context. The Manchester jurisdiction indicates the inquest being held less often (9% of cases) than nationally. In this jurisdiction, form B is also used less often (58% of

cases reported). The corollary is that in Manchester post-mortem examinations were held on only 67% of deaths reported during 1975: the national figure was approximately 87% of deaths reported to coroners. The next two jurisdictions listed at table 5(3)3, Southampton and York, show a very substantial difference when compared to Manchester. In Southampton and York during 1975, no form As were issued, i.e. post-mortem examinations were held on every death reported to these coroners. Looking back to the Mid Buckinghamshire jurisdiction, it can be seen in contrast that post-mortems were held there on only 53% of deaths reported to the coroner in the same year. (It might finally be noted that in considering Southampton and York, the "extra" post-mortems in Southampton simply meant "extra form Bs", while in York there were "extra inquests").

Many features can be isolated in comparing apparently different practices in different coroners' jurisdictions. No doubt some apparently significant differences are spurious, especially when a relatively small number of deaths were reported, in total, during the year. For this reason, it is perhaps unproductive to pursue a lengthy speculative analysis of the possible practices of different coroners. Certainly, however, the substantial variations between jurisdictions in the use of form A, form B, and inquest (and in some cases inquest without post-mortem) suggest substantially varying practices. It is reasonable to suggest that, for instance, in the widely differing use of the post-mortem examination, pathological facilities are of some relevance, but the individual perceptions of "coroners work" held by coroners themselves are also of importance. The comments of coroners in Chapter Three above tend to reinforce this conclusion. The discussion of

coroners' discretion might also be recalled.

Two further coroners' jurisdictions, Grimsby and Liverpool, complete the statistical illustration of selected jurisdictions in table 5(3)3. It can be seen that in the Grimsby area the use of form 'A' and form 'B' is broadly comparable: 43% and 46% respectively. This is considerably different, again, from the overall national picture. The Liverpool jurisdiction deals with by far the largest number of deaths of jurisdictions summarised in table 5(3)3, i.e. 3,100 deaths reported in 1975. It is interesting to note that, despite so many deaths being reported in Liverpool during that year, not a single case involved the inquest-without-post-mortem procedure.

The inquest statistics from the jurisdictions selected for inclusion in table 5(3)3 suggest that national figures for the use of form A, B and the inquest have meaning as an aggregate summary of what coroners in total are doing, but may have limited meaning in considering the nature of coroners' work in a particular jurisdiction. It is clearly necessary, in terms of seeking to describe and understand coroners' work, to balance overall national material with the detailed study of the work of individual coroners. The research elements of interview, observation and statistical discussion have been directed toward construction of the basis for general statements about coroners' work, by referring throughout, as necessary, to the very particular. It is not a case of studying the general or the particular: the two together can be described in order to provide the basis for understanding.

Leaving aside questions relating to 'types of death occurring', it was stated above that coroners' statistics are to be seen as accurate records of what coroners are doing, insofar

as they are the statistical realities produced by coroners' activities. Must it now be concluded, however, that coroners' statistics are of no sociological use as records of coroners' activity, if indeed the examination of national statistics reveals so little of the individual coroner's work? The answer seems to be no, for coroners' statistics (e.g. inquest verdicts from 1926 to 1975, recorded at table 5(2)4 above) do present a generalised version of what coroners, in total, are doing, and this is of some use. It is useful, for instance, to know that during the fifty-year period the post-mortem examination was increasingly used, and the inquest was held with decreasing frequency in England and Wales. The use of such general statements, however, must be based on a recognition that they are abstractions. An abstract statement, based upon the total activities of the total number of coroners, may be a valuable aid to understanding: provided it is recognised as <u>not</u> being a description of what individual coroners are, necessarily, doing.

The relationship between the general and the particular is, then, complex, but from its complexity understanding may be achieved. One of the conclusions of Chapter Three above was that "coroner's work" for the individual coroner may be "substantially influenced" by that individual coroner's definition of what coroners' work - <u>his</u> own work - is. Discretion and authority were also discussed. It was clear from the interview programme that <u>different coroners</u> have <u>differing definitions</u> and perceptions of what their work is supposed to be. A consideration of the statistics of coroners' jurisdictions in 1975 is consistent with the conclusion reached in Chapter Three.

To sum up, let us suggest that to make a statistical statement about what coroners, in total, were doing in 1975

(what procedures they were adopting, what verdicts they were producing) may be useful. It has meaning. Moreover, such a statement can contribute to the tasks of description and understanding. However, such a general statement must be treated with caution in application to particular jurisdictions. The general statement may be useful and meaningful as a general (abstract) statement. It may lose meaning in spurious application to the particular. The social world of the coroner is made "real" in particular ways.

Table 5(3)4 provides additional information about inquests conducted during 1975. The discussion of coroners' ancient powers in matters of "treasure trove" may be recalled from Chapter Two above. Table 5(3)4 indicates that only 17 inquests dealing with treasure trove were conducted during 1975. It might also be noted from table 5(3)4 that, throughout England and Wales in total, almost 72% of inquests were conducted without a jury. There were of course variations between jurisdictions in the use of the jury, as in other matters. Taking an historical perspective, the decline of the inquest as one part of coroners' work as a whole, and the more recent decline of the inquest jury to its present - in formal terms - peripheral role, are again of interest.

Two statistical points about the 153,366 deaths reported to coroners in England and Wales during 1975 remain to be made. Firstly, in addition to the total figure for deaths reported to coroners in 1975 given above and throughout this chapter, another 33 deaths occurring in England and Wales were dealt with under Section 7 of the Visiting Forces Act 1952.* Such

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* Source: Unpublished Home Office statistics

TABLE 5(3)4: ADDITIONAL FEATURES OF INQUESTS HELD IN 1975*

Total number inquests (excluding treasure trove)		
with juries	6,588	(28.1%)
without juries	16,823	(71.9%)
	23,411	**

Total number inquests dealing with treasure trove	17
Total number inquests held by order of the High Court	3
Total exhumations ordered by coroners	5

* Source: unpublished Home Office statistics

** The total figure 23,411 denotes inquests completed during 1975: the larger figure of 23,455 included in the previous table includes some inquests not completed.

deaths do not reach the statistics of sudden death collected from coroners' returns to the Home Office. Secondly, it may be of interest to note that of the 153,366 deaths which were reported in 1975, 64,356 (42%) were female, and 89,010 were male (58%).*

Finally, to clarify some less central statistical matters, it may be recalled that a number of inquests are adjourned (and not resumed) each year in circumstances where proceedings are to follow in the criminal courts. Table 5(2)4 indicated that in 1975 the number of inquests thus adjourned was 1,059. It is possible to trace the ultimate result of criminal proceedings in such cases, and table 5(3)5 presents a summary of the disposal of these cases in 1975. It may be seen that, following adjournment, in 703 cases (over 66%) the accused was found guilty as charged. 157 cases (almost 15%) resulted in acquittal. (The other disposals can be seen at table 5(3)5). In the early part of the twentieth century - and for hundreds of years before - such verdicts of guilt and innocence would effectively have been made not in "another court" but at the coroner's inquest itself. Another contemporary aspect of such cases is that of those found guilty 497 cases (over 70%) concerned the causing of death by dangerous driving. Murder, manslaughter and infanticide convictions in the criminal court accounted for the remaining cases where the accused was found guilty.

In considering the statistics of coroners' work during one year, 1975, it may be concluded that the examination of <u>inquest verdicts</u> alone (table 5(2)4) reveals only the formal statistical

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* Source: Unpublished Home Office statistics

TABLE 5(3)5 INQUESTS ADJOURNED UNDER SECTION 20, CORONERS (AMENDMENT) ACT 1926: FEATURES OF SUBSEQUENT PROCEEDINGS IN THE CRIMINAL COURTS: 1975*

RESULT OF CRIMINAL PROCEEDINGS	NUMBER OF CASES INVOLVING CHARGE OF:				TOTAL
	MURDER	MANSLAUGHTER	INFANTICIDE	CAUSING DEATH BY DANGEROUS DRIVING	
Accused acquitted: and not found guilty of any lesser offence	22	15	1	119	157
Accused found guilty of offence as charged	110	92	4	497	703
Accused found not guilty by reason of insanity	1	3	-	-	4
Accused found unfit to plead	2	-	-	-	2
Other result	122	41	1	29	193
TOTAL	257	151	6	645	1059

* Source: Unpublished Home Office statistics

product of one part of coroners' work. It was necessary, therefore, to consider the use of form A, form B, and inquest procedures to describe more adequately the content of coroners' work, the "typical nature" of their activities. Examination of the national figures indicated, for instance, that a coroner's "typical disposal" (in 72% of deaths reported) was by post-mortem examination alone. This observation has some value: it enables, for instance, a broad historical comparison. It also describes what the total number of coroners are, in total, doing. However, it became clear that, in examining the statistics from individual coroners' jurisdictions, the overall national statistics may be of limited relevance, - or, more specifically, have limited meaning - in describing and understanding the particular work of particular coroners. The relation between the general and the particular must therefore be treated with caution. Description of both is necessary.

In the next section of the discussion, a further approach to coroners' statistics is made. Coroners' work in a particular jurisdiction - "City" - is examined, through its statistical products, over a fifty-year period which, as before, refers to the years 1926 - 1975. In this case, there is particularity of location in geographical terms, accompanied by the generality of a considerable period of time i.e., what are the general characteristics of coroners' work in this particular jurisdiction over a fifty-year period?

5(4) One Place: Coroners' Work in 'City' 1926-1975

Coroners' work in England and Wales has so far been approached in two ways. Firstly, national statistics over a fifty-year period were considered. Secondly, statistics for a single year were examined, moving from a concentration on the

average national statistics to an emphasis on the importance of the particularities of coroners' work in particular areas. It seems that some conclusions can properly be drawn about coroners' work 'as a whole' by consideration of the total statistical product, but if such conclusions are based only on accumulated totals or calculated averages, their scope is limited. In this section of the discussion, therefore, the statistical products of a single coroner's jurisdiction - 'City' - over a fifty-year period are examined.

Access to the work of 'City' coroner over the period 1926 to 1975 was by study of the handwritten 'ledgers' kept in the coroner's office. Numerous visits were made to the coroner's office over a five month period in order to gather this information (see Appendix I). Full access was freely given, but the nature of the records involved a rather laborious task of collecting information which remained less than systematic: for instance, it was not possible to collect details of all inquests, form As, and form Bs over the entire fifty-year period as the different non-inquest cases, in particular, were not invariably clearly distinguished. Despite these difficulties, it was felt that the 'City' ledgers nonetheless were capable of yielding valuable material relevant to the overall project.

It was decided to concentrate on completed inquests where a verdict had been recorded. Even here periodic difficulties remained: table 5(4)1 therefore includes notes which amplify some of the interpretations necessarily made in the course of the field research and also provides additional details for particular deaths, particular verdicts or particular years. The verdicts of suicide, accident/misadventure and open verdicts were selected for inclusion at table 5(4)1: other verdicts,

TABLE 5(4)1 ANNOTATED STATISTICAL SUMMARY OF "CITY" INQUEST VERDICTS 1926-75

YEAR	THREE PRINCIPAL VERDICTS SUICIDE (Number; %)	ACCIDENT/MISADVENTURE (Number; %)	OPEN VERDICT (Number; %)	TOTAL ALL VERDICTS
1926	31 (9.3%) Differentiated in the ledger between "shooting";"poisoning" "hanging"& other means	108 (32.4%) Differentiated in the ledger between "drowned" "burns" "scalds" "falls" & "suffocated". The ledger distinguishes "accident" and "mis-adventure", but they are merged here	29 (8.7%)	(333) For the years 1926-28 only, it has not been possible to separate "total verdicts" from the total number of cases (inquest and non-inquest) dealt with by the coroner.
1927	36 (9.2%)	123 (31.3%)	15 (3.8%)	(393)
1928	54 (13.8%)	113 (28.8%)	15 (3.8%)	(392)
1929	32 13.3%	134 55.6%	17 7%	241 From this point, non-inquest cases are excluded. Also, "total verdicts" means completed inquests where a verdict was recorded. Inquests adjourned without a verdict are excluded.
1930	33 15%	120 54.8%	25 11.4%	219
1931	45 18.8%	135 56.5%	23 9.6%	239

TABLE 5(4)1 Continued

1932	36	18%	113	56.8%	33	16.6%	199
1933	36	17.1%	137	65.2%	20	9.5%	210 The ldeger starts to record "Manslaughter S.20 Coroners Act 1926 Charge of Manslaughter Against....." in this year
1934	45	21.2%	116	54.8	21	9.9%	212
1935	46	-	109 Ledger starts to record "deaths motor vehicles involved".	-	17	-	Not known.
1936	46 Some differentiated as "felo de se"	21.1%	136	62.4%	25	11.5%	218
1937	31	14.4%	137 Includes one verdict of "in-attention at birth - misadventure".	63.8%	18	8.4%	215
1938	42	13.9%	190	62.9%	24	7.9%	302 Includes another unclear verdict: "abortion - murder against person or persons unknown".
1939	50	16.4%	204	67.1%	20 Includes, throughout, deaths only recorded as "found drowned." Also includes puzzling verdict of "open verdict following accident".	6.6%	304

TABLE 5(4)1 Continued

1940	32	11.4%	The only case recorded as "felo de se" is that of a prisoner. The moral disapproval implicit in the "self-murder" verdict is also seen below (e.g. 1945, 1946)	183	65.3%	20	7.1%	280
1941	36	(1 1.2%)		241	75% Including many through "war operations"	16	5% Including one case of "open verdict - abortion"	320
1942	21	9.3%		127	56.2% Including deaths through "war operations".	11	4.9% Including one person named as guilty of murder.	226
1943	28	12.2%		135	58.7%	9	3.9%	230
1944	48	17.8%		155	57.6%	10	3.7%	269
1945	28	11.3% Including two cases of "felo de se": both are named as responsible for "wilful-murder".		144	58.3%	11	4.4%	247
1946	47	22.5% Including one case of "felo de se" (as above)		122	58.4%	9	4.3% Includes one case only recorded as "found gassed".	209
1947	32	20.2%		110	69.6%	10	6.3%	158

TABLE 5(4)1 Continued

1948	40	26.3%	96	63.1%	8	5.3%	152
1949	37 Including two recorded as "lunatics"	25.3%	92	63%	8	5.5%	146
1950	49 Includes first case of barbiturate poisoning noted on ledger.	35.8%	79	57.6%	6	4.4%	137 It can be seen that only 3 verdicts in 1950 were other than suicide, accident, or open verdict.
1951	47 Again, "felo de se" recorded in one case, involving homicide	29.5%	92	57.9%	11	6.9%	159
1952	30 Again, "felo de se" in one case only.	22.5%	81	60.9%	13	9.7%	133
1953	39 One case recorded as "lunatic"	25.5%	98	64%	7	4.6%	153
1954	47	32.9%	86	60.1%	2	1.4%	143
1955	50	29%	104	60.5%	4	2.3%	172
1956	38	23.9%	109	68.5%	2	1.2%	159
1957	47	29.2%	78	48.4%	5	3.1%	161
1958	55	30.7%	103	57.5%	2	1.1%	179
1959	52	29.5%	96	54.5%	7 Including one "lunatic"	4%	176

TABLE 5(4)1 Continued

1960	45	30.6%	82	55.8%	6	4%	147
1961	52	33.8%	96	62.3%	2	1.3%	154
1962	37	24.6%	109	72.6%	1	0.7%	150
1963	47	32.6%	91	63.2%	3	2.1%	144
	Includes one case of an electrician's suicide by electrocution, and another of car-dealer's suicide by exhaust fumes: of interest in terms of "suicide and opportunity".						
1964	50	36.5%	82	59.8%	2	1.4%	137
1965	31	22.3%	96	69.1%	2	1.4%	139
							Five cases included in total of "asphyxia due to drowning" - verdict not stated
1966	36	25.5%	97	68.8%	5	3.5%	141
1967	30	20.7%	112	77.2%	6	4.1%	145
			Includes one case of misadventure where cause of death given as asphyxia due to hanging - male, age 14.				
1968	33	21%	119	75.8%	2	1.3%	157

TABLE 5(4)1 Continued

1969	30	22.9%	88	67.1%	1	0.8%	131 Including one case where verdict given as "manslaughter: both parents arrested on HM Coroner's warrant".
1970	27	19.1%	108	76.6%	4	2.8%	141
1971	21 Includes one case of suicide via N.Sea gas: unusual, as non-toxic: led to choking after inhalation.	16.3%	100	77.5%	4	3.1%	129
1972	24	21%	83	72.8%	3	2.6%	114
1973	19	18.4%	79	76.7%	4	3.9%	103
1974 Jan to March "City"	8	32%	16	50%	nil		25 The remaining verdict (i.e. other than suicide or accident) was one of natural causes.
April to Dec. "County"	44	29.7%	95	64.2%	9	6.1%	148 It can be seen that no verdicts other than those detailed were recorded during this period.
1975 "County"	35	23.6%	106	71.6%	5	3.4%	148 Plus 17 cases of inquests adjourned, mainly road traffic deaths.

in this single coroner's jurisdiction, were numerically few, although notes are added where it appeared relevant. It should be added that verdicts of accident and misadventure are merged at table 5(4)1 (as they are in coroners' returns to the Home Office) although they were recorded separately in the 'ledgers'.

Thus table 5(4)1 records features of the principal inquest categorisations made by the 'City' coroners from 1926 to 1975. Conclusions may be drawn about the pattern of coroner's inquest work in one jurisdiction over a lengthy period of time. Such conclusions may be evaluated in conjunction with the national figures for the same fifty-year period: and, more generally, with reference to the overall consideration of the statistical products of coroners' work.

The records of the city coroner dated back to the early nineteenth century. The opportunity was therefore also taken to record some of the verdicts returned at that time, which reflect not only some important legal developments and medical changes, but also reflect the shift in "levels of adequacy" of coroners' verdicts since the nineteenth century. Some verdicts from this period are presented at table 5(4)2.

The search of handwritten records in the 'City' coroner's office not only raised the practical question of how to render information (of varying quality) manageable, it also raised the issue of exactly which details it was relevant to collect, present, and subsequently discuss. The aims and emphases of the research as a whole allowed a suitable selection to be made. The central criterion was recording of material relevant to the characteristics of coroners' work in one jurisdiction over a period of time, rather than material relating to characteristics of the deceased. Had the latter emphasis been chosen instead,

details of age and sex characteristics of those despatched into the categories of suicide, accident/misadventure and open verdict during the fifty-year period in 'City' could, in fact, have been collected in a sufficiently systematic form. However, such information on the personal characteristics of those whose deaths were reported to the 'City' coroner, and upon whom an inquest was subsequently held and completed, would have had no clear relevance to the study as a whole. It may well have had relevance to another study, with different aims and interest. However, it would have made little contribution to an understanding of coroners' work.

Consistent with the perspective adopted throughout the study, local statistical material was collected in order to illuminate the process of categorisation. It constitutes another approach to the statistical facts-of-death produced by the coroner, consistent with and complementary to the presentation of national statistics over a fifty-year period, and statistics from individual jurisdictions for a single year. As might be expected, the handwritten records of the 'City' coroner included entries which were at times idiosyncratic, but largely the following details were available for collection: index number of the case; date of death; before whom held (coroner or deputy); name and address of the deceased; sex; age; occupation; date of inquest where applicable; medical cause of death (perhaps accompanied by a sketch of circumstances); fees paid to doctors and jurors; the verdict where applicable; and the originator of the authority to remove the body (the coroner or the police). From this information, table 5(4)1 was assembled.

Special features at the beginning and end of the fifty-year

period can be noted. Firstly, for the years 1926 to 1928 inclusive, the total number of verdicts is unavailable, as the records recorded inquest cases and non-inquest cases together. Secondly, local government re-organisation in 1974 involved a major change in the boundaries of the jurisdiction, as 'City' became 'County'. In terms of broadly comparable information, table 5(4)1 thus covers, essentially, the slightly truncated period 1929-1973.

Table 5(4)1 indicates that 241 verdicts were recorded in 1929, rising to over 300 verdicts in 1938, 1939 and 1941, but then falling until 1973, when only 103 verdicts were returned. More than twice as many verdicts were recorded in 1929 than in 1973. However, the fall in the number of inquests opened by the coroner during this period would not be quite as dramatic as the figures for completed inquests would suggest, as indefinite adjournments have become required of the coroner in cases of suspected homicide and certain road traffic deaths.

Notwithstanding the relevance of adjournments, it remains clear, from table 5(4)1, that fewer inquests as a whole were being conducted in 'city' as the fifty-year period continued. The decreasing use of the inquest in 'city', indeed, was consistent with the national trend (see table 5(2)2). In this instance, the 'particular' and the 'general' are compatible.

Against this background of a falling number of inquests (and verdicts), it is of interest to consider the three selected verdicts in turn. In absolute numbers, verdicts of suicide in 'city' total 32 in 1929, rising to 46 in 1935 and 1936, and to 50 in 1939. There is a low figure of 21 in 1942. Suicide verdicts reach 50 again in 1955, and their maximum of 55 in 1958. The lowest figure of all, 19, is recorded in 1973. On the basis

of absolute numbers only - which, of course, should be treated with caution, especially in isolation from population statistics and other points of reference - there appears to be no systematic pattern in the recording of suicide verdicts over this period in 'city'. All that can unarguably be said is that the number of suicide verdicts recorded in "city" between 1929 and 1973 varied between 19 and 55, with no uniform pattern of increase or decrease. It will be seen, however, that table 5(4)1 also recorded suicide verdicts as percentages of all verdicts recorded. Suicide amounted to 13.3% of all "city" verdicts in 1929; increasing consistently to over 21% in 1936; falling for the next ten years; and between 1946 and 1969 remaining at between 20 - 36.5% of all verdicts. Again, is there any pattern to this? It seems unlikely. In absolute numbers, there were more than twice as many suicide verdicts in 1931 than in 1973, but suicide verdicts as proportions of all verdicts demonstrate no consistent trends. Such variations as occurred in "city" during this period were perhaps linked to legal changes (e.g. 1961 Suicide Act) relating to suicide and importantly, to changes in the moral and normative environment. Perhaps the latter appears vague, yet it is implicitly referred to in the "city" coroners ledger. It can be seen, for instance (table 5(4)1) that in 1940, the only suicide verdict (from a total of 32) to receive the special, censorious, label of "self-murder" was that of a prisoner. In 1945, 1946 and 1951 the only cases to be specifically recorded as "felo de se" are, again, the "morally unworthy": in these cases, people named as guilty of "wilful murder". This "special" kind of suicide implies conscious

choice, and, in these cases, a wilful avoidance of the consequences of the law. At the other end of this continuum are those cases of suicide (1949, 1953) where the word "lunatic" has been added, in red ink, to the standard details. The bare statistics of suicide verdicts in "city" reveal relatively little about the nature of categorisations: the occasionally appended note in the ledger reveals more, especially in terms of the reasoning within the generic categorisation.

Verdicts of accident/misadventure number 134 in 1939; slightly over 200 in 1939; rising to 241 in 1941. (The high figure of 241 in the latter year is accounted for by the effects of the Second World War and the level of bombing: this is not to introduce an inappropriate "explanation" for the apparent "incidence" of accident/misadventure cases, it is simply that the category of "war operations" is an extra basis for categorisation as accident/misadventure, absent from all years except 1941 and, to a lesser extent, 1942). From 1946 until 1973, verdicts of misadventure number figures either somewhat greater than, or smaller than, 100 each year. As a proportion of all verdicts, accident/misadventure verdicts appear to increase: with the exception of 1957, verdicts of accident/misadventure amount to more than half the total verdicts reached by the city coroner throughout the period 1929-73, and from 1965 to 1973, such verdicts on average amount to more than 70% of all verdicts. It is tempting to conclude that accident/misadventure verdicts represent, for coroners themselves, the typical form of inquest work: such verdicts are after all recorded more often than any other; they are, historically, a constant feature of inquest work and indeed, in "city", they represent an increasing proportion of inquest

work.

