Public Inquiry into the Identification of Victims following Major Transport Accidents

Report of Lord Justice Clarke

Volume 1

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1. Introduction

1.1 This is the fourth report that I have made arising in one way or another out of the collision between the BOWBELLE and the MARCHIONESS and its tragic consequences. The first three were the interim and final reports of the Thames Safety Inquiry (‘TSI’), which were published to Parliament as Cm 4350 and Cm 4558 on 2nd December 1999 and 19th February 2000 respectively, and the report of the formal investigation (‘FI’) into the collision and its consequences which I have completed much more recently. Fifty-one people lost their lives as a result of the collision and its aftermath. Some of their bodies were recovered from the wreck of the MARCHIONESS and some from the River Thames. It was of course necessary to identify them.

1.2 In the course of the identification process, the hands of a number of the deceased were removed. When the relatives subsequently discovered that that had happened they were naturally very distressed and, almost ever since then, have been pressing for a public inquiry into the circumstances in which that occurred and into identification procedures for the future. In the course of my final TSI report I considered whether a public inquiry should be held. In paragraphs 12.21 to 12.33 and 13.37 to 13.41 of that report I gave my reasons for concluding that it should not. However, the Deputy Prime Minister, the Rt Hon Mr John Prescott MP, took a different view and on 14th February 2000 asked me to conduct an inquiry on a non-statutory basis. I accepted.

1.3 This inquiry is entitled an inquiry into the identification of victims following major transport accidents. My particular terms of reference are in these terms:

1. To consider and report on the procedures followed to establish the identity of the victims of the collision between the BOWBELLE and the MARCHIONESS.

2. To review and to report on the procedures currently followed when establishing the identity of victims following similar accidents.
3. In the interests of minimising distress to the families of the victims:

(1) to advise on what additional procedures should be followed, if any, when the need to identify victims arises following similar accidents, and

(2) to consider and advise on procedures for the notification and involvement of the next of kin in cases when it is necessary to establish the identity of such victims.

1.4 In attempting to respond to those terms of reference I shall disregard the preliminary views which I expressed in my TSI report. I shall consider paragraph 1 of the terms of reference in what I have for convenience called part one of the inquiry. In the course of the interlocutory activity which led to the hearings and public debate in November and December 2000 I categorised paragraphs 2 and 3 as forming part two of the inquiry, but it now seems to me to be more sensible to consider paragraph 2 of the terms of reference as part two of the report and paragraph 3 as part three.

2. Significance of Issues

2.1 The terms of reference raise questions relating to the past, the present and the future. In so far as they relate to the past, they have, perhaps inevitably, involved a number of criticisms being advanced of those concerned, or said to be concerned with the decision or decisions to remove hands for identification purposes. I shall consider those criticisms in the course of this report and it is right to say that a significant part of what I have to say in part one below is concerned with them. However, as the title to the inquiry shows, the essential purpose of it is not to dwell on the past but to consider identification of victims following major transport accidents in the future.

2.2 In this context the past and the present are important in so far as they assist with the problems of identification after the mass transport accidents of the future. The last 15 years have seen a distressing number of such major accidents and, as appears below, many lessons have been learned. Nevertheless this inquiry has prompted responses from a considerable number of people and organisations
with experience in the field and has enabled me to make a number of recommendations which I hope will be of assistance in the future.

2.3 In making oral representations on the penultimate day of the inquiry Charles Haddon-Cave QC, who represented the Marchioness Action Group (‘MAG’), said this:

The care with which our dead are treated is a mark of how civilised a society we are. Much goes on for understandable reasons behind closed doors. For this reason there is a special responsibility placed on those entrusted with this work and the authorities who supervise it to ensure that bodies of the dead are treated with the utmost care and respect. That is what bereaved and loved ones are entitled to expect and what society at large demands.

I entirely agree with those sentiments. Respect for the dead and for the relatives of those who have died, especially where the death has been unexpected, is indeed the mark of a civilised society and should be the touchstone against which each question which arises should be determined.

3. Procedure and Approach

3.1 I appreciate that removal of the hands from the deceased caused a great deal of distress which has caused harsh things to be said over the years. The purpose of this part of the inquiry is not, however, to afford an opportunity for recriminations, but to identify what occurred and, where appropriate what went wrong, partly in order to set the record straight and partly in order to inform part three of the inquiry with a view to ensuring so far as possible that the best possible procedures are adopted in the future.