It has already been noted that the accident/misadventure verdict is sufficiently nebulous to accomodate changes in what common-sense knowledge sees, routinely, as different "sorts" of deaths. Ledger-notes point to some of these changes, which can be seen as the "renewal" of the wide boundaries within which accident/misadventure is legitimately said to "have happened". In 1935, the ledger adds "deaths motor vehicles involved" to the initial sub-classification of accident/misadventure cases as "falls", "burns", and so on (table 5(4)1). War operations were brought into the remit of the verdict in temporary circumstances. In 1967, it can also be seen that a means of death usually routinely associated with suicide verdicts may exceptionally be brought in to the category of misadventure.

In "city", open verdicts have been recorded in relatively small numbers throughout the period 1929-73. A maximum of 33 cases was recorded in 1932, and thereafter numbers tended to fall: 20 open verdicts in 1940, 11 in 1945, 6 in 1950, 4 in 1955, 6 in 1960, 2 in 1965, 4 in 1970. Table 5(4)1 also indicates that open verdicts have steadily decreased as a proportion of all verdicts, although percentage calculations on the basis of such small numbers must be treated with care. Fewer open verdicts were recorded at the end of the period than at the beginning. What sort of meaning, if any, can this development be thought to have? It might be suggested that this development is simpler to approach, conceptually, than 'fewer accidents' or 'fewer suicides' would be, as laymen and sociologis would not see open verdicts as a natural feature of the world: one would not talk of 'fewer open verdicts happening'. That

would have no meaning at all. So, to talk of 'fewer open verdicts' (as opposed to other verdicts) is to talk of fewer open verdicts <u>being recorded</u> rather than fewer such verdicts <u>happening.</u> The account is already pointed in the direction of coroners', and others', <u>activities</u>, rather than toward supposed events-in-the-world.

To consider possible accounts of 'fewer open verdicts' in 'city' is to consider numerous different factors: it may be that the arrival of a new coroner brought a changed perception of the desirability of open verdicts (interviews indicated varying perceptions of the worth of this verdict amongst coroners); it may be that changes in medical, police, administrative or other facilities in and around 'city' rendered the open verdictless appropriate so far as the coroner's true stories were concerned; it may be, as we have noted above, that 'levels of adequacy' at the inquest change over time and, in the case of 'city', a consequence was that open verdicts were recorded less often. There is no definitive account. It can only be concluded that (as a statistical product of what coroners do) open verdicts in the 'city' jurisdiction decreased as a proportion of all inquest verdicts, whereas suicide and accident/misadventure did not.

The <u>national</u> (England and Wales) statistics of coroners' inquest work during the period 1925 to 1975 have already been discussed (see table5(2)4). It was suggested that the continuing 'relevance' (to coroners) of the accident/misadventure verdict lay in its capacity to accomodate changed meanings and absorb a range of potential true stories. This conclusion can be applied both to the national statistics and to the local statistics collected from the 'city' ledgers. The comparison of 'national'

and 'city' open verdicts is not so simple, as (in terms of absolute numbers) the national totals for open verdicts tend to show an increased, rather than decreased use, reinforced further by the overall fall in numbers of inquests held during the fifty-year period. Perhaps this observation lends weight to the thesis that national statistics are <u>not</u> 'larger' representations of substantially <u>similar</u> proportions of verdicts amongst individual coroners, but that particular coroners form their categorisations in rather different ways, and this may be reflected in the local statistics of any particular verdict. In suicide verdicts throughout England and Wales, there was a gradual fall in absolute numbers during the fifty-year period. There was no consistent trend in the numbers of suicide verdicts recorded in 'city' during the same period. Again, it is clear that national trends, discernible in total collections of many local statistics, do not necessarily indicate the particular features of particular coroner's inquest work.

In summary, table 5(4)1 presented three inquest verdicts recorded in 'city' over a fifty-year period. It was not possible to include all ledger notes, but not infrequently such notes provided valuable additional information, especially about statistically unusual features. For instance, a note attached to the 1965 totals in the handwritten register of the coroner gave brief details of seven inquests which were opened but not completed following circumstances where seven people were assumed to have died at sea. "Bodies not recovered. Presumed dead under Home Office direction, by virtue of Coroners (Amendment) Act 1926 Section 18." An inquest may be held (indeed, it may be completed, unlike the cases above) even in the absence of a body.

It was not part of the planned project for local study of coroner's office statistics to trace coroners' verdicts back to the nineteenth century and beyond. Nevertheless, informal collection of some verdicts from the mid-nineteenth century was felt to be of interest, and details are included at table 5(4)2. The rapid nature of the changes in coroners' categorisations - and the legal, medical and moral contexts in which coroners' activities take place - is quite clear, especially viewed in terms of the coroner's eight-hundred year-old history. Verdicts listed in table 5(4)2 are, in this sense, part of the coroner's recent history. An early twentieth-century popular medical encyclopaedia also reveals the changed context of coroner's decisions:

> "DEATH, Sudden
> No matter what the cause of sudden death is, whether an accident or sudden illness, the ultimate reason of a person dying is always one of the following three: Syncope [heart failure], asphyxia, or coma."
> ("1000 Medical Hints. An Encyclopaedic Dictionary on the Care of the Body in Health and Disease." No Date).

TABLE 5(4)2 EXTRACTS FROM "CITY" INQUISITION BOOK 1857/1858.

VERDICTS

1) Died by the Visitation of God (several)
2) Accidental Death (several)
3) Died by Excessive Drinking (several)
4) Found Dead in Bed
5) Manslaughter Against (named individual)
6) Murder Against (named individual)
7) Hanged/Drowned Himself Whilst Insane
8) Died of Consumption
9) Found Dead with Marks of Violence
10) Found Dead
11) Died by Overdose of Godfrey's Cordial

The anecdotal details given above emphasise that any historical consideration of coroners' verdicts (local or national) must recognise the changing context of coroners' work, the considerable changes in the stocks of technical and commonsense knowledge from which coroners draw, and the substantial changes in the required 'level of adequacy' of coroners' verdicts. (In 1857 - 1858 death through "visitation of God" was an adequate account) If specific legal and procedural changes in coroners' work are also added, it is a matter for surprise that consistent patterns in the use of a particular verdict appear at all. Indeed, it may be suggested that in considering either a number of coroners' jurisdictions in a particular year, or one coroner's jurisdiction over a lengthy period of time, some of the apparent regularities in total accumulated national statistics disappear.

The final section of this discussion of the statistics of coroners' work gives further consideration to verdicts of suicide.

5(5) Suicide: 1975 - 1980: A Special Case?

The present study has so far treated suicide much like any other coroner's verdict. The formal organisational process of 'constituting' suicide, (i.e. rendering suicide as, for all practical and statistical purposes, 'real') has been considered alongside the organisational process of categorising any other sudden death and constructing any other verdict. The same sociological perspective has been adopted. A brief consideration of published suicide statistics for the period 1975 to 1980 permits an evaluation of whether suicide is a 'special case': that is, whether anything needs to be said of suicide (for the

purposes at hand) that is not to be said of other verdicts.

The view taken in this study has been that suicide is not an inherently meaningful thing-in-the-world but is, instead, a phenomenon (or range of phenomena) that can only be intelligibly described and discussed in terms of the methods by which 'suicide' acquires meaning. This does not imply the absurd philosophical position that the experiential world of 'suicide' has no existence. Rather, this perspective suggests that coroners give meaning, formally, to disorganised events, words, documents and other artefacts by producing suicide verdicts - and officially sanctioned statistics. Members of society may informally give meaning to sudden deaths, and these informal categorisations may or may not correspond with those of the coroner. Others (such as sociologists of suicide, psychiatric researchers or psychologists), using their particular stocks of knowledge, may choose to re-define certain deaths, claiming a 'more accurate' production of the facts-of-suicide. This may or may not be a worthwhile exercise, depending on the aims the researcher has in mind, but the result of any exercise in redefinition of deaths, from whatever stock of knowledge, is merely the production of another true-story.

For our purposes, the coroner's true story remains solely responsible for the publicly known and officially-sanctioned facts-of-the-matter. In short, although any member of society may personally and informally categorise any death as a suicide, this lay process of definition would have no significance for the formal, statistical end-product: it would not affect the 'facts of sudden death' as received through organisational processes. Of course, informal categorisations made by community members, friends or family involved may have considerable

significance for those immediately concerned: an informal definition of a death as being a case of suicide may certainly have a personal significance. However, such informal categorisations do not constitute the 'facts of suicide' as tangibly and formally recorded in suicide statistics. At most, informal categorisations only produce 'private facts'.

Indeed, 'expert' reclassifications of suicide are akin to lay classifications, insofar as neither have significance for the formal rate-producing process. The significance of coroners' categorisations lies in the coroner's formal authority to make binding judgements about the nature and meaning of 'what really happened' and to ensure the transfer of these judgements into permanent statistical records: in this case, records of suicide. It is from this point that the available facts-of-suicide for the period 1975-1980 may be considered.

The three tables relating to verdicts of suicide present the same information in three different ways. Table 5(5)1 presents the absolute numbers of suicide verdicts for the six relevant years, and the progressive annual increase in numbers is clear. Table 5(5)2 adds the total number of deaths for each of the relevant years, and expresses suicide verdicts as a rate per 1,000 deaths. It can be seen that while the year-to-year increase does not correspond to that suggested by absolute numbers of verdicts alone, the annual increase in suicide verdicts remains. Table 5(5)3 expresses the statistics of suicide in what is perhaps the more usual form, i.e. as a rate per 100,000 population (years 1976 to 1980), and also treats male and female cases separately. Once more, an increase is evident, and, indeed, the conventional ratio of female suicide to male suicide is confirmed. As the various possible present-

TABLE 5(5)1 NUMBERS OF SUICIDE VERDICTS, ENGLAND AND WALES, 1975-1980*

YEAR	TOTAL SUICIDE VERDICTS
1975**	3,693
1976	3,816
1977	3,944
1978	4,022
1979	4,195
1980	4,321

TABLE 5(5)2 SUICIDE VERDICTS PER 1,000 DEATHS, ENGLAND AND WALES, 1975-1980 ***

YEAR	TOTAL DEATHS	SUICIDE VERDICTS PER 1,000 DEATHS
1975	582,841	6.34
1976	598,516	6.37
1977	575,928	6.85
1978	585,901	6.86
1979	593,019	7.07
1980	581,385	7.43

*Source: Central Statistical Office (1981) years 1975 to 1978;
Central Statistical Office (1983) years 1979 to 1980

** The 1975 figure does not correspond to the total suicide verdicts for that year included at table 5(2)4 i.e. 3,717. It would appear that different accounting procedures lead to two different sources giving two different figures. See Appendix II for further discussion.

*** Source: Central Statistical Office (1981; 1983): Column 2

TABLE 5(5)3 Suicide Rates Per 100,000 Population England and Wales, 1976-1980*

Year	Suicide Rate Per 100,000 Population	
	Male	Female
1976	9.7	5.9
1977	9.9	6.3
1978	10.2	6.3
1979	10.7	6.5
1980	11.0	6.7

* Source: Office of Population Censuses and Surveys (1983)

ations of suicide statistics for the period 1975 to 1980 yield such consistent results, there is no doubt that coroners were producing more verdicts of suicide during this period. Just as the 'falling suicide rate' of the early 1970s may be accounted for by changes in coroners' activities (the introduction of the requirement to prove suicide was important, and so too is the typical view of coroners at interview that this fall was 'more apparent than real'), perhaps the subsequent 'rise' may be similarly accounted for by the activities of coroners. Eglin et.al. (1983) account for the 'suicide epidemic' in a part of Canada in terms of changes in coroners' work. This will be discussed in more detail in the concluding chapter below. For now, let us consider whether the British figures for the late 1970s mean that there has been an increase in suicide and/or an increasing suicide rate.

Insofar as coroners have been recording more suicide verdicts, there has indeed been an 'increasein suicide': the greater number of verdicts are there to see. Similarly, if one accepts that a suicide rate is ordinarily a convenient means of expressing absolute numbers in relation to given amounts of population (e.g. 1000 or 100,000) then there has also manifestly been an 'increasing

suicide rate' during the period in question. Dispute arises in considering the meaning of this.

It may be that one takes the view that, from 1975 to 1980, an event-in-the-world called suicide happened with increasing frequency, that coroners, correctly, discovered this event in appropriate cases, and that the suicide statistics therefore represent, with reasonable accuracy, a real change in the behaviour of individuals out-there. This position is internally logical, and would tend to lead to a search for why, in short, more people are committing suicide. It may then be that a causal factor of particular significance is sought and found, or, more usually, that a correlation is found between the increase in suicide and the increase (or decrease) in something else - perhaps, during the late 1970s, the rise in unemployment would be particularly examined in this context (e.g. Platt 1982). It is permissible, without implying either criticism or approval, to describe such an enterprise as positivist. The positivist sociologist ascribes a particular meaning to the facts-of-the-matter for the period in question, and then proceeds in the direction outlined above. However, judgement about the value of such an explanatory enterprise is - in this study - left open.

Two observations are to be made about suicide in the late 1970s. Firstly, more suicide verdicts were being recorded in considering the period 1975 to 1980. Secondly, the necessary material to account for this development is not available, either in this study or in existing sociological studies. Apart from further elaboration of these and related points in Chapter Seven below, little more can be said of suicide verdicts during the relevant period.

In contrast to the position taken here, some existing work

within the 'sociology of suicide' has not clearly distinguished the issues it is addressing from those it is not. Sociological material on suicide is discussed in detail in Chapter Six below, and that discussion may be prefaced here by a brief consideration of some aims and methods within the sociology of suicide.

Douglas (1967), for instance, did not satisfactorily demonstrate whether he broke (or wished to break) from the Durkheimian tradition. Douglas perceived in Durkheim's approach to suicide a concern with "social meanings" which Douglas himself adopted (1967, 41-42). Douglas also read Durkheim's Suicide (1970) as ultimately a non-positivist work, insofar as it focussed upon such "social meanings" (Douglas 1967, 76). Yet Douglas claimed, equally, that Durkheim's method was to ascribe essentially common-sense meanings to collections of behaviours which thus became 'suicide' (1967, 68). Douglas also appears to regard Durkheim as being primarily interested in erecting a particular theoretical/methodological construct, which only secondarily has any bearing on suicide at all: a criticism perhaps also to be made of Douglas' study, or that of Atkinson (1978). Douglas' theoretical position was never clearly stated and, notwithstanding the lasting importance of his critique of official statistics, the status of suicide statistics as either (more or less) reliable indicators of events out-there in the world or as constructions or artefacts which, in principle, cannot be linked, reliably or unreliably, to events out-there was left unresolved. "Social meanings", as a term used by Douglas, served to blur, rather than clarify, both the object of study and the method of study.

Atkinson's position (1978) is ultimately that of an ethnomethodologist, and although his preceding theoretical and methodological positions undergo considerable change, the options are

set out explicitly. Atkinson describes the initial concerns of his study as "naively 'positivist' in character" (1978, 4). The next stage was to adopt a "labelling theory" of suicide and coroners' activities drawn from interactionism (1971). Ultimately, a 'solution' to the 'problem' of coroners' categorisations of suicide (and members' categorisations of phenomena, and their maintenance of social order) is found in ethnomethodology (Atkinson 1978, 5-8). The adoption of the ethnomethodological position takes place at the close of Atkinson's study: thus the description of what an ethnomethodological study would look like is entirely 'programmatic' (1978, 175-197). However, Atkinson claims that criticisms of ethnomethodology as unspecific, vague and 'programmatic' are rooted in a misunderstanding of ethnomethodology:

> Such a complaint ..... reveals a profound misunderstanding of the distinction between the correspondence and congruence theories of reality ..... and, in particular, seems to stem from a persistent adherence to the correspondence version ..... to complain that ethnomethodology fails to tell us what kind of study is indicated by their programmatics is to complain that they are accepting the logic of their own programmatics, namely that the task of formulating a literal description of some object in the world (which in this case would be 'ethnomethodological work') with that concrete object itself is an infinite and impossible task. (Atkinson 1978, 180-181)

In short, it seems that an ethnomethodological study of suicide or of coroners' categorisations cannot be described until it has actually been completed, and Atkinson does not proceed to further work specifically in this area.

To sum up, it has been argued that, in considering the suicide statistics for the years 1975 to 1980, the theoretical position adopted will influence the direction in which analysis proceeds and the questions which are posed. To adopt a positivist position, involving the search for causal factors behind the

'increase in suicide', has been said to be an internally logical enterprise, but not one which interests us here. The present study has adopted a perspective which, in the sense outlined above allows that 'suicide' can indeed be said to have 'increased', but which does not then proceed to ascribe a meaning to this phenomenon which would lead to the search for 'causes' or 'correlations'. Such areas are outside the scope of the present discussion. It has further been argued that neither Douglas (1967) nor Atkinson (1978) provide a useful basis on which to consider the available facts-of-the-matter, for their theoretical and methodological frameworks are, in the former case, muddled, and, in the latter case, unclear on the level of research practice.

It might briefly be added that the success of Durkheim's attempt to provide a sociological explanation of a social fact called suicide has still not been finally evaluated. The originality of Durkheim's enterprise remains clear, as in the following passage:

> Disregarding the individual as such, his motives and his ideas, we shall seek directly the states of the various social environments ..... in terms of which the variations of suicide occur. Only then returning to the individual, shall we study how these general causes become individualized so as to produce the homicidal results involved. (Durkheim, 1970, 151)

In carrying out his project, Durkheim found his evidence of the 'variations of suicide' within the officially-produced statistics, the published 'suicide rate', akin to the rate expressed in the tables above. Individual characteristics or circumstances might accompany instances of suicide, but for Durkheim individual factors could not explain the suicide rate (1898, 297). The "determining causes" of suicide lay elsewhere (1970, 297). Thus it was possible for Durkheim to speak of the "suicidal aptitude" of a society (1970, 299).

It is reasonable to characterise Durkheim's position as that of a positivist, moving from the facts expressed in the suicide-rate to a systematic explanation of the determining causes of variations in this rate. Douglas' reading was rather different insofar as he saw Durkheim's study of suicide as a break with positivism, and insofar as it was allegedly concerned with what Douglas understood to be "social meanings"(1967, 76). Taylor's more thorough consideration of Durkheim is expressed more cautiously: Durkheim's study "..... represented an important, though by no means complete, break with the positivist approaches of competing works" (1982, 7).

Theoretical labels can be discussed endlessly, perhaps with decreasing meaning. In short, it may be concluded that the positivist sociologist (in the sense in which positivism is defined at the beginning of the present study) would, on the basis of the increase in verdicts of suicide between 1975 and 1980 in England and Wales proceed to address questions of cause and explanation which are outside the scope of the present study. This position - of excluding matters which are simply beyond the scope of the task at hand - is perhaps more satisfactory than the obscurity into which discussions of competing theoretical options can sometimes lead and preferable to the tendency which views all such competing theories and methods as somehow indefensible.

Are the suicide statistics for the years 1975 to 1980 then a 'special case' in any sense? In terms of the statistics' meaning and significance for the present study, the answer is no, for the statistics are the tangible products of coroners' activities like any other coroners' statistics. An increased number of suicide verdicts during a recent period of British history poses questions which are of interest on many levels,including a "political" level,

but the temptation is resisted to explore areas of supposed causation and association which are properly the concern of another study, with other aims. Suicide verdicts are arrived at within an organisational setting, using certain practical rules, toward a formal goal, i.e. production of the facts-of-the-matter. Suicide verdicts are no more, or less, interesting in terms of the sociological analysis of their production than any other coroners' verdict. Nor can any special case be found here for suicide in terms of any unique relation to 'events in the world' - again, this must be looked at like any other verdict. Differences will be found in the manner of production of particular verdicts, as we noted in Chapter Four, but these differences do not signify essential differences in methods of producing the facts-of-the-matter.

Sociologists without doubt will continue to be especially interested in suicide, amongst all other areas of coroners' inquest and non-inquest work, partly because a body of knowledge called "the sociology of suicide" already exists, partly because suicide might be held to indicate some prevailing features of society, and partly because suicide, since Durkheim, has occupied a revered place in the elaboration of particular sociological theories, rules, and methods. However, no justification can be found here for treating suicide as a "special case" within the area of activity known as "coroners' work".

5(6) Conclusions

The statistics of coroners' work have been examined in a number of ways: inquest and non-inquest cases; use of the post-morte

examination; inquest verdicts nationally over a considerable period of time; detailed aspects of coroners' work during a single year; comparisons between individual coroners' jurisdictions; the status of suicide as a 'special case'; adjournments; and the work of coroners in one city over a lengthy period. All such statistics have been viewed as formal products of coroners' activities, the constructed facts arising from those processes discussed at interview with coroners and observed in attendance at a coroner's court. Statistics have been derived from published sources, unpublished sources, and field research in a coroner's office and, as a whole, constitute the third and final element of empirical material upon which the study is based.

The following conclusions may now be suggested:

1) The statistics of coroners' work are a rich source of <u>descriptive material about coroners' activities</u>. The statistics can productively be used in this way while suspending all judgements about the 'incidence' of 'different types of deaths'.

2) The national statistics indicate that an <u>ever-increasing</u> number of deaths were reported to coroners during the period 1926 to 1975.

3) Coroners' work (form A, form B, and inquest) has become an increasing feature of the State system for <u>dealing with death in general</u>.

4) Within the enlarged number and proportion of deaths reported to coroners, a <u>decreasing</u> proportion involve an inquest. There has not only been a general change over the fifty-year period in the numbers of deaths dealt with by coroners,

there has also been a change in the coroner's typical manner of 'settling' those deaths: the post-mortem examination is now the coroner's key instrument.

5) There has been a progressive <u>medicalisation</u> of coroners' work, based on the increased centrality of medical evidence, increased use of the post-mortem examination, curtailment of coroners' powers in criminal matters, changes in verdicts available, and changes in the "level of adequacy" required of and by coroners.

6) There has been a <u>bureaucratisation</u> of coroners' work. Coroners' work is now a major part of the bureaucratic system for dealing with death in an advanced industrial society. Some ancient functions and powers have been abandoned. Coroners' work is an increasing part of the social organisation of death in general.

7) While coroners' work as a whole tends today to form part of the medico-bureaucratic system, rather than the criminal-investigative -legal system, the inquest itself retains the structure associated with its former functions.

8) Consideration of the total (national) statistics of coroners' work over a substantial period exposes some of the legal, moral and normative changes which have occurred in the <u>framework</u> of coroners' activities. The effective boundaries within which constructions are produced are subject to change over time. The script by which coroners write true-stories is not static.

9) Examination of inquest verdicts over a period of time reveals that alongside the disappearance of some verdicts (murder, manslaughter, infanticide) there has been a re-

emergence of others (e.g. addiction to drugs). In the former case, the disappearance of a verdict was accounted for by formal change in the verdicts available while in the latter case, perhaps more interestingly, the 'renewal' of a verdict may be accounted for by the renewal of its meaning. It is also on the level of meaning that the continued central use of the accident/misadventure verdict can be accounted for, as this verdict has a particularly wide sweep of potential meanings: the potential true-stories which ultimately constitute accident/misadventure verdicts change over time but remain substantial enough in number to ensure its continued use.

10) Changes in verdicts recorded, and verdicts available, over a period of time suggest that normative, moral or ideological changes in society may "leave behind" the formal verdict and its typical meaning, and that, subsequently, formal legal changes in the verdicts available may "catch up" with changed mores and meanings in the wider society e.g. previously available verdicts such as "felo de se" or "excessive drinking".

11) An adequate account for a coroner at one time may no longer be an adequate account a number of years later, i.e. the criteria of adequacy, so far as coroners' categorisations are concerned, are subject to change. This conclusion is meant to apply to general criteria of adequacy (which may or may not be formally defined) in coroners' work as a whole. Additionally, there may also be differences between individual coroners in what is perceived as a necessary adequate account of the death at hand.