3.2 With these ends in view I have tried to avoid an adversarial approach to this inquiry, although I recognise that the process has inevitably involved criticism or potential criticism of those who played a part in the decision to remove the hands of so many of the deceased. That is not I think surprising given the profound shock of many of the families of those who died when they discovered what had happened.
3.3 It seemed to me from the outset that the appropriate course was to treat this non-statutory inquiry (‘NSI’) as inquisitorial and not adversarial. In paragraph 11.60 of my final report in the TSI I expressed the view that inquiries should be inquisitorial in nature and I have repeated that view in the report of the FI, which I hope will be published at about the same time as this report. In this particular NSI, given the fact that many of the interested groups and persons were represented, it seemed to me to be appropriate to invite those who wished to advance criticisms of others to do so, in order to ensure that I considered the points which they wished to make and at the same time to ensure that all those against whom criticisms were advanced would have a fair opportunity to respond to them.

3.4 There were thus no parties to the NSI, but only participants. A list of participants and their representatives is included in Annex A to this report. So too is a dramatis personae and a list of the witnesses who provided statements to each part of the inquiry. It seemed to me to be appropriate for the vast bulk of the evidence to be documentary, but to hear some oral evidence. A list of the witnesses who gave oral evidence is also included in Annex A.

3.5 So far as witnesses who gave evidence in part one are concerned, I would like to thank them all, but, in particular I would like to thank the members of the families who gave evidence and I would like to thank Dr Paul Knapman. This inquiry was only set up after and as a result of many years of pressure from the families of many of those who lost their lives. Their written and oral evidence contains a powerful and poignant account of their concerns, which I found both valuable and moving. Those family members who gave oral evidence were (in order of their evidence) Margaret Lockwood-Croft, Shirley Bourke, Peter Bourke, Eileen Dallaglio, Angela Bensemann, Sally Smith, Lucy Garcia and Judy Wellington.

3.6 I have mentioned Dr Knapman in particular because I know that he has been the subject of criticism over the years, sometimes in harsh terms. He was the coroner who was principally concerned with the processes of identification. As coroner, his role was at least in part judicial and, in these circumstances, he was initially reluctant to give oral evidence. He would have been fully entitled to do so because, since this is an NSI without any powers of any kind, no-one was or is compelled by law to assist the inquiry, whether orally or in writing. However, in the event Dr Knapman decided to assist the inquiry, not only by providing a
considerable amount of written material, but also by coming to give oral evidence and I would like to thank him for doing so.

3.7 In the event most of those concerned with the various decisions at the time gave either written or oral evidence or both. I would like to thank them for doing so because it cannot be stressed too strongly that an NSI of this kind cannot sensibly proceed without the co-operation of all those concerned. Such an inquiry will almost always involve a consideration of the workings of government or of the public service. It seems to me that a person holding an NSI at the request of the relevant Secretary of State can reasonably expect all public servants with evidence to give, including those who may be criticised, to assist the inquiry as appropriate. I am pleased to say that I have received extensive co-operation for which I am very grateful.

3.8 The only witnesses of potential importance who are still alive and who did not provide any evidence are Bernard Sims, the odontologist, Detective Chief Superintendent Michael Purchase, who was the senior police officer concerned with identification, and Detective Inspector George Raison, who also played a significant role in that regard. However, Mr Sims is too ill to be able to help and I understand that DCS Purchase was unwilling to assist because of serious family illness and that DI Raison was not fit to do so. Detective Superintendent Alan Lewis, who also played a role in the identification process and who now lives out of the jurisdiction, was unwilling to give oral evidence or to sign a statement but he did provide information to the police, which was made into a draft statement which is before the inquiry. Detective Chief Inspector Kenneth Collins, who was in command of the police relative liaison officers, has died since the relevant events. Mr Robert Thompson of the Westminster mortuary staff gave oral evidence. Mr Manuel Pereira, who was the acting mortuary manager at the time, provided a statement but did not give oral evidence because of stress.

3.9 Although it is a pity that evidence was not available from Mr Sims, DCS Purchase, DI Raison and Mr Pereira, there was enough evidence to enable me to have reasonable confidence that the facts set out below are correct.

3.10 I would like to thank all counsel and solicitors for their assistance. It would be invidious to name only some, but perhaps I can be excused for thanking Sarah Winfield who represented the solicitor for the Metropolitan Police Service (‘the MPS’), and thus the MPS, for all her help in the preparation of the evidence. I
would also like to express my particular thanks to the NSI secretariat and counsel to the inquiry. As in the case of the FI, I have been very lucky to have the assistance both of the secretariat led by Bill Sandal, Nathali Veitch and Beth Griggs and of counsel, namely Nigel Teare QC, David Goldstone and Samantha Leek, to whom I am particularly indebted for the preparation of a series of schedules which the other interested parties have been able to consider in detail and have agreed.

3.11 There is a further group of people who deserve my thanks. They are the counsellors who assisted the families during the inquiry, which must at times have been a very emotional experience for them. There were times when it was emotional for us all, but for those whose memories were of their children as young and vibrant human beings it must have been extremely distressing. A list of the counsellors who helped is included in Annex A.

3.12 A considerable amount of documentary material and written submissions was received from many quarters, for which I am very grateful and from which I have learned a great deal. In this regard, while (except to a limited extent in the course of the TSI) this is the first time that I have ever given any consideration to the problems of identification after death, many of those who made submissions or other contributions have a great deal of experience. Much of that experience has been gained in dealing with the major transport casualties of recent years. I hope that they will forgive any errors which appear in this report, for which I take full responsibility. A list of the documentary and written submissions is also included in Annex A, as is a list of those who contributed to the public meeting on 18th December 2000.

3.13 During the course of the NSI I was invited to visit Westminster mortuary, which I did on 29th November together with the inquiry team. I found the visit most useful and would like to thank Alex Parker-Brown, who is the mortuary manager and who showed us around, for his courtesy and the thorough way in which he answered our questions. We also visited the Coroner’s Court and the offices of the coroner’s officers, which are next door to the mortuary and which we found very interesting. I would like to thank Dr Knapman for allowing us to make the visit and also, in particular, Elizabeth Riley, one of the coroner’s officers, for her informative guided tour and for answering all of our questions. As a result of the visit we were better able to picture the situation in the coroner’s offices and mortuary when evidence was given as to what was happening there in the aftermath of the collision.
3.14 We also attended New Scotland Yard at the invitation of the MPS and were shown around the Central Command Complex by Chief Inspector Peter Doolan, who was in fact duty manager for the Central Command Complex at the time of the casualty. I am grateful to PC Graham Hardy and the other officers to whom we spoke for the very thorough tour of the Information Room, Casualty Bureau and Special Operations Room (GT), all of which gave us a useful insight into the way in which a disaster was and would be managed from the police side.

4. Particular Concerns

4.1 In the course of their evidence the members of the families highlighted a number of particular concerns, the most important of which seem to me to be these:

- the removal of the hands for identification purposes at a time when identification by non-invasive means was likely in the near future;

- the failure of anyone in authority to inform the relatives that the hands had been removed;

- the refusal to allow the relatives to view the body;

- in some cases, the return of the body without the hands;

- the failure thereafter to return the hands to the body;

- in one case the disposal of hands which were discovered much later without informing the relatives and without their authority;

- the issue of inaccurate and insensitive interim death certificates;

- a lack of detailed information available to families; and

- a lack of overall co-ordination of the identification procedures.
4.2 That is not a complete list of the points highlighted by the evidence from the families, to which I shall refer further below. It does, however, serve to underline issues about which most members of the public would be seriously concerned. It is to my mind important to have in mind throughout that most members of the public have no knowledge or experience of the sudden death of a relative or loved one and are likely to be very distressed on learning of the possibility that a loved one may have been the victim of a disaster such as occurred on 20th August 1989.