12) Discussion of inquest verdicts may productively occur even when a sceptical attitude, or a suspension of judgement, is adopted toward the relation between verdicts and the "incidence" of the "sort of death" they ostensibly describe. The verdict of still-born, however, may be conceptually different from other verdicts, for it may refer only to the fact of death and, as such, describe a natural event-in-the-world, not a construction. It may in some circumstances become a construction (see above) but is not necessarily so. In the nineteenth century and before, some other verdicts (e.g. "found dead") were akin to the verdict of still-born, but they have gradually disappeared as the criteria of adequacy have changed. Even the verdict of natural causes is not, today, akin to the still-born verdict, because for a death to reach the inquest stage, and then to become a verdict of "natural causes", other potential categorisations must have been conceptually possible: "natural causes" at an inquest is thus a construction, otherwise it would have been dealt with at the form A or form B stages.

13) Examination of the total statistics of coroners' work permits a description of coroners' total activities. In this sense, general statements about what coroners, in total, have been doing are possible, and the national statistics have a meaning, and a use, on such a level. Such statements cannot, however, necessarily be regarded as describing what individual coroners are doing. Consideration of the statistics of individual jurisdictions suggested that different coroners may have rather different practices. Conclusions about particular jurisdictions must be based

upon study of those particular jurisdictions. This is consistent with the differing perceptions of coroners described during interview, and the discussion above of coroners' discretion.

14) If, as concluded above, the post-mortem examination is now the "key instrument" of the coroner, this would seem to bear out the focus of the present study on coroners' work as a whole, and not only upon the inquest. Notwithstanding this, the inquest remains highly important insofar as it is a public display of the process of categorisation, where the construction of the facts-of-the-matter is visible for sociological study. This is not to suggest that the inquest is important only because it is, usually, publicly-available. There is also a sense in which the inquest alone reveals the "essential form" of coroners' work, because the account presented at the inquest is so much more a thorough-going (causal) true-story than the minimal information required by form A or form B. The inquest demands a much greater level of adequacy than form A or B.

15) In considering suicide verdicts for the years 1975 to 1980, it was concluded that suicide (i.e. verdicts of suicide) has indeed increased (i.e. more verdicts have been recorded, absolutely, in relation to total deaths, and in relation to population) during the relevant period. However, a meaning was not attached to this development which would permit the search for causal accounts or explanations. The choice of those sociologists and others who wish to seek such explanations was not dismissed, but was regarded as non-relevant within the terms of this discussion. It was also

concluded that examples of sociological work which gloss over the choice between either fully embracing explanations, or fully setting them aside, produce ambiguous and (theoretically/methodologically) unsteady results. The historical importance of the sociology-of-suicide was noted, but it was concluded that <u>suicide, as one of the verdicts available to coroners, is not a special case</u> when the sociological project is to examine the processes of categorisation at an inquest or the salient characteristics of coroners' work as a whole.

16) The statistics of coroners' work, to restate, are the formal products of coroners' activities. The legal, moral and other contexts in which coroners' activities take place change over time. The stocks of knowledge from which coroners draw also change over time and, on the level of commonsense knowledge, may also change from place to place. The level of adequacy of coroners' true-stories also changes: both in terms of what is required <u>of</u> coroners (e.g. statutory changes) and in terms of what is required <u>by</u> coroners (in their control over the construction of the formal account). Aggregated statistics may not describe the particular activities of individual coroners, but they can have meaning on an abstracted level: for instance, in drawing conclusions about the medicalisation and bureaucratisation of coroners' work. It also remains possible, and important, to draw conclusions about the <u>typical methods</u> by which coroners categorise deaths (and produce statistics) and the <u>essential characteristics</u> of such methods and activities.

Chapters Six and Seven below form the final part of the study. The theoretical bases of the approach to coroners' work have been elaborated, coroners' activity has been placed in its historical context, and the material gained through interviews with coroners, observation of the inquest, and examination of published and unpublished statistics has been discussed in detail. Chapter Six considers "death in society": that is, the sociology of death in an industrial society, existing sociological work (which has largely concerned suicide in particular), ideology, "routinisation" of death, some philosophical work, and the situation of coroners' activities within some larger contexts. Finally, Chapter Seven elaborates some overall conclusions.

PART THREE

CHAPTER SIX: SUICIDE AND DEATH IN SOCIETY

6(1) Introduction

As the results of interviews, observation and statistical searches have now been discussed - and provisional conclusions reached - it is appropriate to consider the wider context in which coroners' activity takes place, and to review some available stocks of knowledge. Firstly, some attempts at a definition and an aetiology of suicide will be critically evaluated. It has been suggested above that suicide is not a 'special case' in any consideration of coroners' work or the processes of categorisation. Nevertheless, most writing about sudden death within sociology, psychiatry and elsewhere has focussed upon suicide, and it is appropriate to discuss in a little more detail some of the work already mentioned in passing. Secondly, some 'images' of suicide and of death from the realms of literature and philosophy will be considered, as a concentration on sociological and commonsense views may leave out of account potentially rewarding 'stocks of knowledge'. Thirdly, the 'images' of suicide and death present in Press reports will be briefly discussed, reintroducing a topic already examined, in part, during discussion of the inquest. Finally, the 'handling' of death in general, and the coroner's concern with sudden deaths, will be located within identifiable cultural and ideological boundaries.

Diverse sources are thus being used in order to examine: specific theories; images of death in the widest sense; the 'handling' of sudden death and how it is 'treated' (by the

industrial State, by a Press report, or within philosophy or sociology); and the contemporary bureaucratic system for dealing with death, of which the coroner system is a part. Values and ideologies underly the way deaths are conceptualised and dealt with. The particular focus of much writing - not only within sociology - upon suicide alone must be elaborated. In short, ways of thinking about and dealing with suicide, sudden death and death in general will be examined. The immediate concern is with 'suicide and death in society'.

6(2) The Search for Definitions and Aetiologies of Suicide

There are several ways in which the definition of suicide can be approached. It was permissible, in examining coroners' inquest work, to leave open the question of an abstract, non-contextual definition of what-suicide-is: after all, a suicide verdict is one verdict amongst many, and to elaborate the many possible bases of an abstract definition may not reveal a great deal about coroners' work. Nevertheless, the word 'suicide' is routinely used by coroners, sociologists and laymen as though its definition were self-evident and unproblematic. 'Everybody knows' what sucide is on an abstract level, and it would be quite possible to retain a personally 'obvious' definition of what-suicide-is even if one chose to regard <u>coroners'</u> definitions as an entirely separate issue. Because 'everyone knows' what suicide is, it is of interest to examine routine, taken-for-granted abstract definitions. Perhaps the <u>notion</u> of suicide itself is problematic.

Two dictionaries yield the following definitions of suicide: as a noun referring to a person who intentionally kills himself; as a noun denoting "intentional self-slaughter"; as a figurative

term for some "action destructive to one's own interests or continuance in some capacity ....." as in "political suicide" (Concise Oxford Dictionary). Additionally, suicide refers to "the act or an instance of killing oneself intentionally"; "the self-inflicted ruin of one's own prospects or interests" as in "financial suicide"; "a person who kills himself intentionally"; and "(modifier) reckless, extremely dangerous" as in a "suicide mission". (Collins English Dictionary). The derivation of the word suicide is from the Latin SUI (of oneself) and CIDIUM (from CAEDERE, to kill).

So, leaving aside the figurative use, "suicide" abstractly refers to the act or the person performing the act. A definition on such a level thus needs to comprise several elements: the individual; the act; the intention to die; and the fact of death. "Suicide" emerges as an act of killing, directed against onself, where this act is intended to succeed, and where it does so. This might seem to resemble any commonsense definition of suicide. Yet it is unlikely that the layman's answer to the question "what is suicide" would include all the elements listed above. A lay definition might typically be that "suicide is when someone kills him/herself", yet those who die in road traffic accidents or mountaineering mishaps equally "kill themselves", if one assumes that nobody else was involved. Further, those who die as a demonstrable (in a clinical sense) result of their own consumption of alcohol or tobacco "kill themselves", literally, but are not routinely considered suicides. The layman therefore has to introduce the presence of intention into his definition of suicide. However, it is precisely on the level of intention that definitions of suicide become problematic.

Intention is problematic for the coroner because evidence of

intention must be retrospective. For the coroner, it is a practical problem. It is not only a practical problem however. Intention underlies purposeful action. But what does it mean to say that the individual's self-destruction was intended? If the "balance of mind was disturbed", when some mental imbalance was allegedly present, when intoxication by alcohol was present or when depression was present, then it would seem that the notion of intention becomes rather hazy. Indeed, the existence of depression (a central element of lay discussions of suicide) would seem to cloud the possibility of straightforward intention by introducing irrationality and an element of determination (that suicide was caused rather than chosen) into the definition of suicide.

Commonsense definitions of suicide, in short, contain potentially contradictory elements: that suicide was chosen, intended (it must have been intended to "be suicide") and deliberate; yet also that suicide occurs at times of imbalance, depression or irresponsibility and was thus not fully intended. Yet if not fully intended, it cannot "be suicide". One might take this contradiction further by considering suicide and homicide. The clinician's definition of the defendant as conforming to certain patterns of mental illness may denote that the individual was not responsible for his actions, with consequences for the subsequent application of criminal law. Yet a similar definition of the individual suspected of committing suicide as mentally ill, while logically removing his responsibility for his action, paradoxically confirms his suicidal status.

The above consideration of an abstract definition is designed to indicate that there are contradictions even within a routinely 'recognised' self-evident concept such as suicide. Lay thinking

about suicide is complex and contains inconsistencies. The coroner, in his formal construction of a suicide verdict, not only adheres to meeting a burden of proof, he also draws from 'professional' expert practical knowledge about the many 'cases of suicide' he has dealt with - and from his own connection with lay, commonsense reasoning about (and definition of) suicide. The complexity of the coroner's project is evident: so too is the ease with which it routinely seems to be completed. A central means of smoothing over the difficulties of defining suicide (in coroners' work or in lay reasoning) is language.

The importance of language in the symbolic process of ordering the world and ascribing meaning has already been discussed. Let us note that language glosses over difficulties and contradictions. It manages inconsistencies and makes the world intelligble and orderly. It is not surprising that the way suicide is talked about "itself" renders suicide an unproblematic notion.

It was noted above that some coroners, at interview, were more sceptical about the meaning of the (then) "falling suicide rate" than researchers, using the rates as the basis for subsequent explanations, have tended to be. Similarly, at least two of the coroners interviewed were rather more aware of the problematic status of "intention" than some theorists have been.

For instance, Lester and Lester (1971) proposed a continuum of suicidal behaviour: there were held to be degrees to which behaviour might be more, or less, suicidal. Yet given the discussion above, there would seem to be different senses in which behaviour might be "suicidal", together with complex and not always consistent elements to incorporate into the definition which could not be dealt with by such a continuum. Lester and

Lester's definition of suicide lies in four elements: behaviour, lethality, intention, and "degree of consciousness preceding the act." (1971, 10). Concern with abstract definitions of every possible occurrence of suicide led Neuringer, of the Los Angeles Suicide Prevention Centre, to construct a rather daunting list: intentional suicide; psychotic suicide; automatization suicide; chronic suicide; manipulation suicide; accidental suicide; neglect suicide; probability suicide; self-destructive suicide; suicidal threats; suicidal thinking; test suicide (Neuringer 1962, 273-278). Incidentally, the category of "self-destructive suicide" is taken to include people who

> ..... overeat, smoke too many cigarettes, climb mountains, pass on the right when driving fast on the highway, hunt mountain lions, cross the street against the signal lights etc.
> (Neuringer 1962, 274)

Elaborations of such non-contextual definitions of suicide could be performed ad infinitum. Let us merely note the extent to which such elaborations may go, once divorced from the practical problem of dealing with sudden deaths. In terms of the present study, the relevant meaning and definition of suicide was found in its use: in particular, in coroners' use and realisation of suicide as a category. A consideration of Blum (1970) is a useful point at which to commence further consideration of meaning-in-use. Blum suggested that:

> ..... a sociological phenomenon is defined in terms of its production. That is, it is defined in terms of the methods and procedures which members employ to make the phenomenon describable.
> (Blum, 1970, 32)

The perspective adopted by Blum is consistent with the congruence model of reality.* It is not consistent with an

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* See Atkinson (1978, 176-180) and Chapter One above.

abstracted non-contextual approach to definition because

> ..... to understand a use we must see it within a context ..... it is the socially organised ways in which meanings are applied that make particular usages intelligible.
> (Blum, 1970, 37)

The use of, and definition of, 'suicide' is intelligible in the context of coroners' activities, within the organisational processes surrounding categorisation of a sudden death. Coroners' work is not the only context in which suicide is intelligible of course: it is intelligible (although not necessarily synonymous in meaning) in lay use, religious use, legal use, and so on. However, the formal setting of immediate interest, i.e., the coroner's court, is a means of making not only some sudden deaths intelligible 'as suicide', but also of making 'suicide itself' intelligible.

The bases on which definitions are possible are important because within the debates about official statistics in sociology, and within the practice of positivist theorising lies the assumption that if sociologists' "definitions" and coroners' "definitions" were somehow matched, or plausibly assumed to be similar, then the business of sociological theorising could proceed without reservations about the reliability of suicide statistics or definitional problems. Definitions-in-use, however, could not be non-contextually matched in such a manner.

In considering the problem of definition, and locating meaning in use, the central focus of the present study re-emerges: coroners' production of the practical facts-of-the-matter, the ascription of meaning by organisational process, and situating meanings and definitions in their day-to-day uses. Consideration of the problem of definition also involves a re-emergence of some

of the theoretical bases of the study. Symbolic interactionism (in the form of G.H. Mead's early philosophical project) and phenomenology have already been introduced. Other elements of philosophy may also be relevant.

Routinely, a word 'means'such-and-such insofar as it is assumed to refer to some concrete or intangible thing. Yet clearly an individual has not defined every word he or she uses, nor can it be known that the word refers to something he or she has seen, touched or heard about. Even if every word were to be defined, it is not clear how past experience of something can be linked to what is being said now. The connection is problematic. It is the problem of linking definition to subsequent expression (Winch, 1958, 24-26). This problem, of course,is routinely smoothed-over by the use of language, as noted above. Further, to address the problem again, one could not know that a word is being used now in the same way as on some previous occasion (or when compared to its original abstract definition) unless the specific context of its use was always known. (This has some relation to the ethnomethodologists' discussions of "indexicality"). To use Wittgenstein's example, even the expression "the same" is not always "the same", unless the circumstances of its use are known (1967, paragraph 215). Wittgenstein held that only by means of a rule may it be said that "the same" has a specific sense. "The use of the word 'rule' and the use of the word 'same' are interwoven." (Wittgenstein, 1967, paragraph 225). What is it, then,'to follow a rule'?

Rule-following is based in others' reaction to the use of a rule by a member of society, i.e. it only makes sense to speak of someone following a rule if one can discover, in principle, what that rule is. Rules may not necessarily be socially recognised,

but they must be socially recognisable. Otherwise, what sense would the word 'rule' have? (Winch, 1958, 30). Wittgenstein suggested that rules produce consequences as a matter of course, i.e. routinely. Rules are employed 'without thinking', as part of the taken-for-granted fabric of the constructed social world. In this sense, rules and language are comparable, and both are indispensable elements in 'constituting' the social world.

Finally, it might be recalled that at the beginning of this study the nature of interpretation was held to retain certain difficulties, especially for a sociology which does not embrace the positivist method. It might now be noted that disembodied interpretations, isolated from specific (concrete) usages, are problematic. An interpretive sociology must address this issue.

> ..... any interpretation still hangs in the air along with what it interprets, and cannot give it any support. Interpretations by themselves do not determine meanings.
> (Wittgenstein, 1967, paragraph 198).

Meanings are located in use. One of the sociological tasks is to make usages visible. This study has been concerned in part with this task of 'making visible' - in a formal setting.

Such a perspective may be taken further. Perhaps ethnomethodology, rather than 'taking further' has 'taken in a different direction', but Coulter's contention that subjectivity 'itself' is not only accessible, but is available for sociological investigation, remains of potential importance (Coulter 1977). Coulter considers "understanding" and "intending", where understanding is not activity but achievement (1977, 323) and where the criteria for understanding are "scenic", not private (1977, 324). Coulter adds that

> A description of an intention is a description of an action (an envisaged action), not of an experience. Avowals and ascriptions of intentions, then, are organized by, and gain their intelligibility from, not some mental divinations, but the particularities of public states of affairs.
> (Coulter 1977, 326, emphasis in original).

Coulter's comments are of relevance not only to our continuing consideration of the problems of description and understanding, but also to the coroner's specific imputation of "an intention" in suicide, and the basis on which this process is intelligible. For Coulter, intention is made intelligible by "public states of affairs"(1977, 326).

The search for a definition of suicide has reintroduced some central themes of the study. It is now appropriate to consider once more the stock of knowledge and area of activity known as 'the sociology of suicide'.

Douglas (1967), Atkinson (1978) and Durkheim (1970) have already been introduced into the discussion. Durkheim's study of suicide, first published in 1898, has had, and retains, a considerable influence upon sociological writing about suicide, yet the nature and importance of Durkheim's study has still not been finally resolved. Taylor's consideration of Durkheim will be discussed below (Taylor 1982). For now, some features of Durkheim's project are briefly examined.

Durkheim's task was to present the archetypal sociological study. Psychological factors, as they were then understood,

> ..... may perhaps cause this or that separate individual to kill himself, but not give society as a whole a greater or lesser tendency to suicide.
> (Durkheim, 1970, 51).

For Durkheim, suicide, of course, was a social fact, and in constructing his four-fold typology of suicide, Durkheim was not

only interested in describing "types", he was also linking "type" to specific cause.

a) Egoistic suicide was seen by Durkheim as a direct result of inadequate social integration:

> ..... suicide varies inversely with the degree of integration of the social groups of which the individual forms a part.
> (Durkheim 1970, 209)

b) Altruistic suicide was a direct result of what amounts to 'over integration':

> When man has become detached from society he encounters less resistance to suicide in himself, and he does so likewise when social integration is too strong.
> (Durkheim 1970, 217)

So for Durkheim there appears to be an optimum level of social integration. The concept of altruistic suicide also carries within it the assumption of duty, and the subordination of self to an actual or perceived will of society.

c) Anomic suicide is perhaps Durkheim's central type of suicide, given the importance of the concept of anomie both in Durkheim's work and in the development of sociology. Anomie denotes a normative vacuum, a lack of binding mores in society or, as Frankenberg has put it, an "alienation from norms". (1966, 277). Central to anomie are "disturbances of the collective order" (Durkheim, 1970, 246) and it is important that anomie refers both to an objective state in society and to a subjectivity.

d) Fatalistic suicide, the fourth and final part of the typology added by Durkheim "for completeness' sake only" (1970, 276n.) is the logical opposite of anomic suicide. It is taken to occur when 'too many' norms and constraints bind the individual

to a rigid society e.g., the suicide of slaves. Durkheim saw this category as of no relevance to late nineteenth-century Europe, and for this reason it was not elaborated further.

Durkheim does not wish to treat his three principal types of suicide as exact representations of reality and indeed they have tended to be treated as Weberian ideal-types within the sociology of suicide as a whole. Whether or not Durkheim's study stands as an example of positivist sociology, and whether or not Durkheim is obliged to make assumptions about social meanings in order to make his material intelligible, are problems that were introduced in Chapter One. The difficulties of using officially produced suicide statistics are also, of course, relevant. Durkheim explicitly seeks to trace

> ..... the various currents which generate suicide from their social origins to their individual manifestations.
>
> (1970, 277)

Consequently, de facto personality types are constructed to correspond to the appropriate form of suicide (Durkheim 1970, 279-284). Durkheim's account seems to contradict its initial rejection of psychological factors and assumptions are made about the direction of causality (i.e. between society and the individual) on no very clear basis.

Durkheim's central concern to establish sociology as an independent and legitimate discipline does, of course, account for some features of his project which may now be regarded as idiosyncratic. The historical location of Durkheim's work also accounts for the dualism, the opposition of different "types of suicide", which is a striking feature of his study. Although Durkheim was ostensibly concerned with the creation of a truly

sociological theory (explanation) of suicide, other themes, quite unrelated to suicide, are equally apparent: the causal relation between social factors and individual behaviour; the interest in the tendency of societies as a whole toward a greater or lesser manifestation of a given phenomenon (e.g. suicide); the problematic relationship between man and society and the problem of the subordination of the individual; and the importance of establishing sociology as a scientific mode of inquiry, separate from all others.

While sociology has been characterised as a dialogue with the ghost of Marx, the sociology of suicide has sometimes appeared to be a monologue by the ghost of Durkheim. This is not altogether surprising, given Durkheim's importance within sociology as a whole, and it would be reasonable to suppose that had, say, 'the sociology of work' or 'the sociology of the family' been characterised at an initial stage by a study with the force and detail of Durkheim's Suicide then the development of those areas of interest within sociology would similarly have been dominated by that single initial study. The 'sociology of suicide' has developed in such a way that it seems quite permissible to speak of a dominant Durkheimian inspiration. Gibbs and Martin's "status integration" theory of suicide is an example:

> The theory of status integration was not developed to explain individual cases of suicide, but to account for variations in the suicide rates of populations. It is a sociological theory in that it looks to a measurable characteristic of the social structure as a source of explanation. (Gibbs and Martin 1964, 4).

This, of course, sounds very familiar. Gibbs and Martin's "measurable characteristic" is the degree of integration of the individual into the status position, and associated roles, he

occupies. Starting from the premise that Durkheim's theory has not been formally tested - "..... nor is it testable" (Gibbs and Martin 1964, 7) - Gibbs and Martin attempt to render Durkheim's concept of social integration more precise and specific, and thus, in fact, open to empirical testing. Gibbs and Martin interpret Durkheim's use of "integration" in terms of "..... the strength of the ties of individuals to society." (1964, 16). Social relationships are seen as a concrete embodiment of such ties.

Gibbs and Martin derived five postulates from their study. Firstly, that

> ..... the suicide rate of a population varies inversely with the stability and durability of social relationships within that population. (Gibbs and Martin 1964, 17).

Secondly, notwithstanding the above, relationships may be influenced by externalities, such as others' expectations, and thus the strength of social relationships varies directly with the degree to which individuals conform to expectations and social demands.(Gibbs and Martin 1964, 18). Thirdly, as individuals occupy several statuses, and the associated roles may not be compatible, Gibbs and Martin hold that an inverse relation exists between conformity with social expectations, and the degree of role-conflict (1964, 19). Fourthly, (and not very clearly dissimilar to the previous point) the extent to which individuals experience role-conflicts varies directly with the extent to which they occupy incompatible statuses (Gibbs and Martin 1964, 24). Finally, as some combinations of statuses are more compatible than others, they tend to occur more frequently: the relative frequency with which a certain status-combination is occupied is referred to by Gibbs and Martin as the degree of

status-integration (1964, 26). Hence, the fifth postulate: the degree of status-integration is inversely related to the extent to which incompatible status-combinations are occupied (Gibbs and Martin 1964, 26). A general "theorem" is then suggested:

> The suicide rate of a population varies inversely with the degree of status integration in that population.
>
> (Gibbs and Martin 1964, 27)

Gibbs and Martin's study aimed to render the "untestable" Durkheimian concept of social integration open for empirical investigation, by refining "social integration" into the ostensibly more rigorous concept of "status integration". Yet in operationalising "integration" in this manner, Gibbs and Martin succeed only in importing a new stock of meanings: those of American positivist sociology of the 1960s. These are as culturally-specific as the background meanings within Durkheim's own work. Furthermore, despite the use of "natural-science" terminology, the essential terms of Gibbs and Martin's constructed argument (durability, status integration, social expectations, incompatible status-combinations) are open to the ascription of so many meanings as to render the final "theorem" a virtual parody of the natural-scientific stance. Gibbs and Martin could be criticised on more detailed grounds (e.g. combinations of statuses may be 'incompatible' for some members of society, at certain times, while quite 'compatible' for other members, or the same members at other times; or, roles and statuses may not be freely chosen as Gibbs and Martin assume). However, the object here is not a detailed critique of Gibbs and Martin, nor is it an elaboration of the failures of an over-

crude attachment to what is taken to be scientific method. Taken as a piece of sociological work on suicide, the three central criticisms of Gibbs and Martin's study are that

a) definitional problems are not addressed;

b) central issues of meaning, and its construction and ascription, are not explicitly dealt with;

c) an apparent emphasis on empirical sociological analysis relating to "suicide rates" <u>in fact</u> amounts to a concern with individual suicides, a concern with individual aetiology.