4.3 I shall of course return to this below, but it seems to me that the principal lesson which can be learned from this and other major disasters is the importance of respecting the dead and their relatives, of acting with sensitivity throughout and of ensuring that (save where a compelling public interest requires otherwise) full, honest and accurate information is given to relatives at every stage. I recognise that many of these lessons have already been learned over the past 11 years since 1989, but the evidence in this inquiry has underlined them and, having been asked to conduct it, I may perhaps be excused if I emphasise them in this report.
Part One: The Past

5. First Steps

5.1 The collision between the BOWBELLE and the MARCHIONESS occurred at about 0146 on 20th August 1989. It was evident from the outset that there had been considerable loss of life and in the event 51, mostly young, people lost their lives. It was not, however, apparent at the outset how many fatalities there would be.

Recovery of the Bodies

5.2 The first body was recovered from the water in the early hours of 20th August 1989. It was given the number 2600 (and later identified as Carmella Lennon Gorman). Thereafter, a further 26 bodies were recovered from the river, all of which were given the prefix 26 and were numbered from 2601 to 2626. Save for body numbered 2600 these were recovered on and after 22nd August 1989. Twenty four bodies were recovered from the wreck of the MARCHIONESS in the afternoon of 20th August 1989. For identification and continuity purposes they were given the prefix 29 (to distinguish them from those bodies found in the river) and numbered from 2900 to 2923. All of the bodies were first taken to Wapping police station and thereafter to the Westminster mortuary in Horseferry Road. In order to ensure continuity of the bodies, each body was accompanied by at least one police officer from the time of its recovery from the river to the time that it arrived at Westminster mortuary.

Assumption of Jurisdiction by the Coroner

5.3 Dr Knapman is and has since 1980 been the coroner for Inner West London. His jurisdiction encompasses the City of Westminster, the Royal Borough of Kensington and Chelsea, the London Borough of Wandsworth and the London Borough of Merton. A coroner has jurisdiction in respect of bodies ‘lying within his district’: see section 8 of the Coroners Act 1988 (‘the 1988 Act’). As stated above, the first body to be recovered was that later identified as Carmella Lennon Gorman. Her body was recovered from the north side of the Thames between Lambeth Bridge and Vauxhall Bridge. At that time Dr Knapman was in Devon on holiday. While in Devon he was telephoned by DCS Purchase who
told him that the first body had been found, as Dr Knapman put it, ‘on my side of the river at Vauxhall’. Dr Knapman was asked ‘would it be in order if the bodies were brought to Westminster?’ There was no evidence as to Dr Knapman’s response but it is plain that he must have agreed. Dr William Dolman, the then deputy coroner for Inner West London, told me that it was normal for bodies thought to arise from a particular disaster to be brought within the same jurisdictional area. This is what happened on this occasion. Thus Dr Knapman assumed jurisdiction for all those who were thought to have died as a result of the collision. It seems to me that this was an eminently sensible way to proceed since untold confusion would have arisen if all the bodies had been taken to different places and dealt with by separate coroners.

The Involvement of the Metropolitan Police

5.4 As is explained in part two of this report, in any major incident the tasks of controlling and co-ordinating the operation to recover bodies and the collation of information for the purpose of identification fall to the police service from an early stage. This case was no different.

5.5 Thus at 0320 on 20th August the MPS opened the casualty bureau at New Scotland Yard in order to begin the process of receiving information which would assist in establishing the identity of those who had lost their lives in the collision. It first received calls at 1020 on 20th August and remained open until 2200 on 23rd August. An incident room was set up at Cannon Row police station from which the Major Investigation Team ran the criminal investigation. DCS Purchase headed this investigation and was also ultimately responsible for the work on identification being carried out by the police team based at Westminster mortuary and the relative liaison team, also based at Cannon Row (in a separate relative liaison suite). Cannon Row was the co-ordination centre for all of the investigations and used the HOLMES system to log all processes and actions undertaken.

5.6 The casualty bureau was opened by the MPS in order to obtain as much information as possible from the public and from the friends and family of those thought to be on board the vessel, in order to establish the possible identity of those on board, to establish who had survived the collision and thus eliminate them from the identification process and to collate ante mortem information about those people who were thought likely to have died in the collision (ie. to find out as much as possible about the physical description, including clothing,
jewellery and property, tattoos and scarring). The relative liaison officers also
sought information from the family and friends of those thought to have died.
The information received was passed on to the incident room at Cannon Row
where the ante mortem information received from family and friends was
matched with the post mortem information provided by the police teams,
pathologists, odontologist and fingerprint officers working at the mortuary.