The first two criticisms are perhaps by now familiar. The third criticism refers to the problem that Gibbs and Martin are indeed concerned with the commonsense lay question: "why do people commit suicide?" For Gibbs and Martin, the answer to this question lies in the individual's degree of status integration. <u>Despite a stated concern with the sociology of suicides, the actual concern is with the individual aetiology of suicide</u>.

Moreover, criticisms of such work (in terms of definition, meaning, and the <u>de facto</u> concern with explanations of individual acts of suicide) do not only apply to Gibbs and Martin's study. Work within the "sociology of suicide" which similarly adopts an over-simple reading of Durkheim and a neglect of the constructed social world achieves comparable results. Indeed, the criticisms outlined above must to some degree be turned on Durkheim's study of suicide itself.

A final point remains in considering Gibbs and Martin's study (1964). Even assuming that their postulates are sound, and that the topic is being approached rigorously, there appears to be no factor which accounts for <u>suicide</u>, in contrast to, say,

crime, or indeed <u>any other</u> phenomenon, being the product of a lack of status-integration. Gibbs and Martin were aware of this drawback, but merely note

> ..... it will be assumed that the loss of social relationships has a specific as opposed to a general consequence. (1964, 30)

A further established contribution to the sociology of suicide was that of Henry and Short (1954). Henry and Short saw both suicide and homicide as aggressive responses to frustration, which itself was based in the vagaries of the "business cycle": males, whites, those over sixty-five years of age were held to be more prone to such frustration than females, blacks, younger age groups, and so on, as in each case

> ..... the group with the higher status position reacts more violently to fluctuations of business than does the subordinate status category with which it is compared.
> (Henry and Short 1954, 41)

For Henry and Short, the turbulence of the business cycle appears to produce a form of anomie, disruptive of authority and other relations, which is manifested on the individual level in acts of suicide or acts of homicide. It is, of course, interesting to consider the relationship between suicide and homicide, and the assumptions Henry and Short make about this, but it is of more fundamental interest to consider how Henry and Short can account for both suicide and homicide in terms of an economic system specific to the industrial world at a specific stage of development. The historical particularity of the approach is - again - of note.

The "sociology of suicide" is not monolithic in theory or methodology. Alongside the quasi-Durkheimian tradition (and

leaving aside the issue of how far Durkheim's position has been vulgarised by twentieth-century followers) stands the ecological approach, with its roots in the Chicago school. Although far from mutually exclusive, the two strands are sufficiently distinct to allow separate consideration.

Sainsbury's study of suicide in London (1955) examined the relevance of social disorganisation, integration and social mobility, reaching conclusions not incompatible with a Durkheimian approach, but the <u>city</u> was held to have a particular significance:

> In the city, populations are mobile and relationships ephemeral, ... there are few shared values or common goals, social cohesion is minimal.
> (Sainsbury, 1955, 12)

Aside from introducing the "ecological" element, Sainsbury remained reluctant to claim direct causal links e.g. perhaps particular areas of the city with a high suicide rate attract those who, for some other reason, are already more likely than others to commit acts of suicide. Sainsbury suggested that perhaps Durkheim oversimplified the causal relationship between suicide rate and lack of social cohesion, and that he also dismissed the relevance of psychological factors too readily (1955, 23). It could be argued, alternatively, that although Durkheim ostensibly dismissed psychological factors, he indeed fell back upon psychological theorising in completing his project.

Sainsbury considered several London boroughs in examining his hypothesis that the degree of social isolation and mobility is related to the rate of suicide. Statistical correlations appeared to be found. Clearly, the measures of "social isolation" are crucial here, and as an example Sainsbury claimed that individuals living alone, in rooms, or in lodgings, were more prone to suicide (1955, 41). More generally, and moving his

discussion to the level of suicide rates, Sainsbury suggested that

> ..... the eight highest rankings for mobility occurred among the ten boroughs which have the high suicide rates.
> (1955, 43)

Sainsbury concluded that

> The variations in suicide rate in the London boroughs can be explained by the hypothesis that the social character of city districts is determined by the extent of social mobility, isolation, or cohesion, and that these factors also predispose to or diminish the tendency to suicide.
> (1955, 87)

There is a certain caution in Sainsbury's study in the matter of direct, unmediated, causal links, but certainly the theory being propounded remains determinist. Further, the consideration of psychological factors is made explicit, and a concern with suicide <u>rates</u> gives way to a stated interest in the individual <u>tendency to suicide</u>. In these senses, as well as in the introduction of the role of the urban environment itself, Sainsbury's study may be contrasted with other examples from the "sociology of suicide". In other senses, particularly on the level of meaning, Sainsbury's study resembles quasi-Durkheimian research.

Sainsbury's study may be considered in the context of the early example of Chicago sociology represented by Cavan's research on suicide (1928). Cavan's position was stated quite clearly:

> Suicide cannot ..... be compared fairly with deaths due to physiological disorders. Suicide belongs in another series: deaths due to sociological and psychological causes.
> (Cavan, 1928, 9)

From this initial statement of interest in causality, Cavan moves

on to an historical survey of attitudes to suicide, which appears to pre-date Douglas' concern with social meanings while it also draws from Durkheim's concern with anomie:

> In the first place, the dependence of suicide upon attitudes regarding it is clear ..... The second point is the co-incidence of out-breaks of suicide with periods of social disorganisation.
>
> (Cavan 1928, 24)

Cavan emphasises the latter point by also referring to the increase in suicide during "periods of great social change." (1928, 56).

Cavan's "ecological" perspective, associated with a continuing emphasis on anomie, becomes clear in her investigation of "urban conditions" in Chicago, where suicide is held to be associated with particular city areas which are characterised by both "social" and "personal" disorganisation (1928, 103). A low suicide rate is said to be linked to stable social organisation and coherent social control (Cavan, 1928, 106-107). Yet "personal" disorganisation may over-ride social factors:

> In even the most stable social organisation there is probably some personal disorganisation, some people who cannot fit themselves wholly to the demands of customs and institutions
>
> (Cavan, 1928, 107-108)

Cavan continues by discussing psychosis and suicide, and the relation between personal and social disorganisation. Amongst her conclusions is a reference to the city being permanently in a state of disorganisation (Cavan, 1928, 330).

Thus, Cavan is interested in a causal theory about suicide which refers both to suicide rates and to individual aetiology. Cavan explicitly considers the interplay of "social" and "personal"

factors, in the context of a Durkheimian theory of anomie. Attitudes to suicide are held to be important. The city itself is held to be centrally important.

Cavan's study cannot be viewed as a simple adaptation of Durkheim in the manner of Gibbs and Martin (1964). For Cavan, an interest in individual psychology and the specific aetiology of acts of suicide was made explicit, rather than being submerged beneath a structure which purports to be exclusively "sociological". Cavan hinted at the relevance of the meanings of suicide, in her historical revue, although the argument was not developed. Definitional problems were not addressed, and Cavan's study, like Sainsbury's later ecological work (1955), remains deterministic. Cavan's study of suicide in Chicago stands as an early example of research which can draw from more than one tradition, raising issues which may, or may not, be taken up in later studies.

It has been suggested that the "sociology of suicide", while constituting a stock of knowledge and an established area of sociological activity, is not monolithic. The brief consideration of examples of work within the sociology of suicide indicates continuing dominant concerns (causality, anomie) as well as points of contrast. It has been suggested that definitional issues, problems of meaning, and a <u>de facto</u> interest in individual aetiology have characterised the sociology of suicide as a whole, although specific studies may reveal these difficulties to a greater or lesser degree. Despite a stated concern with suicide rates in society or part of society, the sociology of suicide has implicitly involved a search for the aetiology of individual acts of suicide.

The criticism of the sociology of suicide provided by

Douglas (1967) and Atkinson (1978) will be, by this point, familiar. A central point, however, must be clarified. To describe the sociology of suicide as determinist or positivist, does not constitute a critique, nor even an intelligible criticism. Within sociology, determinism and positivism denote certain assumptions about the nature of the world, the operation of causation, and methods of investigation. Sociologists who take other theoretical positions make different assumptions about these matters. It is to be emphasised, then, that to describe the sociology of suicide as determinist is only to describe one of its features: it cannot of itself be a sensible criticism. The grounds for building a critique of the sociology of suicide cannot lie in its positivism: the basis for a critique lies in the inconsistency between stated concerns and actual concerns, in the neglect of issues (definitions, meanings) which materially affect the status of factors claimed to be "social facts", and in straightforwardly unwarranted assertions - as in Gibbs and Martin's casual assumption that suicide, rather than anything else at all, will be assumed to be the result of a lack of status-integration (1964, 30).

In short, to state that the sociology of suicide derives from a Durkheimian position, adhered to more, or less, closely in specific studies, and that this tradition has a broadly common theoretical perspective, is not to make a criticism. The necessary critique of the sociology of suicide must be built from specific inconsistencies and omissions present in particular studies. Some of these inconsistencies and omissions have been suggested above.

Finally, Baechler's interpretation of some of the issues raised by Douglas may be briefly considered (Baechler, 1979).

This is of some relevance, for although Douglas' examination of"common patterns of meanings" (1967, 284-319) provided Baechler with the foundation for his exploration of typical meanings, Baechler's study is not universally regarded as a sociological study at all.

The elements of Baechler's study are that it is not concerned with a general or explanatory theory of suicide, that it is non-Durkheimian, that suicide is seen as having meanings which require elaboration and that 'suicides' rather than an act of 'suicide' are the appropriate focus for study. Baechler's approach is to describe and to seek to understand suicides, which are taken to comprise a variety of acts and activities. Suicides, then, are seen as meaningful, but as the meanings are not self-evident, Baechler aims to describe particular examples of meaning.

Baechler asserts that

> Durkheim was not interested in suicide and even less in suicides when he wrote his book. He was interested exclusively in sociology.
> (1979, XIX)

Baechler's own project is to address the question

> What are human beings doing when they end their own lives?
> (1979, XIX)

After reviewing existing approaches to suicide in sociology and psychology, Baechler offers a definition of suicide:

> Suicide denotes all behaviour that seeks and finds the solution to an existential problem by making an attempt on the life of the subject.
> (1979, 11)

Baechler regards suicides as a solution to the human existential struggle, where completed suicides are an 'inelastic' statistical feature of society and attempted suicides are much more 'elastic' (1979, 33-34). Suicides are seen as characteristics of the free self-conscious human population, which excludes the mentally ill (Baechler 1979, 38). For Baechler, suicide is a "manifestation of individual freedom" (1979, 49). Baechler is not concerned with causation in the "because ....." sense, but only with accounts in the "in order to ....." sense , e.g.

> If someone has just killed himself at the end of a period of mourning, it would not be right to say: he killed himself <u>because</u> he lost a dear one, but he killed himself <u>in order to</u> resolve the problem posed by the loss ofthis person. Our fundamental thesis is that every suicide is a solution to a problem.
> (Baechler 1979, 53)

From this initial philosophical standpoint, which clearly owes more than a little to the existential tradition, (see below) Baechler notes that suicides have a multiplicity of possible meanings, where 'meaning' refers to the interpretation of converging 'elements' of the suicide and their 'realisation' (1979, 59). Suicides are seen as means to an end, i.e. solutions to problems, not as ends-in-themselves. The central argument of Baechler's study is that typical meanings of suicides can be identified and elaborated, as follows

1) "Escapist suicides" where the prevailing meaning is to "take flight", divisible into three subtypes:
   (a) Flight: "an escape from a situation sensed by the subject to be intolerable"
   (b) Grief: "occurs following the loss of a central element of the subject's personality or way of life."
   (c) Punishment: "occurs in order to expiate a real or imaginary fault"
   (Baechler, 1979, 63)

2) "Aggressive suicides" where the prevailing meaning is to damage another, divisible into four subtypes:

   a) Vengeance: "is intended either to provoke another's remorse or to inflict the opprobium of the community on him"

   b) Crime: "involves another in one's own death"

   c) Blackmail: "puts pressure on another by depriving him of something he holds dear"

   d) Appeal: "informs one's friends and neighbours that the subject is in danger ....."

(Baechler, 1979, 63)

3) "Oblative suicides", divisible into two subtypes:

   a) Sacrifice: "seeks to save or to gain a value judged to be greater than personal life"

   b) Transfiguration: "seeks to attain a state considered by the subject to be infinitely more delightful"

(Baechler, 1979, 63)

4) "Ludic suicides", divisible into two subtypes:

   a) Ordeal: "entails risking one's life in order to prove oneself or to solicit the judgement of others"

   b) Game: "to take a chance on killing oneself where the sole purpose is to play with one's own life"

(Baechler, 1979, 63)

Baechler suggests that such typical meanings do not describe concretely any particular suicide, but are ideal-typical constructions of meaning. Moreover, causes are not being presented, but, instead, description and interpretation is suggested (Baechler, 1979, 64). Nor are motives being presented: instead, the aim is to elucidate suicides as meaningful and intelligible (Baechler, 1979, 65). The bulk of Baechler's study is an elaboration of meanings.

Finally, Baechler's treatment of the question of aetiology is to be noted, given its considerable difference from that of

other sociologists. He suggests that "abstractions" such as the greater male propensity to suicide are of no use in the task of understanding: rather,

> ..... one must build a conceptual system that allows for the interpretation of masculinity and femininity <u>insofar</u> as they have a relation to suicide.
> (Baechler 1979, 208, emphasis in original)

Baechler dismisses official statistics on suicide (1979, 209) and then offers an approach to aetiology as follows:

> The definition of suicide used in this study, namely, that it is a solution to a problem, allows us to pose a central question for its etiology: <u>who is looking for what solution to what problem?</u>
> (1979, 212, emphasis in original)

There are for Baechler two aetiological problems of suicide: what personal factors suggest to the individual that a solution to a problem is to risk their lives; and what 'problems' are relevant? (Baechler, 1979, 212)

To sum up, Baechler treats suicides as meaningful, intelligible phenomena. The meanings of suicide can be described and, in this process of description, 'suicides' may to some degree be understood. Matters of causation are not dealt with, and aetiology is interpreted in a manner unrelated to its treatment within the sociology of suicide. Suicides are defined as attempts to solve problems.

Baechler is an historian and sociologist and it is possible to read his study as a philosophical, rather than sociological, exercise. It may be objected that Baechler was, in fact, offering an explanation of suicide-in-general, that is, a general causal theory, rather than a descriptive and interpretive study. It

might also be objected that Baechler merely lists the various possible 'social meanings' of suicide following Douglas (1967) without adding further to any understanding of the area of study: an objection that might (as was noted at the beginning of this study) be stated as merely listing "indexical particulars". It might indeed be considered that an excessively discursive elaboration of a central theme bears little demonstrable relation to actual observation of the constructed social world.

Notwithstanding such objections, it would seem that Baechler does address the problems of definition, meaning and aetiology: precisely those problems which the "sociology of suicide" has tended to neglect. Moreover, Baechler has adopted a non-positivist orientation while still maintaining a central focus on suicides per se, which is to be considered with the position of Atkinson (1978) who, in rejecting positivism for an ethnomethodological approach, appeared to abandon the possibility of further understanding of suicides in particular. It may be suggested in conclusion that Baechler's study of suicides provides a useful example of sociological work on suicide which is separate both from the "sociology of suicide" as traditionally understood, and from some of the less than productive alternatives.

Discussion, at this stage, is concerned with the wider context of coroners' activities. Coroners' production of a categorisation known as suicide has attracted more sociological attention than any other aspect of coroners' work, and thus the nature of the established body of knowledge known as "the sociology of suicide" has been examined. It has been suggested that considerable definitional problems exist in any abstract consideration of suicide and that lay definitions of the common-

sense category of suicide also contain difficulties. The problem of intention has been examined. The work of Durkheim (1970), Gibbs and Martin (1964), Henry and Short (1954), Sainsbury (1955) and Cavan (1928) was considered, and although the "sociology of suicide" was not found to be a theoretically or methodologically monolithic enterprise, it was found to contain difficulties on the levels of definition, meaning and aetiology. A possible resolution of these difficulties was suggested to be in an emphasis on meaning-in-use and definition-in-use, where pre-definition is rejected. Baechler's study (1979) provides an alternative to the established positions within the sociology of suicide, by focussing specifically on the identified meanings-of-suicides and rejecting a determinist mode of theorising.

The present study has considered the coroner's "definition-in-use", and his construction of verdicts, including verdicts of suicide. The coroner is concerned with the realisation of the formal, organisational, category of suicide. The "sociology of suicide", as discussed and evaluated above, appears at this stage to contribute little to the coroner's realisation of suicide and production of a true-story. The approach adopted by Baechler (1979) is perhaps rather more compatible with our overall concerns.

Some sociological accounts of suicide have been considered. It is now of interest to briefly consider some philosophical accounts, firstly, because the discussion has already touched upon existentialist and other philosophical perspectives and, secondly, because philosophy and literature offer "images" of suicide and of death which help to situate coroners' work beyond the organisational process, in the wider area of culture and

ideas.

6(3) Images of Death and Suicide: Literature and Philosophy

Western culture, and its manifestations in morality, law, religion, literature and philosophy, has been characterised historically by profound condemnation of suicide. Whether seen as absolute sin, criminal act or deviant behaviour, attitudes to suicide have been centrally influenced by the interpretation of Christianity offered by Augustine and Aquinas, i.e., that man,in receiving life from God, acquires a "right of use" but not of "lordship" (Sprott, 1961,2). Later, the sixth commandment became presented as further reason for a general prohibition of suicide (Sprott, 1961, 5). The office of coroner, it will be recalled, has its origin in the twelfth century, and clearly the work of coroners has continued during periods of considerable moral and legal debate about the nature, meaning and permissibility of suicide. It may also be recalled that suicide remained a criminal offence in England and Wales until 1961.

The basis of the traditional Christian condemnation of suicide is open to argument. For instance, Williams traces the origins of this attitude to St. Augustine, noting that no clear-cut prohibition of suicide is to be found in the Bible: the Old Testament includes four suicides, none of which were condemned (Williams, 1958, 225). Indeed,

> there is no condemnation of suicide in the New Testament, and little to be found among the early Christians, who were, indeed, morbidly obsessed with death.
> (Williams, 1958, 229)

Williams suggests that the traditional strictures of the Christian

church against suicide originated in a "pre-Christian popular horror of suicide". (1958, 232). Attitudes to suicide and to death itself have not always followed a parallel course. By the Middle Ages, when the souls of suicides had effectively been lost forever, there was also a widespread preoccupation with death in general:

> The great popular image of all this ..... was the Dance of Death, in which a jaunty skeleton waltzes away forty times with the different orders of the living.
> (Alvarez, 1974, 173)

In literature and religious-philosophical thinking, John Donne's 'Biathanatos', written at the beginning of the Seventeenth Century, was an early example of a challenge to the orthodox attitudes to suicide. Alvarez characterises John Donne's work not as a defence of the idea of suicide, but as an argument that suicide is not necessarily sinful or undesirable (Alvarez 1974, 180). Sprott looks at 'Biathanatos' in detail (Sprott, 1961).

Philosophical and literary work on suicide and death cannot be given a detailed presentation here. However, having noted the prevailing current of religious-philosophical thinking, it is interesting to examine in a little more detail a philosophical perspective - existentialism - which placed death, suicide and 'nothingness' (Sartre,1958) very firmly within its epistemology. A consideration of existential philosophy is also of relevance insofar as it was derived directly from phenomenology, and insofar as it has influenced sociological work such as that of Baechler (1979).

Existentialism may be taken to be represented by the writings of, amongst others, Heidegger, Kierkegaard, Camus and Sartre. It does not denote a fixed body of theory, nor does it represent

a discrete strand within philosophy as a whole: Sartre, for instance, was equally concerned with elaborations of Marxism as he was with existentialism, and Heidegger (according to Warnock) gradually moved away from existentialism and phenomenology altogether (Warnock 1970, 49). Nevertheless, as a perspective, existentialism has identifiable features: the meaning-less nature of the world and the ways in which meaning is ascribed; the rejection of determinism and the concern with choice, freedom and the 'moment' of experience; the emphasis on authenticity and inauthenticity; the 'absurd' and forms of challenging the absurd; the view of death as the only certainty of 'being-in-the-world' i.e., the only certainty amongst the collection of possibilities which comprise individual human experience; the experience of nothingness as a 'thing'; and the relevance of suicide, about which views may differ. Suicide can be seen as the ultimate existential choice, a revolt against absurdity - yet for Camus it was quite the opposite: suicide was seen as submission to the absurdity of a meaning-less world, an acceptance and, as such, a negation of revolt (Camus, 1975, 54).

Existentialism has been elaborated not only in philosophical texts, but also in the novel and the play. Karl and Hamalian (1973) interpret the concerns of existentialism widely, and include extracts from Dostoyevsky, Kafka, Beckett and Tolstoy, some of which, of course, pre-dated phenomenological philosophy. Like Camus, Pavese dealt directly with the nature of suicide (Karl and Hamalian, 1973, 198-211). Sartre sketched out the elements of his philosophy in the novel Nausea in 1938 before writing his central philosophical work in 1943 (Sartre 1965; 1958). Camus, similarly, developed his philosophical themes

primarily in the novel (Camus 1960; 1961) while dealing separately, again in quasi-literary form, with the specific topic of suicide, to which we refer above (Camus 1975).

Existentialism, in both its literary and philosophical expression, places death and nothingness at the centre of its project. Even where the existential attitude to suicide (i.e. rejection) may seem to resemble the Christian-moral-historical tradition, the emphases of existentialism are at odds with the 'images of death and suicide' routinely found in Western culture. The development of existentialism from phenomenology, and the centrality of 'nothingness' in its view of the world, become clear in a more detailed consideration of Sartre's philosophy.

Sartre talked of being-in-itself and, when consciousness is added, of being-for-itself: consciousness is 'of', and cannot be considered in the absence of being (1958, 73ff). In short, consciousness cannot exist unless it is consciousness of something. The influence of phenomenology, and the relevance of intentionality, are evident here. Sartre was concerned with the relation between consciousness and the world. A feature of this world is nothingness, and Sartre held that consciousness of such 'nothingness' was possible, and also that 'nothingness' and 'being' were inextricably bound together:

> Nothingness lies coiled in the heart of being - like a worm
>
> (Sartre 1958, 21)

In Sartre's discussion of 'temporality', his emphasis is clear. He saw a paradox in conceiving of the present, which we "willingly define" as "being" i.e., "..... what the present <u>is</u> - in contrast to the future which is not yet and to the past which is no longer." (Sartre, 1958, 120, emphasis in original). The

paradox lies in conceiving of the present as some form of continuing event when, in fact,

> ..... a rigorous analysis which would attempt to rid the present of all which is not it - i.e., of the past and of the immediate future - would find that nothing remained but an infinitesimal instant
>
> (Sartre 1958, 120 , emphasis added)

Thus when the 'present' is stripped of the 'past' and the 'future' it ceases to be what is understood as the present. Being and nothingness are bound together.

In addition to being-in-itself and being-for-itself, Sartre elaborates upon being-for-others and here the discussion is close to the phenomenological treatment of intersubjectivity. Perhaps this will be clear when Sartre says:

> ..... if the Other-as-object is defined in connection with the world as the object which sees what I see, then my fundamental connection with the Other-as-subject must be able to be referred back to my permanent possibility of being seen by the Other. It is in and through the revelation of my being-as-object for the Other that I must be able to apprehend the presence of his being-as-subject.
>
> (Sartre, 1958,256, emphasis added)

The centrality of nothingness in Sartre's philosophy has been noted. Finally, it should be added that it is in Sartre's discussion of relations with others that nothingness is seen to permeate being itself: attitudes of love are self-destructive containing within them the annihilation of the self and other (1958, 364-369) and an attempt to transcend the destructiveness of mutual relations leads only to treatment of the Other as object, with equally pessimistic implications (1958, 379).

Kaufmann notes that "extreme experiences" figure prominently in existential thought (1959, 39). It is therefore not surprising to find death treated so centrally, as in the words of Kierkegaard:

> We wish to know how the conception of death will transform a man's entire life, when in order to think its uncertainty he has to think it in every moment, so as to prepare himself for it .....
> (quoted in Blackham, 1952, 108)

Kierkegaard's words may conveniently close our brief review of existentialism. As we have already noted, existentialism's embrace of the 'nothingness' at the core of 'being' is at variance with earlier philosophical perspectives, and certainly at odds with classical philosophy. Plato condemned suicide (St John Stevas, 1961, 246). Aristotle saw suicide as both cowardly and anti-State in its effect (St John Stevas, 1961, 247). It is possible for the existentialist to also reject suicide - as did Camus (1975) - but this is only after a working-through of a philosophy which places consideration of death and nothingness at its centre. Epicurus appeared to adopt the most pragmatic attitude of all:

> Epicurus, who thought that man should live for pleasure alone, and denied the interference of the gods in human affairs, naturally drew the conclusion that the free man was the arbiter of his own life and death. If life ceased to be a pleasure, the remedy was to make an exit.
> (Williams, 1958, 227)

Schopenhauer's conception of magic, as an 'extra-causal' method of bringing forces, irrationally, under control was used by Wahl to conceive of suicide as a "..... magical act, actuated to achieve irrational, delusional, and illusory ends." (Wahl, 1957, 92)

It has been suggested that 'images' of death and suicide are present in the ways in which philosophers have treated these subjects, and that such images have a place in the overall

cultural/religious/normative attitudes to death and suicide in society. Some philosophers have expressed such 'images' in the novel or the play and Meerloo's view of art as "one huge struggle with the shape of death" might be noted (Meerloo, 1962, 115). The world of literature and the arts again produces potentially relevant 'images' of suicide and death which cannot, necessarily, be dealt with further in the present study.

The characteristic treatment of death and suicide within some of the elements of Western culture (the Christian tradition, the law, philosophy) has been discussed. Dominant cultural attitudes have been noted, and the example of one particular philosophical strand, existentialism, has been examined in a little more detail, because it is at variance with other perspectives, and also because it derives from phenomenology, which is of continuing interest.

It has been noted at several points that the coroner works in a 'wider context' than that of the individual coroner's office. This 'wider context' might denote relations with police and medical structures; relations with the bureaucratic State system for dealing with deaths as-a-whole; a concern with overall social order; and relations with dominant <u>ideas</u> in society about sudden death. The very widest 'context' of coroners' work refers to the ideas, religious/normative/legal traditions, and cultural 'images' of death and suicide discussed above. It is possible to talk of <u>ideologies</u> of death and to examine coroners' work in terms of these ideologies. Marcuse may serve to introduce the discussion:

> In the history of Western thought, the interpretation of death has run the whole gamut from the notion of a mere natural fact, pertaining to man as organic matter, to the idea

of death as the telos of life, the distinguishing feature of human existence. From these two opposite poles, two contrasting ethics may be derived: on the one hand, the attitude toward death is the stoic or skeptic acceptance of the inevitable, or even the repression of the thought of death by life; on the other hand the idealistic glorification of death is that which gives "meaning" to life, or is the precondition for the "true" life of man.

(Marcuse, 1959,64)

Before considering the ideology of death further, it is appropriate to briefly re-examine a central means by which 'images' of death and suicide are publicly produced i.e., the media of mass communication in industrial society.

6(4) Images of Death and Suicide: the Press

The media of mass communication are highly important vehicles for the transmission of cultural images. It has been argued that such 'mass media' amplify the deviant behaviour they describe (Young, 1973). Such 'amplification' need not concern us here, but it may be noted, firstly, that the 'images' of death and suicide constructed in and displayed by Press reports are of cultural significance and, secondly, that Press reports are the typical means by which coroners' work in general is routinely 'known' to lay members of the public.

Atkinson considered newspaper reports of inquest verdicts of suicide (1978). Atkinson suggested that Press reports theorise, implicitly or explicitly, about suicide and that such theories resemble the theories of sociologists (1978, 157).

> ..... in the vast majority of cases the reader is left with a fairly clear view not only that the death was a suicide, but also of why the suicide took place.
>
> (Atkinson, 1978, 164 emphasis in original)

Consideration of the Press reports of inquests attended during the present study (see Chapter Four above), indeed reinforces the view that explanations are being offered in reports of cases of suicide. However, Atkinson fails to note that the newspaper's search for a causal account can fairly be applied to the range of verdicts and not only to suicide. For instance, it was seen at Inquest B, above, that alcohol was emphasised in the Press report as the key causal factor behind all that followed, although a misadventure verdict was recorded. Even at Inquest A, where a misadventure verdict was also recorded, there was a clear search for a causal account, albeit one which ended fruitlessly, and where the prevailing message of the newspaper report was one of mystery.

Press reports indeed theorise, and offer causal accounts (that is, explanations), about inquests resulting in suicide verdicts. Press reports similarly 'theorise' in reporting inquests in general, irrespective of verdict. Indeed, this is hardly surprising. Just as the coroner himself is involved in the construction of a causal true-story, so the newspaper, in its reconstruction of the coroner's construction, reproduces that account, notwithstanding the tendency of Press reports to effect such reproduction in a condensed, truncated, expanded or otherwise changed form. There seems no justification for considering Press reports of suicide in particular: once more, it is not a special case.

Newspaper reports of sudden deaths dealt with at inquests differ in emphasis (perhaps aiming for mystery, for a succinct and journalistically "complete" explanation, or perhaps raising matters of "public concern") and there is no uniform model of a newspaper-report-of-an-inquest. Similarities of form do exist

in Press reports of coroners' work at inquests,but perhaps the sociological task then becomes an examination of journalists' accounts and the presentation of news in general rather than an extended consideration of further inquest reports. The relevance of further study of how coroners' inquests are treated in the Press is open to some doubt. Yet the media of mass communication remain of central importance in transmitting cultural images of sudden death. How then is the study of the role of the Press to proceed?

An available starting point is Cohen and Young's distinction between the "mass manipulative" and "commercial laissez-faire" models of the media (Cohen and Young, 1973, 10). The former is taken to denote a model of the 'mass media' which views the public as unassertive receivers of whatever monolithic body of mystifying information the media care to produce (Cohen and Young, 1973, 10). The mass-manipulative model assumes social control to be a characteristic of the media's handling of news. The laissez-faire model hinges on the supposed diversity of images presented by the media,and the approximate balance which results from this: the ways in which news is constructed may reinforce the public's existing views, but its effect is far less thoroughgoing than the mass-manipulative model would imply. Cohen and Young suggest that the chosen model for examining the role of the media includes within it assumptions about the selection, presentation and effects of news (1973, 10-11). They therefore recommend that these three aspects of 'the manufacture of news' be considered separately.

Cohen and Young's prescription is of some use so far as it goes. Readings contained within Cohen and Young's collection tend to end on an inconclusive and somewhat bland note: e.g.

> In conclusion, the findings in this study suggest that although the press do present a consistently biased impression of crime and criminals through their process of selection, there is little evidence to suggest that this is very influential on public perceptions of, and opinions about, these phenomena.
>
> (Roshier, 1973, 39)

It is reasonable to suggest that 'media studies' of the early 1970s, following on the discovery of so many hitherto unexplored areas within the 'sociology of deviance', tended to be theoretically weak, reproducing conclusions not dissimilar to those of commonsense reasoning. There has been a tendency to present sociological truisms as discoveries of great import: e.g.

> Underlying the press's representations of reality is a belief in the essential justice and desirability of the present organization of society.
>
> (Chibnall, 1977, 14).

> One of the most effective and easy ways of implanting bias is one that the public could never be aware of. We have no way of knowing what news stories the editors decide not to print on any given day ..... Newspapers handle more news than any other news medium, yet what finally ends up in the paper is only a small portion of the news that is available.
>
> (Cirino, 1973, 40)

In general terms, and certainly in terms of understanding the images of sudden death presented by the media, the perspectives associated with the National Deviancy Conference have perhaps not proved wholly productive. The subsequent elaborations of quasi-political perspectives on the role of the mass media produced by the Glasgow University Media Group (1976; 1980) re-emphasise the initial impetus provided by Cohen and Young (1973), and are substantially documented, but again do not always develop beyond a restatement of the relationship between the media and the state which by now is familiar.*

The theoretical and methodological bases of sociological studies of the media have been criticised in ethnomethodological terms by Sharrock and Anderson (1979). The work of Hall and others (1978) provides alternative guidance on how examination of the media of mass communication might proceed. For instance, Hall et al point to the structural position of primary definers of reality, whose definitions of what is real, important and newsworthy are re-produced by the media in their capacity as secondary definers of reality (Hall and others, 1978, 57-60).

In short, a number of possible methods by which sociological study of the media might proceed is available. The applicability of existing sociological perspectives within media studies to the work of the coroner or the area of sudden death is, however, questionable. A continuing examination of newspaper reports of coroners' inquests is also of rather limited value, and of limited sociological importance. Areas of relevance remain: it would be possible, for instance, to examine the very considerable publicity and coverage given to some inquests in recent years, and to consider the bases for their de facto status as 'controversial' cases. Such an examination would go far beyond a consideration of mere 'newsworthiness'. It would also, however, shift attention away from precisely those coroners' cases referred to earlier as 'normal' sudden deaths and, concomitantly, away from the central concern of the present study with everyday mundane coroners' activities.

In conclusion, an adequate Press report is of course different from an adequate sociological or lay or coroner's account. Press reports of sudden death may contain identifiable

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* However, Hoggart's foreward to the Glasgow University Media Group's first study is of interest (1976,IX-XIII)

features. The means of studying how the media transmit images of sudden death, however, have not yet been established. The concern of the media with images of death and suicide is, perhaps, to be located on the level of ideology and overall accounts of reality rather than by small-scale study of particular newspaper clippings. Coroners' work is indeed routinely 'known' to members of the public via the 'mass media' but the tools for describing and understanding this process of acquiring lay knowledge are not, on present evidence, available.

6(5) The Ideology and Routinisation of Sudden Death

To discuss sudden death in ideological terms perhaps appears strange. Let us consider, however, the position adopted by Marcuse (1959). After examining the arguments for making the means of suicide widely and legitimately available, he notes:

> Are there other than irrational arguments against such reasoning? Only one. A life with this attitude toward death would be incompatible with the established institutions and values of civilization. It would either lead to mass suicide (since for a great part of mankind life still is such a burden that the terror of death is probably an important factor in keeping it going) or to the dissolution of all law and order (since the fearful acceptance of death has become an integral element of public and private morality). The argument might be unshakable, but then <u>the traditional notion of death is a sociological concept which transforms nasty empirical facts into an ideology.</u>
> (Marcuse 1959, 70, emphasis added)

Marcuse, of course, simplifies a number of arguments here which are dealt with more fully by, for instance, Glover (1977). Yet Marcuse also raises the important issue of how far the culturally-specific <u>fear</u> of death (reflected in the traditional 'horror' of suicide and the obsessions of existentialism alike)

helps to prevent an amoral attitude to death and a weakening or even breakdown of socio-political institutions. To put it another way, the question is raised of whether (and, if so,how) a dominant ideology of death contributes to the maintenance of social order.

It is important, of course, to distinguish microscopic and macroscopic social order. It seems reasonable to conclude that social order in the former sense, that is, 'everyday' social order, is indeed a product of human activities and interaction, a construction of members of society made 'real' by these activities. The everyday social order of sudden death is indeed a construction of coroners(formally) and of lay members (informally) who both draw from, and help to sustain, a view-of-the-world which includes the 'typical' features of sudden death. This world-view amounts to a 'mundane ideology' of sudden death. The question of whether an ideology of sudden death operates on a macro-social level is more contentious. The issue might be approached by considering the coroner's role within the structures of the industrial State.

As we have seen, coroners' work has increasingly become part of the State system for dealing with deaths in general. The growing number of deaths reported to coroners during the twentieth century, and the handling of those deaths by one of the established medico-legal procedures available to coroners, have rendered sudden death a routine feature within the statistical and bureaucratic activity of industrial society. The facts of birth and death, and the organisation of health-care, have been 'routinised'; coroners have increasingly had access to predictable medical and other facilities; and matters connected with death in general have moved from the clergyman's domain to

that of the official employed by the State. There has been a normalisation of death in society and a routinisation of sudden death which have shifted the coroner's role as an agent of social control. The curtailment of the coroner's powers in matters of overt jurisdiction under criminal law has been discussed. Yet the coroner's authority in less tangible areas of social control has remained. Aside from the actual authority, coupled with considerable discretion, which is available to the coroner in any of his investigations lies the crucially important power to determine for all 'practical purposes' the 'real facts' of sudden death. Coroners' methods of doing this have been a central area of interest in the present study.

It is to be emphasised that the coroner's formal and actual independence is not at issue. The point is that the coroner occupies a position which formally embodies tangible (e.g. statutory) and intangible (e.g. ideological) aspects of current attitudes toward sudden death, and that increasingly the coroner functions as one element of the overall bureaucratic system for disposing of the contingencies of life in an ordered, methodical, manner.

In Chapter Four above, the management of information about death was said to be sociologically important (De Vries, 1981, 1082). The coroner has, of course, a formal, and actual, responsibility for the production of information about sudden death. De Vries suggests that "..... it is probably safe to regard talk of death and birth as "controlled information""(1981, 1082) and he adds:

> The legal arrangements of society require the bureaucractic control of information pertaining to birth and death ..... records of birth and death are useful for documenting family relationships, property rights, and insurance claims .....
>
> (De Vries, 1981, 1083)

In short, the normalisation and routinisation of death in an advanced and industrial society are 'useful'. Complexity is rendered manageable. Organisational order is constructed from the unformed and meaning-less potentialities of the social world. Ideologies of death are relevant to the work of the coroner, both at the level of mundane routine theorising about a particular sudden death, and at the level of the coroner's formal responsibility, on behalf of the State, for producing official information about sudden death.

In Chapter One above, it was suggested that an unmodified structural analysis of official statistics and the State, such as that offered by Miles and Irvine (1979), must be applied with caution in any consideration of coroners' work. It is worthwhile to re-emphasise this point, and to re-state that the coroner's concern with social control is not necessarily of an overt or tangible nature. Equally, it is to be emphasised that social control is no less sociologically relevant for being diffuse, indirect or on the level of ideas and information. Miles and Irvine regard official statistics as "profoundly ideological in nature" (1979, 126). They suggest that the State's

> ..... economic and political functions are embedded in the production of official statistics, structuring both what data are produced and how this is done.
>
> (Miles and Irvine, 1979, 125-126)

Along with normalisation, routinisation and the relevance of ideology must be added the process of <u>medicalisation</u> of coroners' work. Starting from a specific statutory reference point - the 1836 Births and Deaths Registration Act - coroners' activity has become increasingly 'medical' in scope and nature;

medical evidence has become more central; the post-mortem has become the key 'instrument' of the coroner; access to medical facilities has become regularised; and a State system of dealing with ill-health within a welfare-capitalist rationale has developed. The process of medicalisation is itself ideological. The development of medical ideology was not, of course, confined to coroners' work. The development of psychiatry or of the treatment model of justice can also be discussed in terms of medical ideology. Conrad has summarised the process by which deviant behaviour has become "medicalised", noting that medicalisation is itself an effective means of social control (Conrad, 1975).

Blauner has said that

> Modern society controls death through bureaucratization, our characteristic form of social structure.
>
> (Blauner, 1968, 354)

Blauner examined the ways hospitals deal with death, suggesting that

> ..... the modern hospital as an organization is committed to the routinization of the handling of death.
>
> (1968, 355, emphasis added)

It may then be suggested that the routinization of sudden death so far as the coroner is concerned is but one part of the routinization of death in general. This issue was also examined by Sudnow (1967). The study of the social organisation of the hospital offered by Sudnow is especially interesting insofar as its theoretical starting-point is not dissimilar from the position adopted throughout the present study:

> A central theoretical and methodological perspective guides much of the study to follow. That perspective says that the categories of hospital life e.g. "life", "illness", "patient", "dying", "death", or whatever, are to be seen as constituted by the practices of hospital personnel as they engage in their daily routinized interactions within an organizational milieu.
>
> (Sudnow 1967, 8, emphasis in original)

Sudnow suggests that death, insofar as it has a situated meaning within the organisational setting of the hospital, cannot be described without reference to its social production (1967, 9-10). In wards reserved for the critically ill, daily organisation was geared "..... to the occurence of deaths as routine, daily events." (Sudnow, 1967, 34). Death and dying were for Sudnow not only 'social states of affairs' but were also sociologically problematic phenomena, with no obvious pre-existing meaning given that everyone, in the strictest sense, is dying (1967, 61). The use of the terms 'death' and 'dying' is reserved for a limited sort of circumstance, with a particular meaning, which Sudnow aimed to describe in the context of the hospital. Insofar as Sudnow was concerned with death and dying outside the hospital, he suggested that death is a phenomenon involving a practical definition of the boundaries of the social group involved, where individuals are either included or excluded from the phenomenon of death (1967, 153-154). It is, significantly, customary to talk of 'private grief'. The public nature of the British coroner's inquest might be recalled here: sudden deaths (that is, deaths dealt with by coroners) are perhaps defined as public property in a manner which distinguishes them to some degree from other deaths. The question is thus raised of to whom sudden deaths belong. The processes of bureaucratisation and routinisation are quite compatible with the "public-isation"

of sudden death in industrial society.

Death 'itself' has no universal invariant meaning. Just as Baechler (1979) referred to suicides rather than suicide, perhaps it is appropriate to refer to deaths rather than death. Such meanings of death have been considered by Kastenbaum, a psychologist, who has also outlined the important concept of the death system (Kastenbaum, 1977, 76). The death system is a network, mediating between individuals and the fact of mortality. The death system might comprise occupational roles (where we may locate the coroner), institutions, places or symbols which, in total, carry certain functions (Kastenbaum, 1977, 81). The functions of the death system might include warning, prevention, organised care of the dying, or social cohesion after death especially, say, following the death of a leader (Kastenbaum 1977, 81-88). Moreover, the death system makes sense of death. (Kastenbaum 1977, 88).

Kastenbaum's notion of a death system may be adapted to refer to the activities of coroners, and others, within a structured legal and normative framework for handling death in industrial society. In the broadest sense, the death system involves an ideological stance toward the routine everyday processing of death which characterises coroners' work. This ideological framework, or death system, may also have relevance on a macro-cultural level. The coroner's task, as part of a wider network, is centrally concerned with the routinisation and normalisation of sudden death. The study as a whole has described the organisational practices employed by the coroner in his central task of producing the facts-of-the-matter.

To sum up, the work of sociologists within the area of suicide has been discussed and evaluated. It has been suggested

that although the 'sociology of suicide' is not a monolithic or theoretically indivisible body of knowledge, it does have identifiable features and some common difficulties: the latter include a failure to deal adequately with problems of meaning and definition, and an effective concentration on individual aetiology despite stated interests in the purely sociological. Some problems of meaning and definition have been elaborated, and it has been suggested that meaning is to be located in practical use, not in abstract pre-definition. Historical and cultural perspectives on death and suicide have been outlined, drawing examples from religion and philosophy, and it was concluded that contemporary 'handling' of death by the coroner can usefully be viewed in the context of dominant cultural ideas and their historical development. The images of death and suicide generated by the Press have also been considered, given their central role in popular culture, but it was concluded that the appropriate sociological method for study of the 'mass media' is not yet available, at least so far as coroners' work is concerned. Finally, the 'wider context' of coroners' work can be seen in ideological terms as part of a death system, characterised by a routinisation of death and operating both on a formal level (as part of the bureaucratic structures of the State) and on a cultural level (as part of the dominant modes of conceiving of death).

Part Two of the study (i.e. material drawn from field research) was earlier 'situated' historically by an examination of the origins and development of the office of coroner. Part Two has now also been 'situated' in terms of further sociological sources and some relevant 'images' of sudden death. The final chapter below is concerned with an overall discussion of the process of 'accounting for sudden death'.

CHAPTER SEVEN: ACCOUNTING FOR SUDDEN DEATH

7(1) Producing Sudden Death

It is appropriate, in this final chapter, to consider further some of the conclusions already reached. The focus of study has been the coroner's account of sudden death. The process of 'accounting' has been investigated at interview, by observation, and by statistical analysis. Some of the emerging conclusions have been:

1) It is permissible to conceive of something called a 'coroner system'. This system overlaps with other organisational systems (e.g. the police system, the medical system). There may be institutional or informal ties between such systems. The boundaries of coroners' work as a whole are not precisely defined. The inquest is not wholly separate from other courts of law.

2) 'Coroners' work' for a particular coroner is closely linked to that particular coroner's views, perceptions, and practices. This is not only articulated by coroners in talking about their work, but is also clear in a consideration of the statistics of individual coroners' jurisdictions. Discretion is central. Discretion is exercised within the framework of considerable authority.

3) The inquest is the most visible element of the coroner system. Its contemporary functions are not uniformly consistent with its structure. Historical factors are highly relevant. The verdict itself may not even be the primary practical function at all inquests. The formal task

of the coroner at any inquest, however, is to produce a verdict.

4) Understanding the assembly of an inquest verdict cannot be based upon identification of isolated clues. Construction is a process, characterised by points of significance and key documents. The initial point of construction is long before the inquest, at the scene of death. The nascent verdict is contained within the emerging construction. Constructions follow a predictable course and have a characteristic structure. Causality and explanation are sought for and publicly delivered.

5) Typical processes of construction obtain at the inquest, irrespective of verdict and irrespective of the presence of a jury. There is no reason for the sociologist interested in coroners' work to focus especially upon suicide. It is much like any other verdict.

6) Inquest accounts are not complete: they are adequate, for the practical purposes demanded by the coroner, and the formal task demanded of him. A very limited account may, by these criteria, be quite adequate. The grounds of adequacy may change e.g. by statute or by historical changes. Historical developments also shift the meaning which specific verdicts are taken to have.

7) Typical processes of construction are identifiable. National statistics of coroners' work have a use and value as descriptive indicators of what coroners, in total, are doing. Such overall statistics, however, do not necessarily indicate the particular procedures adopted by individual

coroners. The national statistics, as the formal artefacts of coroners' work, are the total products of individual coroners' work.

8) 'Coroners' work' is increasingly part of the bureaucratic State system of dealing with death in general. Coroners' work has become routinised and medicalised. Insofar as the coroner produces the binding facts-of-the-matter within the context of considerable discretionary authority, and occupies a central role in the production of information, the coroner is involved with the maintenance of social order and the exercise of social control. Further, the typical manner of dealing with death in contemporary industrial society is closely linked to the dominant ideology of death.

9) No conclusions have been made about the relation between coroners' verdicts and 'types of death occurring'. It is not suggested that consideration of 'types of death occurring' is impossible. However, such conclusions properly belong in another study with different aims and a different theoretical/ methodological framework.

10) The end-product of coroners' activity is the true-story. The available facts-of-the-matter, that is, the facts of sudden death, are constituted by the activities of coroners. Coroners make sense of sudden death, impose order, and construct the formal publicly-available reality. Coroners' accounts are, in practise, the binding definitions of the reality of sudden death.