5.7 The MPS co-ordinated the removal of bodies and property from the river and
riverbanks and the transportation to the mortuary. In addition to their
involvement in the collation, documenting and matching of the post mortem and
ante mortem information, they provided family liaison services for the families
of the deceased. Thus a team of relative liaison officers was established, under the
command of DCI Collins. A list of those officers has been provided by the MPS.
They were:

WDC Marshall, PS Crump, DC Walshe, DS Waterson, DC
Crampton, DS Maccormack, DC Concannon, DC Lean, DS
Wells, DC Chase, WDC Gooch, DC Jarret, WDC Blewitt, DC
Ashton and DC Hardy.

The relative liaison officers remained at Cannon Row for most of the week
following the disaster. The officers attended the homes of the relatives in addition
to speaking to them on the telephone and seeing them at Cannon Row.

5.8 The particular officers closely involved with the identification process were as
follows. DCS Purchase as ‘gold control’ was in charge of the investigation (as set
out above), Det Supt Lewis was ‘silver’ and DI Raison was in charge of the team
of the police officers at the mortuary. Detective Sergeant Jeffrey Sinnott (the only
police officer to give evidence about identification) reported to DI Raison at the
mortuary and was involved in the identification process. DI Raison was
responsible for briefing DCS Purchase on the progress at the mortuary. The role
of the team of officers at the mortuary was to assist with the continuity of
evidence from the bodies and with their identification. This included
documenting the movement of each body using unique body reference numbers
and documenting all post mortem information on victim identification forms.

5.9 In his oral evidence DS Sinnott said that he accepted responsibility for the acts
or omissions of the police with regard to the identification process, but it is clear
to me that, while he was involved in the process, he was not the police officer responsible for what happened in the mortuary. The officers responsible for the acts and omissions of the police were not DS Sinnott, but DI Raison at the mortuary and ultimately DCS Purchase as gold control. As stated, DCI Collins was responsible for the provision and co-ordination of family liaison services.

5.10 DS Sinnott, described the situation to me as follows:

The incident room set up at Cannon Row was there to collate all this information they were receiving from us and the family liaison team in making comparisons there so that one unit held all the information.

He also explained that the incident room at Cannon Row passed information back to him at the mortuary and he liaised with the coroner’s officers. He said that he was in constant touch with the coroner’s officers and that they were reporting to the coroner and he was reporting to the incident room at Cannon Row. Thus the forms which were being completed at the mortuary documenting all of the details of each of the deceased at the time of the post mortem were being passed back to those working at Cannon Row police station.

*Post Mortem Procedures*

5.11 All of the bodies were taken to Westminster mortuary where they underwent a post mortem procedure. This had two main phases. The first was the identification and documentation of the general features of the deceased, their clothing and jewellery, any other property found on them and any marks or scars. The second was the thorough internal and external forensic examination of the deceased identifying and documenting injuries and identifying features and any natural disease. They were carried out under authority given by the coroner: see sections 19 and 20 of the 1988 Act. The post mortems in this case were carried out by pathologists from Guy’s Hospital, namely Dr Richard Shepherd and Dr Mohammed Patel. Pathological services were always provided to the Westminster mortuary by staff from Guy’s. There was accordingly no specific or express request made by the coroner for post mortems but Dr Shepherd knew that they would be required by the coroner. In these circumstances Dr Knapman correctly assumed that Dr Shepherd knew what was expected of him and so gave no express instructions.
5.12 Fingerprintswere taken at the mortuary from all the bodies recovered from the river except Antonio Vasconcellos. I discuss below the removal of hands for the purposes of fingerprints. Following the post mortems, Mr Sims, the forensic odontologist, charted the post mortem dental information in order to make comparisons with ante mortem dental records.

The Process of Identification

5.13 The process of identification essentially involves the comparison of ante mortem and post mortem information. By 3.05 pm on Monday 21st August the police had reduced to 63 persons the list of those thought to be missing from the MARCHIONESS and collated information on 51 of those persons. The information obtained in the first stage of the post mortem was compared with the ante mortem information collated by police officers from those who had reported missing members of their family or friends. This enabled the police to make a preliminary identification of the bodies which had been recovered.