Sociologists such as Douglas (1967), Atkinson (1978), and Taylor (1982) who have to some degree examined the coroner's

role in accounting for sudden death, have done so from the perspective of sociologists primarily interested in suicide, rather than primarily interested in the work of coroners. Not surprisingly, their conclusions have similarly referred to suicide. Let us briefly consider, then, an American study which was concerned with:

> ..... an analysis of the coroner/medical examiner role with attention to how its various components might affect the production of manner of death statistics.
> (Henson, 1978, 5)

Henson was concerned to some degree with the practical policy issues of reducing statistical 'error' and of 'improving' the operation of the coroner/medical examiner office (1978, 4-5). In this sense, her concerns diverge from those of the present study, but Henson's focus on "manner of death" statistics as a whole, rather than suicide statistics alone, is of interest. Henson discusses the role of the coroner/medical examiner on three levels: statutory requirements (which might vary from state to state); the occupants' definition of their roles; and the "actual role performance" of coroners/medical examiners (1978, 5). Henson's review of the problems of official statistics (1978, 8-16) indicates an adherence to a correspondence model of reality, that is, "manner of death statistics" are seen as capable of improvement up to the point where they accurately, or more accurately, represent a reality-out-there. The principal theoretical position is that of role-theory: the job of the coroner/medical examiner is said to be characterised by role-conflict and role-strain, evident both in relations between coroners/medical examiners and other officials, and in conflicts within the three levels of coroners'/medical-examiners' work mentioned above.

> The choices a medicolegal official makes in role strain and role conflict situations affect his verdicts which become the official statistics of manner of death and cause of death. Examination of these role conflicts and role strains and the ways in which they are resolved is an important step toward more complete understanding of the nature of the weaknesses in official statistics. Such understanding could make it possible to adjust for some of the bias in the statistics and reduce error resulting from their use in social science research. (Henson, 1978, 28-29)

Henson's study as a whole is devoted to an elaboration of these themes. Field research was carried out with both coroners and medical examiners using personal interviews, mail questionnaires, observation, and examination of case records. As the theoretical orientation was rather different from that adopted in the present study, the questions which were addressed, particularly in terms of the <u>accuracy</u> of information, were also rather different: and of course, the organisational, legal and historical differences between the British coroner system and the American coroner/medical-examiner systems are very substantial. Nevertheless, Henson's research stands as a sociological study of coroner's/medical examiner's work <u>as a whole</u> and in this sense is of relevance to our overall concerns. It would also, potentially, provide the basis for comparison between the British and American systems, in particular by detail of the wide state-by-state variations in the organisation of medico-legal investigation in the United States (Henson, 1978, 58-81). Henson's conclusion that three factors may produce differences in "manner of death" statistics is also perhaps of relevance. The three factors are said to be:

> Size of the medicolegal office, availability of trained personnel and testing facilities, and the type of system in operation and the qualifications of its central official.(1978,172)

This conclusion may bear a relation to our observations upon differences between individual coroners' jurisdictions, differences in attitude and background of coroners themselves, and the subsequent production of the statistical facts of sudden death. There is also a relation here to the Canadian study by Eglin, Abwunza and Hallman (1983) which concluded that an apparent 'suicide epidemic' in Ontario could be accounted for primarily by changes in the coroner system itself: that is, by features of the rate-producing process.

Eglin et.al. detail the many changes in the Ontario coroner system since 1960 (1983, 16-26), concluding that there has been a reduction in the legal significance of coroners' decisions, a more pronounced 'public safety' role, a move toward bureaucratisation, a change in the status of the inquest from court of law to public inquiry, a reduction in the coroners' powers in matters of criminal law (including decriminalisation of suicide) and a relaxation in the criteria for finding that a sudden death was, indeed, a case of suicide (Eglin et.al.,1983, 25). The increased number of deaths reported to coroners between 1969 and 1980, and the fall in the number of inquests held during the same period, is detailed (Eglin et.al., 1983, 24). On the basis of these factors, Eglin et.al. tentatively suggest that the figures for 'teenage suicide' in this part of Canada during this period were far short of being an 'epidemic', and that increased numbers of suicides as a whole arose from an increased number of coroners' investigations and changes in practice (1983, 28-29). Nevertheless, they note, the official suicide rate for the age-group 15 to 19 years has risen faster than for the total population (Eglin et.al., 1983, 29-30). To account for this latter development, Eglin et.al. look to the rise of psychiatric ideology,

its focus upon the teenager, and the perception of 'teenage suicide' as a problem which, in turn, generates 'more' teenage-suicide in terms of the perceptions of schools, coroners, and doctors (1983, 30-35). Eglin et.al. conclude that suicidal intent is to be considered in terms of officials' (and others') perceptions, in terms of cultural notions of what constitutes an act of suicide, and they suggest that the identification of suicide also depends upon "..... the organizational apparatus and practices in which these conceptual notions are embedded and must be applied." (1983, 36)

Eglin's study is oriented toward the problematic nature of the suicide rate. It is not a study of coroners' work as a whole. Nevertheless, it presents a further perspective upon the manner in which the facts of sudden death are produced which is of relevance in considering the conclusions of the present study.

Overall conclusions may now be summarised in the context of the aims of the study. Inquests and verdicts may now be finally considered. Taylor's observation is useful:

> A historical account ....., whether of the French Revolution or Joe Soap's sudden and unnatural death, is a selective reconstruction: an <u>inter-pretation</u> of past events shaped first by the (acknowledged) availability of evidence and, second, by the (less commonly acknowledged) values, beliefs, theories, common-sense under-standings, etc., of the observer. While reports certainly contain verifiable facts, such as the storming of the Bastille, the empty gun lying by the body, etc., such facts are only meaning-ful, i.e. only make sense when organised within contexts of meaning. It is erroneous to assume that if one is diligent enough in searching out 'all the facts', the meaning will evolve by itself.
>
> (Taylor 1982, 74, emphasis in original).

7(2) Producing True Stories: The Coroner's Inquest and the Verdict.

The inquest is the most visible element of the work of the coroner. Although most cases reported to coroners are dealt with by a post-mortem examination, and no inquest, the inquest retains a central importance: it is a court of law where the coroner exercises, publicly, a considerable authority; it produces verdicts which are formally recognised as binding definitions-of-the-situation and informally recognised as official conclusions about 'what happened'; and it systematically ascribes meaning to disordered events by producing an account of reality. To put it simply, the coroner, at his inquest, publicly constructs the social order of unexpected death, and the verdict is the formal embodiment of this.

The emerging construction, the 'true story', of a sudden death is a process. It may be of interest to identify isolated 'cues' or 'clues' used by the coroner in arriving at a particular verdict, but these have little meaning when separated from the total process. The process of construction may begin as early as the scene of death. Within the process are key events and points of significance which may shift the emphasis of the emerging true story, or confirm it. In his discussion of suicide verdicts, Atkinson says

> In this depiction of how the coroner proceeds ..... is a process whereby 'bits and pieces', 'relics' and so on lead him towards a suicide or some other verdict. These I referred to in my original formulation as 'cues', and my concern here is with the kind of cues which specifically point towards a verdict of suicide
> (1978, 112)

Although Atkinson refers to 'process', it seems that the emphasis of his statement should be reversed: process is crucially important, while particular 'cues', although relevant, are not central. The emerging categorisation begins at the time of reporting a death to a coroner, and a provisional categorisation is routinely built from the impression of initial circumstances, the accounts of policemen, doctors and others, and the coroner's stock of experience. The emerging categorisation is 'recognised'. By the time specific cues are explicitly identified, the construction may be, for coroners' purposes, practically complete: the public display of discrete 'pieces of evidence' at the inquest does not necessarily give them the significance they may appear to have. Two issues arise from this: firstly, the extent to which categorisations are already 'accomplished' before the inquest even begins; and, secondly, the extent to which the inquest reveals only part of the available facts-of-the-matter.

Verdicts are routinely 'known' before the inquest begins. As one coroner put it at interview (see Chapter Three) the inquest is a "public recital" or "resume" of parts of the evidence. An informal assembly of the categorisation has already occurred, starting from the initial visit to the scene of death by police and medical personnel (and perhaps by the coroner himself) and continuing with the collection of written statements, post-mortem reports and other artefacts. The inquest publicly displays key parts (especially the 'points of significance') of the informal categorisation, before formally recording a verdict. In this process, the structure of the inquest, and its status as a <u>court of law</u>, are important in publicly signifying that disordered events have been <u>explained</u>, potential incon-

sistencies resolved, and the matter for-all-practical-purposes closed. The inquest's formal function is thus crucial. This should not be confused with the relative informality of proceedings during the inquest: the point is that the formal role of the inquest is to publicly record a verdict, 'settle' the matter, or, in short, to account for the sudden death under consideration. Herein lies the special importance, for the sociologist, in focussing on the inquest in more detail than, say, the post-mortem or the form 'A' procedure. Herein can also be located the coroner's formal task in relation to the bureaucratic organisation of death in general, the production of officially-sanctioned information, and, in the widest sense, the maintenance of social order.

The "public recital" of parts of the evidence at the inquest is also of relevance, insofar as it points to the limited nature of the coroner's account: and to the fact that a limited account may nevertheless fulfil the grounds of adequacy so far as coroners are concerned. Let us also note that officially-produced records, in general, may be limited in their nature while being, for the purpose at hand, quite adequate. Discussing the juvenile court, Lemert says

> records are made and cited ..... to satisfy a number of routine purposes, to comply with substantive and procedural law, and to validate or defend a particular recommendation or court order. But because cases sometimes lead to choice of a disposition not easily defensible in the light of the professed goals of the court there is much that is left unsaid in records. From this point of view the record is a residue of action, whose fuller implications are best inferred from the active processes by which records are made.
> (Lemert, 1969, 360, emphasis added)

The evidence presented at an inquest, and subsumed within the overall, formal, true-story, may omit parts of the potential account of the death at hand, even though such 'hidden' areas may be known to the participants at the inquest. Inquest C (Chapter Four) suggested that an "undercover" true story may exist alongside the publicly-revealed true story, but remains hidden because, in terms of the formal task at hand, 'nothing would be gained' from its unveiling. It is also worthwhile recalling, from the historical and procedural discussion of the inquest in Chapter Two, that its role is, in legal and formal terms, a limited one: it has never been required to produce a 'complete account' even if one were to suppose that a complete account is possible.

The verdict is a formal summary of the adequate account. The methods of producing a verdict tend to obtain, in general, irrespective of whether a jury is present, and irrespective of which particular verdict is recorded. It has also been seen above that the meaning of a particular verdict is not static. The stock of verdicts available to the coroner may be changed by legal amendment e.g. the disappearance of <u>felo-de-se</u> and justifiable homicide. Changes in the use of a particular verdict may denote shifts in medical knowledge e.g. about industrial diseases or may denote a changed normative climate e.g. addiction to drugs or self-neglect. The verdict of accident/misadventure is conceptually wide enough to embrace several sorts of true-story, whose meanings may vary, so long as they match the criteria of adequacy for accident/misadventure as a whole. The open verdict is still wider, of course, but it has been seen that an open verdict may denote a potential true story not otherwise open to definite categorisation, or a

situation where more than one definite verdict (e.g. suicide and unlawful killing) is seen as a potential but inadequate or conflicting true-story, as well as circumstances where there is simply 'not enough' evidence. In short, the open verdict may have an informal positive meaning, although it formally indicates an 'absence' of meaning.

It may also be concluded that the assembly of inquest verdicts involves the use of rules. Such rules may be formal/legal; informal/conventional; or based in the individual coroner's specific perception of his role. For instance, the coroner at Inquest F (Chapter Four above) defined the role of the inquest as that of a de facto public inquiry, and thus the formal verdict became almost subsidiary to the informally-defined primary task. Yet even here, typical methods of constructing the true-story, using typical rules, were seen to be in operation, from the visit to the scene of death to the inquest itself.

The concern of the study has been with all coroners' verdicts. Reference has been made to sociological studies which have focussed exclusively or mainly on suicide, and it has been argued that suicide verdicts are much like any other verdicts: the processes of construction apply in much the same manner. A little more can be said of this, for Taylor suggests, in his discussion of the coroner's search for evidence, that

> there is only a detailed search into the deceased's biography if, from the circumstances of death, suicide or foul play is suggested.
>
> (Taylor, 1982, 76-77).

The evidence of the present study suggests that this is not so. It may certainly seem so, if the researcher's starting-point is

an interest in suicide in particular, or in open verdicts and accidents insofar as these might be 'possible' suicides. However, a focus upon coroners' work as a whole suggests that the coroner's search for biographical information takes place to some extent irrespective of verdict. A concern, for instance, with the deceased's previous health is a general feature of the assembly of any verdict. The burden of proof required in suicide verdicts, however, perhaps does involve a more detailed search of biographical - and other - factors in comparison to other verdicts.

Finally, it has been suggested throughout the study that verdicts are constructions: that is, verdicts are the products of an active process involving the assembly of an account of reality which one might call the true-story. There is one exception i.e. one verdict which is not necessarily a construction and that is the verdict of still-born. The verdict may refer solely to the fact-of-death. If so, the verdict denotes a natural event in the world: not a construction or an explanation. All other verdicts are constructions, assembled through the processes described throughout the study. Even the still-born verdict may become a construction (see Chapter Five): but it is not necessarily so, and in this sense it is different from other verdicts. Prior to the twentieth century, some other verdicts e.g. 'found dead' could similarly be regarded as descriptions of a natural event in the world, rather than as constructions. The criteria of adequacy of coroners' accounts has shifted over time, for today coroners' accounts must be explanatory true-stories of what-really-happened. The contemporary range of verdicts available to the coroner - with the possible single exception above - embody the requirement to

construct an adequate, causal, account of the reality of sudden death. Indeed, this movement in the required criteria of adequacy can be seen, in part, in terms of the bureaucratisation and medicalisation of coroners' work already discussed, and the coroner's role as one element in the State system of accounting for and disposing of the contingencies of life and death.

The verdict, then, is the formal summary of the coroner's account. Methods of producing verdicts have been described throughout the study. Some coroners interviewed - for instance, in discussing the 'reliability' of statistics or the 'incomplete' nature of the inquest - appeared to adopt a perspective not dissimilar from the perspective of the present study. Others, of course, did not, but it might be noted in passing that coroners themselves have written about their own work and coroners' work in general (e.g., Pilling 1969; Chambers 1981; McHugh 1976; McHugh 1983). No doubt coroners' own 'academic' accounts of their work could be an interesting topic for further study. At the very least, more would be learned of <u>what coroners do</u> than is the case in some sociological writing: as an example of the latter, one might consider Atkinson and Drew's lengthy analysis of the words "be upstanding in court for Her Majesty's Coroner". (Atkinson and Drew, 1979, 91).

Coroners' activities become tangible and permanent through their translation into <u>statistics</u>, the 'residues of action' referred to by Lemert (1969, 360). Our concluding comments may now include brief reconsideration of the process of producing statistics.

7(3) Producing Statistics

The statistics of coroners' work have, throughout the study, been read as descriptive indicators of what coroners do, i.e. as reliable records of coroners' activities. National statistics usefully summarise the total activities of coroners. However, it has been concluded above that national statistics may not reliably describe the activities of individual coroners due to the differing perceptions of coroners, the widely varying use of form A, form B and inquest procedures, and coroners' own varying definitions of what constitutes coroners' work. A consideration of coroners' statistics, in total and in relation to individual jurisdictions, was presented in Chapter Five. Additional statistics, which have since been published by the Home Office, are included in an appendix to the study.

No conclusions have been made about the relation between the 'statistics of sudden death' and the 'types of death' to which they might be held to refer, correspond or otherwise represent. As the focus of the study has been on coroners' activities, and the statistics help to provide a description of such activites, it has not been considered useful or relevant to draw conclusions about the relationship between statistics and events 'out there'. That is altogether another issue: and one which has already been referred to in the discussions above of theory, methodology, 'official statistics' in sociology, and the construction of social reality. It has been seen that sociologists have traditionally discussed, first of all, the relationship between 'the facts' and 'the statistics' (e.g. of crime or of suicide): have then drawn conclusions about the greater or lesser degree of accuracy of the statistics; and have then proceeded to theorising - preferably, causal theorising

within the positivist mode of explanation - about the phenomenon supposedly described by the statistics. Let it be emphasised that the present study does not draw conclusions about the permissibility of such a project for sociologists who wish to adopt such a programme with its attendant theoretical and methodological elements. Such a project is simply outside our area of concern. Statistics have been seen as objects of study in their own right and as useful empirical material in describing the activities of those who produce them. This emphasis was evident in the discussion of the British suicide rate, to which we may now briefly return.

In Chapter Five, it was concluded that verdicts of suicide have increased in number over the period 1975 to 1980, whether numbers of verdicts of suicide are considered in absolute terms, in relation to total number of deaths, or in relation to population. Viewing suicide as a natural event in the world, no conclusions or causal explanations were offered, for this would have been to embark upon a process of theorising outside our area of concern: or, to restate a point made earlier, if a real rate of suicide somewhere does exist, it appears at present to be both unknown and unknowable. However, viewing suicide as an organisational product, some conclusions about the relevance of the rate-producing process to an increasing or decreasing number of suicide verdicts are possible.

Firstly, it can be noted that the apparently falling suicide rate of the early 1970s may be partly accounted for by the newly introduced burden of proof in the recording of a suicide verdict. The legal obligation to prove suicide was stated in the case of R. vs. Cardiff Coroner, ex parte Thomas (cited in McHugh, 1976, 357). This has since been restated at appeal e.g.

R. vs. City of London Coroner, ex parte Barber (cited in Current Law Year Book, 1975, item 458). The latter case meant that

> ..... suicide must be strictly proved at a coroner's inquest; it is not a verdict which should be reached as being the most likely cause of death.
>
> (Current Law Year Book, 1975, item 458).

In our terms, this legal ruling involved a change in the criteria of adequacy so far as coroners' suicide verdicts were concerned. Through a formal change in the basis of constructing the suicide verdict beyond the control of the individual coroner, categorisations of suicide would tend to occur less often than before.

Secondly, a further element in the 'decrease' in suicide during this period may - the matter is speculative - have been the disappearance of domestic gas and its replacement, as cause of death, by agents of poison: most typically, by drugs overdose. It will be recalled from Chapter Three that the drugs overdose is less 'obviously' a case of suicide to the coroner than domestic gas was: the cause of death itself does not so readily imply the eventual categorisation. To put it another way, changes in cause of death perhaps made the process of writing the true story more difficult. This may have affected the number of suicide verdicts recorded.

Thirdly, the problem exists of how to account for the increase in suicide verdicts in the late 1970s if the above two points are applicable, for the burden of proof and the predominant cause of death did not cease to apply as the decade progressed. Eglin et.al. (1983) linked an apparent increase in suicide in Ontario to features of the rate-producing process but the features outlined by Eglin et.al. - e.g. the decriminalisation of suicide, a relaxation of the criteria for recording

a verdict of suicide, a move toward the inquest becoming a public inquiry rather than a court of law - do not apply to England and Wales during the relevant period. It can only be concluded that if an account of the increase in verdicts of suicide during this period is possible, then the necessary material for such an account has not been found.

The search for an account of changes in the numbers of suicide verdicts rests, then, on an inconclusive note. The comments of some coroners at interview, in which scepticism was expressed about the conventionally accepted meaning of suicide statistics, might be recalled. Indeed, further research on the nature of suicide statistics hinges on the question of meaning. The meaning attributed to the statistics by the researcher, the coroner and the layman determines not only the account which is likely to follow, but the type of search which is to be made for a relevant account. The theoretical options, as was noted at the beginning of the study, are numerous.

Suicide statistics represent only a small proportion of the statistics of inquest verdicts. Verdicts themselves are only a part of the statistics produced by coroners' work as a whole, covering form A and form B procedures as well as the inquest. Reading national statistics as descriptions of what coroners, in total, have been doing, let us restate some of the conclusions made in Chapter Five. Firstly, during the period 1926 to 1975 an increasing number of deaths were reported to coroners and, in consequence, "coroners' work" (that is, form A, form B, and inquest) has become an increasing part of the bureaucratic State system for dealing with deaths <u>in general</u>. Of the increasing number of deaths reported to coroners during the fifty-year period, a decreasing proportion involved an inquest. Thus the

bulk of coroners' work centred upon the post-mortem examination alone. The traditional image of the coroner, holding searching inquests into mysterious deaths in dusty courtrooms, has virtually no applicability today. In the minority of coroners' cases where an inquest is held at all, there is unlikely to be any element of intrigue, homicide or suspicion. If there is, the inquest's powers to take any action are now very limited: although the coroner's authority remains very considerable. This is one of the internal inconsistencies of the coroner's work today.

Sociological debates upon the nature of 'official statistics' were introduced in Chapter One and have been a recurring focus of attention. The position taken throughout the study has been that if the sociologist chooses to use official statistics at all, those statistics can either be used as more, or less, reliable measurements of the real phenomenon in the world (crime, suicide, murder or whatever) they supposedly refer to and arise from or those statistics can be used as reliable records of the activities of rate-producing agencies. If the former option is chosen, the sociologist is likely then to employ those official statistics in order to theorise about the phenomenon in which he or she is interested, such as crime, suicide or murder. This might be done quite boldly if the statistics are seen as 'reliable', or it might be hedged around with reservations if problems of reliability are given more emphasis. In either event, this option did not seem to be productive within the terms of the study of coroners' work. Instead, coroners' statistics were seen as reliable records of coroners' activities. Other matters were left open.

It is important to note that the choice of one option or the

other in the use of official statistics in sociology carries with it methodological and theoretical assumptions and consequences. It should also be emphasised that the present stage of the development of sociology does not convincingly allow any absolute judgement about the degree to which particular theoretical and methodological choices are correct or permissible (The important choice is the one which creates internal coherence). Further, it would seem that the choice is not whether official statistics should or should not be used: it is, rather, a matter of what official statistics are to be used as, and to be used for, in sociology. On this basis, further material relating to 'official statistics' might be briefly considered.

It has been seen that the concern of Eglin et.al. (1983) and Henson (1978) with the coroner's production of statistics to some degree matches the interests of the present study. Echoing the discussion above, let us note Taylor's succinct summary of the matter:

> The 'problem of official statistics' is not whether or not they are 'accurate' (i.e. the extent to which they reflect the real, or true, rates), or that they are 'unacceptable' because they are the result of human judgement, background expectancies, etc., but whether or not a correspondence has been established between the researcher's use of some set of statistics and the nature of those statistics.
>
> (Taylor, 1982, 122)

Wayne studied the process "by means of which suicide as a manner of death is assigned" (1969, 2). This was in the context of a view of the problem as being one of inaccuracy and "under-enumeration" in suicide statistics (Wayne 1969, 1). Wayne's study of the rate-producing process uncovered varying and

inconsistent death certification and other documents (1969, 2-4). Given the American context, and the wide state-by-state variations in practice, this lack of standardised procedure was unsurprising. Proceeding by personal interviews and postal questionnaires, Wayne developed the hypothesis that medical examiners would produce a higher proportion of suicide verdicts than coroners. No evidence was found to support the hypothesis (Wayne 1969, 19). Indeed, the study ended on an inconclusive note. Its relevance here is in simply noting that the study was, firstly, concerned with suicide (rather than verdicts as a whole) and, secondly, that it was concerned with matters of reliability and accuracy of the statistics. In terms of these twin concerns, 'nothing was found'. Yet had Wayne been concerned with the rate-producing process itself, and with those views articulated by coroners to which he only alludes in passing, a wealth of material on coroners' and medical examiners' production of statistics could have been collected.

The coroner's production of statistics is bound-up with his other record-keeping concerns: the 'key artefact' of the post-mortem report, the transformation of verbal evidence of witnesses into written accounts, the reliance on formal police and medical evidence. The coroner's record-keeping role has a link to the increasing role of coroners' work within the general bureaucratic management of death as a whole in society. It might be recalled that one coroner at interview interpreted 'court of record' in terms of record-keeping. The coroner's record-keeping role is important sociologically, in transferring constructions of the world, events, impressions etc. into tangible permanent artefacts. It is also important in terms of what the 'record-keeper' is saying about himself. Wheeler

suggested that organisations which produce records (about other people, events or things) usually also produce records about the organisation itself (Wheeler 1969, 15). One might consider coroners' annual returns to the Home Office. Such returns constitute information about what are taken to be events in the world, such as the number of accidents on the road, and also amount to information about the practices of coroners, giving a further meaning to 'accounts'.

In addition to the importance of the coroner's own role as record-producer and record-keeper, one might also consider the different roles adopted by researchers who make use of such records. We do not refer here to the different theoretical/ methodological uses of such records already discussed, but to the issue alluded to by Bottomley and Coleman in their discussion of crime rates:

> Even within criminology itself a single consensually agreed approach towards the interpretation of such rates seems unlikely when criminologists adopt a range of radically different roles, including handmaidens to policy makers and administrators, debunkers or demystifiers of established institutions and practices, and more radical critics who would replace the entire set of existing economic and political arrangements.
> (Bottomley and Coleman 1981, 17)

It should be noted, then, that in addition to the 'sociological' problems of official statistics there are also 'social' factors, relating to the position of the record-keeper and the researcher, to consider. Social problems and sociological problems, as we have already noted, are of course quite distinct.

Wheeler suggests that written records have special significance in comparison to other sorts of information:

> To begin with, a file or dossier is likely to attain a legitimacy and authority that is lacking in more informal types of communication. (1969, 5, emphasis in original)

This legitimacy and authority may arise from the permanence of written records; from the ease of copying and transfer; and because the written record may have a "career" which is separate not only from the person to which it refers but also from the organisation which produced it (Wheeler, 1969, 5). Wheeler suggested that the functions of record-keeping include, broadly, social control; "identity-giving"; and "memory-tracing" i.e. they provide a permanent record of what-was (Wheeler 1969,14-15). Bottomley and Coleman concluded that the process of record-keeping is "worthy of study in its own right" (1981, 146). Bottomley and Coleman's approach to the study of police records mirrors the portrayal by Taylor (1982) of suicide statistics and the position taken in the present study in respect of the statistics of coroners' work:

> Questions about the usefulness of police records as a research resource cannot be answered without specification of the objectives of that research and a consideration of the objectives and conditions under which those records were assembled in the first place.
> (Bottomley and Coleman, 1981, 146)

The coroners' production of statistics is part of the social order of sudden death. Indeed, it is part of the social order of death in society as a whole, given the developments in coroners' work discussed above. The coroner produces the statistical facts-of-the-matter which, for all practical purposes, are permanent records of the reality of sudden death. In these senses - rather than ones arising from a superficial impression

of an inquest as a court of law much like any other - the coroner is concerned with social control. Coroners' activities in the production of statistics are to be located within the bureaucratic ideology of the contemporary State.

The consideration of statistics from individual coroner's jurisdictions, together with the views of coroners themselves collected at interview, suggests that coroners' work is based in informal and discretionary practice to a large degree, and is made dynamic by the operationalisation of individual coroner's opinions and perceptions of their work. Yet the formal organisational context of coroners' work, and the formal structure of the inquest, have been, and remain, the vehicle by which coroners' categorisations are produced and completed. It is thus necessary to examine again this apparent tension between structure and function, and between formality and informality.

7(4) Organisation, Ideology and Discretion

Doyal suggests that

> ..... in Britain the information available on both health and illness, as well as medical care, is extremely limited. It reflects the functional orientation of western scientific medicine, which is concerned not with the physical and mental well-being of the whole person in any qualitative and holistic sense, but rather with mending broken people so that they can return to their tasks, in many instances simply to be broken again.
> (Doyal 1979, 248)

Doyal appears to be referring to the ideologically limited nature of medical statistics (rather than a limited 'amount' of such statistics) and the orientation of the medical system toward the prevailing economic order. It would be a crude over-

simplification to transfer Doyal's perspective, unmodified, on to the coroner system. As we have seen, the coroner's concern with social order is rather more subtle and complex than a straightforward macro-political perspective would allow. Nevertheless, Doyal's position reminds us that the coroner operates within the wider bureaucratic and medical structures defined by the State, and carries with it ideological assumptions about death and the handling of sudden death. Indeed, the exercise of coroners' authority within this broad ideological setting may be seen as a unifying element in view of the possible tension between the 'formal' and 'informal' aspects of coroners' work. Let us elaborate this point.

It was concluded in Chapter Three that the boundaries of coroners' work are not rigidly defined. Although statute and case-law from time-to-time limit or extend the specific duties of coroners, the nature of coroners' work for individual coroners (and coroners' work as distinct from, say, police work or medical work) is substantially influenced by the coroner's own perceptions and subjective definitions of his work. The boundaries of coroners' work are defined in use. (The discussion of definition-in-use might be recalled from Chapter Six). Thus informality and discretion are central. What constitutes 'coroners' work' has a lot to do with the choices made by the individual coroner. This conclusion is based not only upon the evidence provided through interviews (Chapter Three) but also upon the statistical analysis of individual coroner's jurisdictions (Chapter Five). In addition to the informally - and practically-defined <u>boundaries</u> of coroners' work, the activity taking place <u>within</u> those boundaries is also substantially influenced by the varying positions taken by coroners. For

instance, the range of theories of suicide, the differing estimations of the role of the jury, and the various conceptions of the meaning of the open verdict were examples of how the differing views of different coroners may have implications for practice. There are also clear-cut examples of the exercise of coroners' discretion in matters such as deciding whether an inquest will be held, whether evidence is admissible, how witnesses are to be questioned, whether a post-mortem examination will be held, or whether certain categories of deaths (e.g. shortly after admission to hospital) will be notified to the coroner at all.

Yet aside from such very considerable areas of <u>informality</u>, where discretion and authority are exercised according to the judgements of the individual coroner, there paradoxically remains a <u>formally</u> structured system for dealing with sudden death. The 'coroner system' is one part of the wider formal system of death certification and registration. The routes by which particular sudden deaths are to be processed are, on a procedural level, specified quite clearly (see Figure 2(2)1, Chapter Two above). The circumstances in which inquests are to be held and completed, or opened and adjourned, are specified in law. The inquest is linked to other courts of law despite its ostensible separation e.g. the notes of inquest proceedings may be used in a subsequent prosecution in another court. Chapter Two presented in detail the formal/procedural aspects of the coroner system and, in particular, the inquest. The inquest itself is indeed the most formally-structured, as well as the most visible, element of coroners' work.

There appears, then, to be a 'tension' or a 'disjunction' - there may or may not be a 'conflict' - between the formal and informal layers of coroner's work. The production of accounts

of sudden death, whether at the inquest or through form A and form B procedures, is based in organisational processes which are both formal and informal.

Observation of inquests (Chapter Four) suggested an awareness of this disjunction by the coroner himself. Within the formal setting and procedures of the courtroom, the coroner appeared to minimise the significance of this very formality by speaking to witnesses conversationally, addressing them by their forenames, and so on. No doubt this was merely to some degree the 'style' of this particular coroner, but Inquest F (see Chapter Four) indicated a similar minimisation of the significance of the formal surroundings. Indeed, at the inquest - as distinct from other parts of the coroner's work - it is possible to view the disjunction between formality and informality as an inconsistency between structure and function. We have already noted that inquests are a relatively minor part of coroners' day-to-day work. The point has also been made, in passing, by Atkinson (1978, 102) and by Taylor (1982, 67). Yet as a public forum the inquest retains particular importance. It is also the only court of law which may be presided over by a doctor, with considerable discretion, and no legal background. For our purposes, the inquest renders the processes of construction and account-production uniquely visible.

An understanding of the inconsistency between structure and function at the inquest must be based in a familiarity with its development over several hundred years (see Chapter Two). Historically, the functions of the inquest have been gradually curtailed: from being concerned with many sorts of crime and wrong-doing the inquest came only to be concerned with sudden death. Much later, it came to be only concerned with certain

sudden deaths- the others were now dealt with outside the inquest. Even within those deaths dealt with at the inquest, functions in matters of criminal law have all but disappeared. A suspicion of homicide involves immediate adjournment and the transfer of the case to the criminal courts. The functions of the inquest have become more closely circumscribed,just as the role of the coroner has itself changed very considerably over the centuries. In addition to specific statutory changes in the functions of the inquest and the range of available verdicts, there have been equally important changes in the moral, normative and political context in which the inquest is held. The meaning of particular verdicts has changed (see Chapter Five). It might be remembered that the inquest has existed since society was organised along feudal lines, and the scope of the changes in the environment in which it has operated from that time can scarcely be exaggerated.

Alongside such substantial changes in the role of the inquest, its formal <u>structure</u> has undergone relatively little change. Jurors no longer have to view the body in the centre of the courtroom. Juries are summoned to only a minority of inquests. Solicitors and police officers - neither of whom existed in a recognisable form when the first inquests were held - now routinely attend inquests. Yet structurally the inquest today is not essentially different from the medieval inquest. Thus the structural 'shell' of the inquest continues to be the vehicle for producing accounts of sudden deaths, while its functions have undergone considerable change. A particularly important factor underlying the processes of categorisation which take place within the vehicle of the <u>contemporary</u> inquest has been the rise of <u>medicine</u>. This development includes the rise

of medical ideology (visible in areas of mental illness and the response to crime as well as in coroners' work), the development of specific areas of medical knowledge (e.g. about heart-attacks which were, to coroners and others, formerly 'acts of God'), the introduction of new medical procedures (centrally, the post-mortem examination), and the blurring of the distinctions between 'medical work' and 'coroners' work'.

The processes of medicalisation have now been embedded very firmly within coroners' work. Yet the coroner's form of public enquiry remains a court of law, structurally 'referring' to functions long since abandoned. This disjunction between formality and informality runs through coroners' work as a whole. It is most clearly revealed at the inquest.

We have seen that, in practise, coroners may effectively 'deny' the significance of the formal setting in which they find themselves. Coroners' <u>authority</u> -exercised within the ideological context to which we have referred - is the central means of '<u>unifying</u>' the formal and the informal, the gap between structure and function. On a mundane level, the coroner is vested with sufficient authority to smooth over any inconsistencies in the emerging true story and to arbitrate - with the final say - amongst any competing versions of the true-story which might be offered by other personnel e.g. police and doctors. Let us recall that 'coroners' work', 'police work' and 'medical work' merge at certain points of the process of construction, and that the coroner is by no means the only official involved in categorising a sudden death. The fact that there appear to be so few conflicts between different officials in the emergence of the true-story implies a recognition by these officials of the coroner's authority over the investigation. More abstractly,

the coroner's authority is an authority over the very 'facts' of sudden death insofar as those facts, for our purposes, are organisationally produced. The coroner has authority over the dominant, officially-produced, reality of sudden death. In this sense, as we have noted, the coroner is concerned with the social control of sudden death.

The coroner does not produce his accounts and exercise his authority within a vacuum. The coroner's 'perceptions' and his formal activities to some degree draw from those cultural and normative attitudes to sudden death discussed in Chapter Six. The coroner's activities also refer to those conventions and practices built up over the centuries: and, of course, the activity of the coroner also refers to statutory and other formal and procedural requirements. It would seem that the authority of the coroner unifies the diverse strands from which coroners' work is constituted. Herein also lies the systematic and 'unproblematic' nature of the coroner's account, for the coroner, to put the matter simply, has the power to determine the course of his investigations.

Reference has been made to the routinisation and bureaucratisation of coroners' work, which are the central means of locating the work of the coroner within the State system of handling death in general. The process of medicalisation means that the coroner is even less of an isolated official engaged in some self-contained area of work. Kastenbaum's concept of the <u>death system</u> allows a situating of the coroner's work both occupationally and culturally (Kastenbaum 1977). The death system includes individuals, occupational roles, places, objects, methods of physical care, actual disposal of the deceased, and methods of explaining (giving meaning to) particular deaths and

death in general (Kastenbaum 1979, 187-190).

In conclusion, perhaps there can be no 'complete' sociological account of coroners' work but (to turn our perspective back upon the study itself) it is possible to produce a study of coroners' work which is complete-for-sociological purposes i.e. fulfils the criteria of adequacy. Such an account, it may now be suggested, must consider the whole range of verdicts and not only suicide; it must refer to coroners' activity as a whole and not only to those cases dealt with at inquests; it must refer to the activities of other officials whose work essentially comprises a part of coroners' work itself; and it must consider a range of events and concepts, from the first visit to the scene of death, through a consideration of historical factors, to the more abstract level of the ideological and cultural death system.

In discussing discretionary authority, one is referring to a central dynamic of the coroner system: a 'motive force' in the process of production of accounts. The elements of 'discretion' and 'authority' warrant equal emphasis. We have seen that discretion mundanely and routinely operates at the inquest, and indeed Atkinson (1978, 101) and Taylor (1982, 69) also refer to the coroner's discretionary powers at the inquest. It might be noted, incidentally, that the Brodrick Report recommended that coroners should have <u>greater</u> discretionary powers e.g. a complete discretion in deciding when an inquest is to be held (1971, 158).

In the production of coroners' accounts, there is a fundamental interplay between the formal (bureaucracy, authority, statutory responsibilities and procedures, the structure of the inquest) and the informal (the interpretation of statutory requirements, discretion, interaction between coroners and others,

coroners' individual perceptions of what constitutes coroners' work, coroners' individual theories). ·Informal processes may themselves be 'structured', as in the systematic construction of the true-story. Discretionary authority binds together the formal and the informal.

The study opened with a review of sociological theory and methodology. The perspective to be adopted in the task of seeking to describe and understand coroners' accounts of sudden death was set out with reference to the central theoretical 'options' within sociology and some general methodological issues. It is now appropriate to finally re-evaluate some questions of sociological theory and method.

7(5) Sociological Theories and Methods

A theoretical position is contained within the adoption of a particular methodology and the activity of sociological description. The present study has aimed to make the processes of accounting for sudden death 'visible' and has also aimed to make the activity of research, and the theoretical assumptions which underlie it, 'visible'. Theory and method have been regarded as inseparable. Thus, while some 'technical' details of methodology (the interview format, dates of fieldwork etc.) are included in an appendix below, the study itself has discussed methodology in relation to sociological theory.

The impetus for the study lies in phenomenological sociology. The social world and phenomena 'within it', such as sudden death, have been seen as dependent for their sense of reality on the activities of members of society. Reality, that is, is constituted by such activities, and in examining the

production of sudden death the study has focussed upon coroners' methods of producing this reality. Chapter One considered the substantive bases of the phenomenological perspective in the sociological work of Schutz (1954) and its philosophical underpinnings in the work of Husserl (1970; and Koestenbaum 1964).

The perspective adopted has allowed the sociological study of coroners' accounts to proceed as planned. Several points, for the sake of clarification, can now be added.

Firstly, the positivist world-view and method have not been regarded as useful in the present study. Definitions of positivism were considered in Chapter One. Briefly, it can be suggested that the perspective which aims to proceed, without presuppositions, toward higher, generalised, 'scientific' conclusions about the objective world had little to offer, especially as positivism's denial of the sociological relevance of meaning appears to exclude from consideration the most central sociological element of coroners' activity. More specifically, Durkheim's contention that sociological method is to be based "wholly" on the view of "social facts" as "things", as realities external to the individual, has not been accepted (Durkheim 1970, 37-38). The study, then, has declared itself as non-positivist. It lays no claims to be anti-positivist, however. The sociologist who wishes to proceed along the positivist path will no doubt continue to design studies and produce results, in particular those concerned with causality and explanation, which satisfy his or her aims. That, however, is an enterprise the ultimate value of which we prefer to leave entirely open.

Secondly, although a broadly phenomenological orientation has been adopted, it will have become clear by now that the

study does not share the concerns of ethnomethodology. It has argued, for instance with reference to Atkinson's concluding discussion (1978, 175-197), that ethnomethodology is no longer a methodology within the phenomenological tradition, but is something else. That 'something else' - a concern with how individuals transform the context-bound into the apparently objective, an interest in linguistic expressions, a central concern with how reality is produced on the most microscopic level - is a distinct theoretical/methodological option in itself. It can be criticised from a number of standpoints: for instance. Gleeson and Erben offer a tentative critique from a quasi-Marxist position (1976) which is, it must be said, considerably less polemical than the similar viewpoint offered by Bauman (1973; 1976). Possibly the most central criticism to be made of ethnomethodology is that it appears to cut the ground from beneath itself, adopting typical concerns and a characteristic method which is destined to fail to yield any substantial insights into the phenomenon being studied. For instance, Atkinson concludes that

> ..... it seems unlikely that it can be warrantably demonstrated that there is anything special about the procedures used in arriving at recognizably correct possible descriptions of suicidal deaths as opposed to those used in describing any other describable events in the world.
> (Atkinson, 1978, 196)

On the basis of Atkinson's position, there seems to be no 'warrantable' reason for sociologists to have any special interest in <u>any</u> feature of the social world, as all sociological study would focus upon matters both general and microscopic. This appears to hold no prospect for continuing sociological work.

Thirdly, the broadly phenomenological perspective adopted

in the present study has aimed to be rigorous. Phenomenological sociology is not a loose or undisciplined quasi-philosophical pastime. Schutz emphasised that the aim of sociology is to acquire organised knowledge of the social world (1954, 261). Phenomenological sociology aims to describe and understand the social world by focussing upon meaning, the construction of social reality, interaction and experience. The present study has examined the formal and informal organisation of these elements. The use of, for instance, statistical material is quite compatible with this perspective, although of course such statistics might be used differently by the positivist sociologist. Moreover, it is quite compatible with the phenomenological perspective to identify general conclusions, built from concrete observation and description of the particular.

There is little doubt that an excessive (and spurious) significance can be attached to theoretical labels within sociology. The development of the present study suggests that the crucial research task is to ensure consistency between methods, theoretical base, and the overall aims of the study. If these elements are consistent and rigorous, then internal coherence should follow. The choice of a particular theoretical option does not seem to be a matter about which absolute judgements can be made, for sociology remains a pluralist discipline. There would, however, be obvious dangers in shifting the theoretical basis of the research from one perspective to another - and perhaps still further - as the study proceeds (e.g. Atkinson 1977, 31-46). Equally, there are dangers in an inflexible devotion to a theoretical position which is inappropriate, e.g. in not matching the objectives of the research.

To restate, the present study has aimed to render its own

research process 'visible', just as it has sought to make visible the process of categorising sudden deaths. A reflexive sociology is understood here to be one which can turn the analysis back upon itself, thus illuminating the practice of research itself. As was noted in Chapter One, this process can of course be taken too far, as little is to be gained through a self-contemplating sociology-of-sociology. A more fundamental problem is the degree to which sociologists generate or essentially 'produce' (rather than merely record) their own data. This problem is common to sociologies whatever their theoretical hue. The positivist sociologist, for instance, will 'detect' social facts such as suicide, will then 'find' that such facts are represented in total and as a proportion of the population in the form of suicide rates, and will then import the <u>conceptual</u> equipment required for linking the suicide rate to some feature of society as a whole. Phenomenologists, ethnomethodologists, interactionists and Marxist theorists in sociology similarly seek out those phenomena in which they have a prior interest; apply the tools of analysis; and thus generate the results. This matter can be resolved in a number of ways. Firstly, the research process can be made 'visible', as discussed above. Secondly, the sociologist can recognise the centrality of concepts, and their two-way link with the phenomena being studied. Bulmer suggested that

> ..... concept-formation in the analysis of sociological data proceeds neither from observation to category, nor from category to observation, but in both directions at once and in interaction ..... The process is one in which concepts are formed and modified both in the light of empirical evidence <u>and</u> in the context of theory. Both theory and evidence can exercise compelling influence on what emerges.
> (Bulmer, 1979, 653 emphasis in original)

Bulmer was writing of the use of concepts in the handling of qualitative information. His point, however, has a general relevance.

The 'sociology of suicide', as an established body of knowledge within sociology, has been referred to in passing throughout the study, and was discussed in a little more detail in Chapter Six. The studies of Durkheim (1970), Gibbs and Martin (1964), Henry and Short (1954), Sainsbury (1955) and Cavan (1928) were said to be of limited relevance in an approach to sudden death (including suicide) which focusses upon the rate-producing process. In more general terms, the traditionally conceived 'sociology of suicide' appeared to be problematic in the areas of definition, meaning and aetiology. Baechler's reinterpretation of meaning and aetiology was outlined (1979). The location of definition in use was also elaborated, as an approach to coroners' activity and as a further element of the developing perspective of the study as a whole. It might be noted that a quasi-Durkheimian sociology of suicide still flourishes, although the extent to which it still refers to the Durkheimian approach is open to argument: Gibbs and Martin contend, long after the publication of their main study, that the status-integration theory of suicide remains systematic, predictive and testable (Gibbs and Martin 1981, 821). It must finally be emphasised that the sociology of suicide is a far richer and more theoretically diverse area within sociology* than implied by the (necessarily limited) sketch included in a study which has not been primarily concerned with suicide at all. Halbwachs, for instance, was responsible for a study which included officially-derived statistical information (including British statistics) and was broadly located in the Durkheimian

* See, for instance, Sacks (1966), Watson (1975)

tradition, yet took issue with Durkheim at several points e.g. Halbwachs disputed both the meaning and 'amount' of anomie:

> The complexity of urban society is not identical with what Durkheim called anomie
> (Halbwachs 1978, 320)

> ..... while the influence of modern social life does not extend to all details of life, or to all the situations which are encountered, this was certainly also the case with old types of regulation, and nothing permits us to assert that there is relatively more anomie now than formerly.
> (Halbwachs 1978, 322)

Halbwachs also suggested that regional suicide rates tend to converge, at a rising level, "wherever the same style of life, the same type of civilization, succeeds in taking root" (1978, 312). Halbwachs found this development normal; Durkheim found it abnormal. More generally, Halbwachs integrated psychological factors into his definition and explanation of suicide in sharp contrast to Durkheim's rejection of any consideration of individual psychology (Halbwachs 1978, 262-290).

Halbwach's study, first published in 1930, would form a part of any comprehensive consideration of the sociology of suicide. Such a consideration might also usefully refer to Coenen's thesis that there is no necessary or essential opposition between Durkheimian sociology and phenomenological sociology (Coenen 1981). Coenen suggests that a phenomenological reading of Durkheim's work has become possible as phenomenological sociology has moved toward a greater inclusion of empirical information and the unstated assumptions of such information, and away from a search for pure eidetic understanding (Coenen 1981, 962). The discussion of the eidos will be recalled from Chapter One.

Finally, it was suggested at the beginning of the study that explanation is to be distinguished from understanding. Explanation has been specifically referred to as the causal method of theorising characteristic of positivism. Dallmayr and McCarthy drew attention to the historical roots of the divergence between the positivist mode of explanation (with its imitation of natural-scientific method) and an alternative emphasis on understanding (Dallmayr and McCarthy 1977,2).

It was decided, then, at the beginning of the study to seek to understand rather than, in the above sense, to 'explain' the process of accounting for sudden death. The basis of understanding is description: not complete description, which we have argued is in principle impossible, but description which fulfils the criteria of 'adequacy'. Thus a description has been provided which is sufficiently complete to understand the socio-logical processes involved in the work of the coroner. The emphasis on understanding rather than explanation can also be seen to be compatible with the overall theoretical/methodological framework. In conclusion, the necessary basis for carrying out the study as a whole was indeed provided, and no grounds were suggested for having adopted a different position.

The relationship between understanding and explanation is complex. It could be argued that the two are quite separate; or are inseparable; or that explanations 'lead to' understanding; or that understanding, when it is somehow sufficiently 'advanced', then 'becomes' explanation. The debate will be taken no further here. A summary of some of the issues is succinctly drawn by Wrighton (1981). The question of description could also, of course, be taken further. Coulter, for instance, after referring to the issue of whether descriptions may be judged by "decon-

textualised" criteria adds, importantly, that:

> The description of an action is an occasioned event, itself an action, undertaken for some purpose, or guided by some particular interest, which informs our judgements about its adequacy.
> (Coulter, 1979, 14, emphasis added)

If descriptions are, then, to be regarded as actions, the possibilities - and pitfalls - of a reflexive sociology turning its methods back upon itself are again apparent. Even a term such as determinism allows much further discussion. Balandier characterises the early work of Gurvitch as carrying within it a "conditional" determinism: a definition of determinism wide enough to contain a "certain indetermination." (Balandier 1975, 14).

The above examples indicate that the theoretical issues which have been raised and discussed in the present study permit considerable further discussion. Nevertheless, the tasks of providing an appropriate framework for the study as a whole, and of situating methodology within a context which pays more than passing reference to some major theoretical issues, appear now to have been adequately fulfilled.

Some brief concluding comments now complete the study.