5.14 Three schedules have been prepared which set out in detail the means by which each of the bodies was identified and the timing of the various identification procedures (including the removal of hands, dental identification and the opening of inquests). They are to be found at Annexes B, C and D respectively. Annex B comprises the first, which lists the deceased alphabetically and sets out in respect of each person, *inter alia*, the body number, when, where and by whom the body was found, where it was taken, how it was identified and whether and when the hands were removed. It was prepared by Samantha Leek. The second schedule (in Annex C) was prepared by Nigel Jacobs on behalf of the MAG and sets out in chronological order in respect of each body from whom hands were removed, the various means of identification which became available and those which were in fact used to identify the body. The third schedule (Annex D) was also prepared by Samantha Leek and gives a chronological overview of when each of the deceased was found, when (if at all) the hands were removed, when (if at all) a dental match was made, when the body was positively identified and when the inquest was opened.

5.15 In addition to those three schedules, a chronology has been prepared, yet again by Samantha Leek. It is annexed at Annex E. The contents of all three schedules and the chronology have now been agreed. Like all the annexes, they should be treated as an integral part of the report because, except where it seems to me to be
really necessary, I shall not repeat the facts stated in them in the main body of the report.

5.16 Since I have been asked to report on the procedures used to identify the victims of the collision I shall describe the means by which each of the deceased was in fact formally identified. This does not mean that the evidence which was accepted as proving the identity of a particular individual was the only evidence available to identify them. I shall deal in due course with the removal of hands for the purposes of taking fingerprints where other identification material was available or likely to become available imminently.

5.17 The bodies recovered from the wreck of the MARCHIONESS and body numbered 2600, which had been recovered from the river before the raising of the wreck, had not been in the river for a long period and were judged suitable for visual identification. Thus, as can be seen from the schedule in Annex B, the following 25 bodies were visually identified at Westminster mortuary by family or close friends on 21st, 22nd and 23rd August:

David Ayres, Sophie Bennett, Rupert Blackburn, Paul Brookman, Isla Carroll, Tamsin Cole, Sheila Daubeney, Luis de la Huerta, Lino di Girolamo, Marino Drusetta, Michael Gatehouse, Ruth Hadden, David Highfield, Lee Hunt, Julie Ibbotson, France Langlands-Pearse, Carmella Lennon Gorman, Dianne Lim, Neville Lovelock, Dean Palmer, Stephen Perks, Angela Plevey, Vida Shamash, Julian Tremain and Linda Webster.

As a result the inquests into those deceased were opened on 22nd and 23rd August 1989 after the coroner (Dr Knapman on 22nd August and Dr Dolman on 23rd August 1989) had accepted the evidence of visual identification as being sufficient for a formal identification.

5.18 Because of decomposition caused by immersion in water for a long period, the remaining 26 bodies were judged not suitable for visual identification and other methods of identification were therefore necessary in respect of them. This part of the inquiry has been largely concerned with the means used to identify these bodies, since the hands were removed from all but one of them for the purposes of taking fingerprints.
5.19 The following 19 deceased were formally identified by means of dental records and matching items of clothing or jewellery:

Peter Alcorn, Christopher Averill, Timothy Blake, John Clarke, Francesca Dallaglio, Howard Dennis, Elsa Garcia, Christopher Garnham, Jeffrey Gibbs, Hannah Harris, Julie Hunt, Karen Jarvis, Shaun Lockwood-Croft, Shirleen Manning, Rachel Rackow, Simon Senior, Aziz Shamash, Antonio Vasconcellos and Domingos Vasconcellos.

The following four deceased were formally identified by fingerprints alone:

Paul Ellington, Stephen Faldo, Guy Hallez and Tony Lo-Manyem.

The following were formally identified by distinctive clothing and/or jewellery:

Jane Bourke and Michael Carew.

Finally, Peter Jaye was formally identified by a distinctive operation scar and clothing.

5.20 As discussed in more detail below, fingerprint officers took fingerprints from the deceased as part of the identification procedure. The fingerprint officers required the hands of 25 of the deceased to be removed in the mortuary and taken to the MPS laboratory at Amelia Street where prints were taken. In 21 of these cases hands were removed for fingerprinting but fingerprints were not in the event used to identify the body from which the hands had been removed. In the event fingerprints were used to identify particular bodies in only four cases.