7(6) Accounting for Sudden Death

> It is the duty of coroners to investigate the death of the deceased and not, as some of them seem to think, the lives of the living. Even an inquest can be too inquisitive.*

The words above, written in the 1930s, serve as a reminder

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* From A.P. Herbert's criticism of "Dr. Busy", the coroner: quoted in Rights (1980, 6).

that criticism and controversy surrounding the work of the coroner are not only recent phenomena. Indeed, one might consider this case from the year 1249:

> Robert the son of Henry Badding, in climbing up a hayrick in Segre meadow, fell from the rick so that he broke his neck ..... William Skywe, accused of the death of Robert, comes and denies the said death ..... The jurors say he is guilty of the said death, for they say that Robert fell from the rick on to William Skywe and William, startled by this, struck Robert twice on the head with his staff, so that he killed him. But they say that William did not do this in felony but rather out of witlessness because he is under age being twelve years old. So it is awarded that William be taken into custody and this case be told the King etc. It is testified that Henry of Hertham the coroner received one mark to conceal this matter. Henry himself is present and cannot deny this, so he is in mercy.
>
> (Rothwell, 1975, 836)

As noted in the introduction to the present study, the late 1970s and early 1980s have involved the coroner and the inquest in several controversial cases. Public discussion has focussed upon the proper role of the coroner and the nature of the inquest proceedings and verdict. This study has not been concerned with any policy or quasi-political matters. Let us note merely that, firstly, the history of the coroner system is a history of controversies, conflicts, statutory changes and changing functions, and, secondly, that 'policy' debates which refer only to the formal procedural model of the inquest, and the statutory powers of the coroner, thus leaving out of account the organisational processes described in the study, are bound to be seriously incomplete.

However, the interests of the present study have been rather different. A sociological study of the work of the coroner as a whole has been presented. Commencing with a description of the

historical context, research proceeded by interviews with coroners, observation of the coroner's inquest, and consideration of the statistics of coroners' work. The main conclusions have been presented chapter-by-chapter. It was then possible to situate coroners' work in the context of the wider cultural and bureaucratic arrangements for dealing with death in general. Some additional concluding comments can now be made.

In the introduction to the study it was suggested that a coroner system exists in three senses: firstly, coroners' activity constitutes a recognisable (although not discrete) social system; secondly, the inquest is a formal inquisitorial system for classifying sudden deaths; and thirdly, coroners' categorisations have a systematic nature. It can now be added that the coroner system is itself one part of the State bureaucratic system for handling death, and that the systematic nature of the certification, registration and disposal of deaths is linked to the day-to-day demands of the industrial State. The medicalisation and routinisation of coroners' work is consistent with the bureaucratic ideology of society, and 'coroners' work' per se cannot be isolated from this context. Nor can the coroner system be isolated from the police system or the medical system which themselves constitute part of coroners' work. Any sociological approach to coroners' activity, then, must to some degree take into consideration the operation of systems-within-systems, and the points of contact and overlap between coroners' work and others' work.

It might also be noted that the 'contexts' in which coroners' activity is to be located for the purposes of sociological study are numerous: the historical development of the office of coroner; the legal framework; the informal/conventional framework; the

development of police work; the development of medicine (and specific elements such as the post-mortem examination); the dominant cultural ideas about death within society; and, of course, the procedures for dealing with death in general. Again, a sociological approach to the work of the coroner must, at the very least, be aware of such contexts.

The introduction to the study referred to the relevance of coroners' accounts in terms of: verdicts as accounts of sudden death; verbal accounts presented at inquests; statistical records as overall accounts of coroners' activity; and the accounts of their own work offered by coroners at interview. The central importance of 'accounting' is to be emphasised. Further study of the work of the coroner might usefully explore the coroner's production of information; the transformation of categorisations into permanent written records; the binding nature of the coroner's production of the social reality of sudden death when represented by 'official statistics'. All these are aspects of 'accounting' which are of sociological relevance. The relationship between the production of accounts and the exercise of social control might also be productively developed: through detailed description of accounting processes.

There appears to be no reason for further consideration of accounts to be confined to inquest verdicts. Even when the coroner uses form A or form B procedures, he is involved in accounting for the sudden death at hand. It is more difficult to collect detailed information on such non-inquest cases but that does not diminish their sociological importance.

The inquest itself may perhaps be approached by the sociologist in two possible ways: firstly, as a necessary element in the study of coroners' work; and/or secondly, as a court of law,

warranting study in its own right. The latter area is a potentially rich and largely uncharted region for further study. It is of interest to note, for instance, that although the inquisitorial system is at variance with the adversary system in British courts of law as a whole, the inquisitorial model in fact underlies the judicial systems of many continental countries (Roshier and Teff, 1980, 163-164). The inquest jury is another topic of potential relevance.

The study has aimed to render the processes of categorising sudden deaths 'visible'. An attempt has also been made to render the assumptions, methodology and development of the study similarly 'visible'. In exposing processes of categorisation to the methods of sociological description, it has been possible to examine the coroner's construction of the true-story of sudden deaths. In producing the true-story, the coroner is constructing the reality of sudden death. This process signifies more than giving meaning to this or that particular death: in two senses. Firstly, the coroner employs systematic methods in the production of accounts. Secondly, the coroner is engaged in producing the officially-sanctioned reality of a substantial number of all deaths in England and Wales and thus completing the <u>total</u> account of what is otherwise the routine responsibility of general medical practitioners, i.e. the 'facts of death'.

It has been seen that there has been a steady decline of the coroner's powers in criminal law. There has been a medicalisation of coroners' work. The functions of the inquest have changed massively over the centuries, yet its formal structure has altered, in comparison, only in details. There has arisen a disjunction between the formal and the informal elements of coroners' work, a distinction between the legal/

procedural elements and those based in convention and negotiation. The coroner himself has retained a considerable authority, but has fewer areas in which it can be specifically exercised. Coroners' discretion, and the differing perceptions of individual coroners about the very nature of their work, would appear to be central areas for further sociological study of the work of the coroner.

Luckmann wrote:

> The social sciences face a basic theoretical and methodological problem. The human world, whatever else it may be, is a man-experienced world and in part a man-made world. The objective features of historical social realities rest in some fashion on universal structures of subjective orientation in the world. But precisely how they rest on them, and what precisely these structures are, seem to be questions that an empirical science is not equipped to answer. These questions may be taken as the point of articulation between phenomenology and social theory.
> (Luckmann, 1978, 10-11)

Death, of course, is a pervasive feature of the experienced world. 'Sudden death', viewed as organisational product, is an important element of the socially constructed world. The seemingly objective facts of sudden death are linked to subjective and interactive processes and, more generally, coroners' accounts are central elements of routine knowledge about death in society. Sociological research has, from these bases, substantial areas in which to proceed.

APPENDIX I

Further Methodological Details

Statistical Search Twenty-seven visits were made to the 'City' coroner's office to search through statistics from handwritten ledgers. This element of the fieldwork took place between July and November 1979.

Observation Fifty inquests were attended in 'City' between March and November 1977. These were held at three locations in City.

The additional inquest - referred to in Chapter Four as Inquest F - took place in another jurisdiction in July 1978.

Further inquests were attended informally in City in June 1979.

Interviews Seven interviews (six with coroners and one with the coroner's officer) were conducted in February, March and April 1978. The remaining eight interviews were conducted in August, September and October 1979. The interview questionnaire is reproduced below.

INTERVIEWS

name of coroner:

jurisdiction:

date of interview:

1) How long have you been a coroner?

2) Are you a full-time or part-time coroner?

3) IF PART-TIME: are you also ..... a doctor?

a solicitor?

a barrister?

other?

do you have any other professional qualifications?

IF FULL-TIME: what was your occupation before becoming a coroner?

do you have any other professional qualifications?

4) Do you see the coroner's job as part of:

the legal system?
the judicial system?
the medical system?
none/several of these?
..... comments? .....

5) The inquest - do you see this as a court of record in contrast to a 'law court' or court of trial?

6) The coroner's officer -

1) how much of the everyday work of the coroner's office are your officers responsible for?

2) do the same police officers regularly serve as your officers?

3) to what extent does the coroner's officer act on his own initiative - e.g. in arranging post-mortems or inquests?

4) do you consider it necessary that the coroner's officer be drawn from the police: or could the job be done by a trained civilian?

5) have you ever disagreed with one of your officers about how to deal with a particular case, or about the verdict at an inquest?

6) do you have any comments/opinions on the role of the police generally in relation to coroners' work?

7) The pathologist -

1) do you establish regular working relationships with particular pathologists?

2) have you ever experienced any difficulty in getting a post-mortem examination done?

3) how 'routine' is the ordering of a post-mortem examination: are there sorts of cases where a post-mortem would be carried out as a matter of course?

4) do problems ever arise in the interpretation of p.m. reports?

5) how significant is the post-mortem report for your decision about a particular death - would it be particularly important at an inquest, or in a 'pink form B' case?

8) Pathology and medicine -

1) advances in medical knowledge and pathology seem to be making <u>medicine</u> an increasingly important element in the work of the coroner - do you welcome this development, or do you think it undermines the traditional authority of the coroner?

2) what do you see as the advantages/disadvantages of the American medical-examiner system, where the coroner's work is done by someone trained in pathology, and the emphasis is purely 'medical'?

9) What do you see as the <u>most important</u> part of your work?

the inquest?
pink form A?
pink form B?
informal contact with doctors and others?
..... comments? .....

10) The inquest -

1) what do you see as the <u>main purpose</u> of holding an inquest?

to rule out criminality?
to discover exact <u>cause</u> of death?
to discover circumstances of the death?
some other purpose? (specify)

2) are you happy with the <u>public</u> nature of the inquest - or should it be a private inquiry?

3) what is your opinion of the Press, and newspaper reports of coroners' cases?

4) do you think the <u>jury</u> serves any useful purpose at an inquest?

5) are you ever conscious of any external pressure - - such as, from the family of the deceased, or from the police -- towards you bringing in a particular verdict at an inquest?

6) do you usually have a fairly clear-cut idea of what the inquest verdict is likely to be <u>before</u> the inquest begins -- for instance, are road accidents, or suicides, fairly 'obvious' from the start?

7) suicide -

a) do you use the phrase 'while the balance of mind was disturbed?'
- why/why not?

b) what sorts of evidence do you look for in arriving at a suicide verdict?

a suicide note?
a history of ill-health?
evidence of depression?
previous suicide attempts?
other factors? (specify)

c) the decline of domestic gas as an agent of suicide has been matched by an increase in self-poisoning as a method of self-destruction -- what are your comments on this development?

d) do you have any personal theories of suicide -- of 'why people do it'? - do you think men and women commit suicide for broadly similar, or different, reasons? definitions?

e) the suicide rate in this country is falling -
why do you think this is so?
have the Samaritans been important?
is it related to changes in methods of suicide?

f) 'attempted suicide' seems to be increasing -
why do you think this is so?

8) in what sorts of circumstance would you record an <u>open verdict</u>?

9) what are the functions of the solicitors and senior police officers who attend inquests?

11) As a coroner, how much <u>discretion</u> do you exercise in your work - for instance, in accepting a referral; in deciding which procedure to use?

12) How do you see your job, as a part of the whole process of death certification and registration in this country .....? (open-ended ..... comments .....)

13) The duties of the coroner have greatly changed over the centuries, along with changes in the law, medicine, society and so on.

1) do you think the coroner system will continue to change and adapt - or will a time come when another sort of system will be introduced?

2) what sort of changes (if any) relating to coroners would you personally advocate?

14) That completes the interview as such - are there any points or comments you wish to make about the topics we have covered or about other issues?

15) Interviewer's notes.

APPENDIX II

Additional Statistics 1976-1982

The statistics relating to the work of the 'City' coroner, discussed in Chapter Five, were collected by a manual search of records in the coroner's office. Aside from these local statistics, almost all statistical material presented in Chapter Five was drawn directly or indirectly from Home Office sources, i.e. published national statistics up to the year 1969 contained in the Report of the Committee on Death Certification and Coroners - the 'Brodrick Report' - (1971); and unpublished statistics covering the years 1970 to 1975, obtained from the Home Office.

In 1981 the Home Office began to publish annual statistical summaries of coroners' work for the first time (see Home Office 1981; 1982; 1983). Although these published statistical summaries do not include some details to which we were able to refer in Chapter Five by using unpublished figures (e.g. breakdown by individual jurisdiction), they do present total numbers of form A and form B cases, inquests held and verdicts returned, and the particular verdicts recorded. The summary of coroners' statistics from 1976 to 1982, appended here, is drawn from the published statistical bulletins. It might be considered in conjunction with the statistics for the years 1926 to 1975 presented above. Inclusion here provides further material for any future consideration of the statistical products of coroners' work.

Discussion. The intended purpose of this appendix was to provide some simple descriptive statistics for the period 1976

to 1982, without further discussion, for possible future use. However, certain features of the statistics are problematic and require brief comment.

1) The statistics collected here as tables A1 and A2 are approximate. They are reproduced from the published sources which were, in their original form, approximate and simplified. This need not be an essential problem, but it is a matter of which to be aware.

2) There is a divergence between the figures for suicide presented at table 5(5)1 above, and the figures for suicide presented at table A3, in respect of the years 1976 to 1980. (During this period, the annual divergence between the two sets of figures ranged between 19 and 50 'suicides'). Indeed, for these years the Chapter Five suicide figures derived from one published source (Central Statistical Office (1981; 1983)) were consistently <u>higher</u> than the suicide figures derived from another published source (Home Office, 1983). Different accounting procedures are evidently being used and the discrepancy may partly lie in the Central Statistical Office's use of the category of deaths caused by "suicide and other self-inflicted injuries". Yet, if this is so, it is by no means clear where such 'extra' cases of suicide came from: apparently not from a simple reading of coroners' verdicts. The periods of time for annual totalling may, of course, have varied. Whatever account is offered, this particular example of statistical difficulty and apparent imprecision only reinforces the emphasis placed, throughout the study above, on the importance of the rate-producing process. Perhaps further considerations of suicide statistics might first address the question: which suicide statistics? More is said of this below.

TABLE A1: DEATHS REPORTED TO CORONERS 1976-1982*

YEAR	TOTAL DEATHS REGISTERED ENGLAND & WALES	TOTAL DEATHS REPORTED TO CORONERS/PERCENTAGE OF TOTAL NATIONAL DEATHS	
1976	589,500	160,700	27.3%
1977	575,900	158,400	27.5%
1978	585,900	166,600	28.4%
1979	593,000	171,300	28.9%
1980	589,200	170,200	28.9%
1981	578,100	173,600	30.0%
1982	590,000	174,300	29.5%

* Derived from Home Office summary of coroners' statistics (1983,6). The rounding-off of total figures occurs in the original: where some of the totals for deaths registered are noted to be provisional. The above figures should therefore be seen as an approximation for the purposes of simple summary.

TABLE A2: FORM A, FORM B AND INQUESTS, 1976-1982*

YEAR	TOTAL DEATHS REPORTED TO CORONERS	TOTAL INQUESTS HELD/PERCENTAGE OF DEATHS REPORTED		TOTAL FORM A CASES/ PERCENTAGE OF DEATHS REPORTED		TOTAL FORM B CASES/ PERCENTAGE OF DEATHS REPORTED	
1976	160,700	23,400	14.6%	21,300	13.3%	116,100	72.2%
1977	158,400	22,900	14.4%	21,700	13.7%	113,800	71.8%
1978	166,600	23,700	14.2%	23,900	14.3%	119,000	71.4%
1979	171,300	23,800	13.9%	26,300	15.4%	121,300	70.8%
1980	170,200	23,100	13.6%	28,600	16.8%	118,500	69.6%
1981	173,600	22,900	13.2%	30,800	17.7%	119,700	69.0%
1982	174,300	23,000	13.2%	32,100	18.4%	119,100	68.3%

* Derived from Home Office summary of coroners' statistics (1983, 6-7). Again, the rounding-off of figures occurs in the original. It can readily be seen that the total figures for inquests, form As and form Bs for the years 1976, 1979, 1981 and 1982 do not in fact add up to the 'total deaths reported to coroners' reproduced here. Such figures are quite clearly of approximate value only. Percentages have been calculated from the 'total deaths reported' to the nearest decimal point.

TABLE A3: CORONERS' VERDICTS 1976-1982*

VERDICT	YEAR 1976	1977	1978	1979	1980	1981	1982
a) Unlawful Killing†	(112)	(74)	89	93	76	113	138
b) Lawful Killing††	(1)	(2)	(-)	(4)	2	6	2
c) Execution of Death Sentence	-	-	-	-	-	-	-
d) Suicide**	3,769	3,909	4,003	4,145	4,282	4,471	4,356
e) Attempted/Self-Induced Abortion	-	-	-	-	-	-	-
f) Lack of Care/Self-Neglect	47	51	55	65	57	43	41
g) Chronic Alcoholism	395	372	457	524	669	703	712
h) Addiction to Drugs	44	54	74	95	65	57	91
i) Want of Attention at Birth	16	15	19	14	10	16	18
j) Industrial Diseases	784	784	764	809	787	862	1,002
k) Accident/Misadventure	13,453	12,843	13,778	13,533	12,700	12,232	12,189
l) Natural Causes	1,647	1,752	1,690	1,747	1,810	1,692	1,810
m) Still-Born	6	3	4	7	11	7	11
n) Open Verdicts/'All Other Verdicts ***	1,983	1,860	1,868	1,886	1,966	1,890	1,958
TOTAL VERDICTS RETURNED	22,257	21,721	22,801	22,922	22,435	22,092	22,328
o) Adjourned and not Resumed	1,135	987	823	750	727	762	791
p) Treasure Trove	32	29	45	52	57	59	51

† 'Unlawful killing' superceded murder, manslaughter and infanticide from the beginning of 1978.

†† 'Lawful killing' superceded justifiable or excusable homicide during 1980.

* Derived from Home Office summary of coroners' statistics (1983, 8-9).

** These figures for suicide do not correspond to those covering the period 1976 to 1980 presented in Chapter Five, and originating from a different source, i.e. Central Statistical Office (1981; 1983) See discussion.

***The published figures indicate no open verdicts between 1976 and 1980 - the figure occurs instead within 'all other verdicts'. For 1981 and 1982 the published statistics revert to previous practice. The figures are merged here for clarity.

3) The published Home Office material from which tables A1, A2 and A3 are drawn includes some observations on coroners' work in general. It might be particularly noted that the number of deaths reported to coroners, as a proportion of all deaths in England and Wales, continued to increase during the period 1976 to 1981. This tends to support the conclusion of the preceding study that coroners' work is becoming an ever-more central part of the system for dealing with deaths in general. Table A2 suggests that this increased number of coroners' cases has been located to a disproportionate degree in 'Form A' cases. The commentary attached to the published statistics suggests that this development may be partly accounted for by

> the growth in deputizing services, so that the doctor who attended at or after death was not the deceased's medical attendant.
>
> (Home Office 1983, 1).

Hence, such deaths could not be routinely certified and registered, and would tend to become coroners' 'Form A' cases. The <u>total</u> number of deaths reported to coroners has thus expanded. More generally, an earlier statistical bulletin notes:

> The number of deaths reported to coroners rose by over a quarter from 1970 to 1980 and increased from 23 per cent to 29 per cent of the total number of deaths registered. The increase was in those deaths on which no inquest was held.
>
> (Home Office 1981, 1)

The relative decline of the inquest as a part of the coroner's total work is again of relevance. One might, less centrally, wish to note the perhaps surprising increase in the number of cases of treasure trove dealt with by the coroner during the late 1970s and early 1980s. The establishment of the Treasure

Trove Reviewing Committee in 1977 may have had a bearing on the number of subsequent 'finds'. Treasure trove, of course, is a continuing reminder of the ancient origins of what is today an element of the everyday bureaucratic system for dealing with death.

4) The discrepancy between suicide statistics obtained from different sources might be considered in a little more detail. It may be due in part to the use of I.C.D.* categories in some published sources - which would not be reflected in simple counts of coroners' suicide verdicts. The I.C.D. is commonly used for comparisons, on a standardised basis, of mortality statistics and the incidence of fatal diseases between different countries. What is of interest is that I.C.D. categories are periodically revised, and their 'catchment' is thus widened or narrowed accordingly. Bulusu and Alderson draw attention to the 8th revision of I.C.D. categories which introduced a classification called "suicide by late effects of self-inflicted injury". (Bulusu and Alderson, 1984, 12). Although it is pointed out that the category "rarely contains any deaths", an identifiable point of contrast between coroners' totalled returns to the Home Office and standardised classifications of suicide is introduced. Another relevant I.C.D. category, in this respect, is "suicide by other and unspecified means".

5) The I.C.D. refers to all manner of mortality statistics, and not only those which are relevant to deaths dealt with by the coroner. It might be noted (for the purpose of future work based on mortality statistics) that the 9th revision of

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* International Classification of Diseases

the I.C.D. was made in 1975 and accepted in England and Wales at the beginning of 1979: thus many areas of statistical material on mortality are from 1979 onward not precisely comparable with earlier years at all (Office of Population, Censuses and Surveys, 1984, 54).

6) To conclude our comments on the inconsistencies of suicide statistics, brief reference can be made to Bulusu and Alderson's statistical review (1984). They refer to "the total number of deaths by suicide in England and Wales" as 5,714 in 1963, 3,693 in 1975, and 4,279 in 1982 (Bulusu and Alderson, 1984, 11). These figures are all <u>lower</u> than the suicide statistics for the same years cited within the preceding study: table 5(2)4 indicates total suicide verdicts of 5,727 in 1963 (Source: Brodrick Report, 1971, 386-387); table 5(2)4 also indicates total suicide verdicts of 3,717 in 1975 (Source: unpublished Home Office statistics); and table A3 indicates a total of 4,356 suicide verdicts 1982 (Source: Home Office, 1983, 8-9). This apparent problem in fact brings understanding closer, by pointing to the sources used for each of the figures. Throughout the preceding study, suicide statistics have referred to total numbers of coroners' verdicts of suicide recorded in a particular year - derived directly or indirectly from coroners' returns to the Home Office. Given the central interest in coroners' verdicts, this of course is precisely the relevant figure. Bulusu and Alderson's accounting procedure, however, gives them lower annual totals. Evidently such totals are not collected directly from coroners' verdicts. Factors referred to above (the basis for annual totalling, the use of standardising classifications) may of course also be relevant. Indeed, Bulusu and Alderson proceed from the totals of "deaths

by suicide" referred to above to further present adjusted totals, adopting a calculation for constant population size. (Bulusu and Alderson, 1984, 11). Yet another version of annual suicide statistics is thus produced. To add a final point to this complexity, as we noted above some published sources (Central Statistical Office (1981; 1983)) yield suicide statistics which are higher, not lower, than the number of coroners' verdicts of suicide notified to the Home Office. Here, use of I.C.D. categories and other standardised classifications, along with their periodic revision, may be relevant in expanding the figure derived from coroners' returns to the Home Office.

7) The problems associated with the use of statistical material relating to coroners' work are complex but not impenetrable. Indeed, it is of some relevance to the perspective of the study as a whole that so many versions of statistical reality are possible. Future work on the rate producing process might consider the minutae of classification systems alongside the substantive theoretical and methodological issues in sociology. Future work on the statistics presented in the study, referring to coroners' work from 1926 to 1982, has considerable scope for further exploration of the rate-producing process, and of the manner of assembly of official statistics - from wherever those statistics originate.

8) Underlying any consideration of the statistics of coroners' work are the changing powers and duties of the coroner and the coroner's jury. Verdicts are abolished and other verdicts introduced. The meaning of the same verdict may undergo considerable change. It can finally be noted that from 1st. July 1984 juries became unable to record a verdict of

"lack of care" (see row (9), table 5(2)4); row (f), table A3) except where it is recorded as an addition to one of the four specific verdicts of natural causes, industrial disease, addiction to drugs or want of attention at birth. The change occurred through amendment to the Coroners' Rules and, like some earlier changes, perhaps had the object of curtailing the use of a verdict which implied censure. Without doubt, the meaning of particular verdicts, and from time to time their availability, will continue to be subject to change. 'Additional statistics' for years to come may need to take into account yet further changes.

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