5.21 The purpose of taking fingerprints is of course to match those prints with prints known to belong to a particular person. Thus, if there was a record of the fingerprint in national police files the deceased could be identified in that way. If there was no such record, then ‘latent’ prints would have to be lifted from, say, the home of the person suspected to be deceased and compared with prints taken from the body. Any matching prints could then form part of the evidence leading to a formal identification. In the event the former method was used in two cases and the latter in two cases.
5.22 The inquests on the bodies recovered from the river, save for that numbered 2600 (Carmella Lennon Gorman), were opened between 25th and 31st August and on 5th September. In each case the inquest was opened following formal identification by the coroner, Dr Dolman.

6. Why were the Hands Removed?

6.1 As just stated, the hands were removed for the purpose of taking fingerprints. I now turn to consider how it came about that the decision was made to remove the hands for those purposes and why so many pairs of hands were removed in circumstances where dental records were available or likely to be available in the near future.

Authority to Remove Hands

6.2 It was suggested by the MAG, the Marchioness Contact Group (‘MCG’) and the MPS that Dr Knapman ought to be criticised for his conduct in relation to the removal of the hands. In order to consider whether Dr Knapman can fairly be criticised it is necessary to consider whether he gave authority for the removal of hands and if so in what terms.

6.3 As already stated, at the time of the collision Dr Knapman was on holiday in Devon. At some stage, either before or after he had the telephone conversation with DCS Purchase referred to above, he telephoned Dr Dolman, who recalled receiving instructions in these terms: ‘Put on a suit, go to Scotland Yard, find the Commissioner, tell him who you are.’ Dr Knapman returned to London later that day and visited the Coroner’s Court in Horseferry Road, which adjoins the mortuary. There is no written record of the meetings he had on his return to London, but on 6th January 1993 Dr Knapman stated on affidavit that on 20th August 1989 he had a meeting ‘with Dr Dolman (my Deputy Coroner), a Senior Police Officer and Dr Shepherd (a Pathologist).’ He further stated that at that meeting ‘we discussed the methods which should be used to deal with the identification of the bodies.’ Dr Shepherd recalled attending the Westminster mortuary on the afternoon of 20th August 1989 and coming across a group of people including Dr Knapman. He has a recollection of being asked by Dr Knapman for his opinion as to the need for fingerprinting as part of the identification process, particularly in relation to decomposed bodies. DS Sinnott
(who is now retired) recalls learning from his superior officer DI Raison in the late afternoon of 20th August 1989 that the coroner had set out minimum acceptable standards of identification. Further, Dr Knapman accepted in his written and oral evidence that on Sunday 20th August 1989 he authorised the removal of hands where that was considered necessary by the fingerprint officers. He said that he gave his authority to DCS Purchase.

6.4 Thus, although no witness has a clear or full recollection of a meeting taking place at which identification criteria were discussed, the totality of the evidence supports a finding (as do the probabilities) that at some stage on Sunday 20th August 1989, probably late in the afternoon, Dr Knapman had a meeting at which identification criteria were discussed. Dr Shepherd was there, as in all probability was a senior police officer. Dr Knapman recalls that that officer was DCS Purchase. He had a senior role in the police inquiry and was based at Cannon Row police station but it is possible that he visited the mortuary on 20th August 1989. If the senior police officer present at the meeting was not DCS Purchase, it must have been DI Raison who was the head of the police team at the mortuary. However, Dr Dolman has no recollection of attending the meeting and there is no support for Dr Knapman’s recollection in an affidavit which he swore in 1993 that Dr Dolman was present.

6.5 In the light of the evidence of Dr Dolman that he was entirely unaware that hands had been removed for the purpose of fingerprinting until long after 1989, if that evidence is accepted, it seems clear that Dr Knapman is mistaken in his recollection that Dr Dolman was present. It was, however, submitted on behalf of the MPS that Dr Dolman was aware of the removal of the hands. Reliance was placed on a document found within the coroner’s file relating to Stephen Faldo which referred to the fact that a pair of hands had been examined by the MPS fingerprint branch and recorded that the fingerprints were those of Stephen Faldo.

6.6 It is true that careful attention to those documents might have suggested to the reader that a pair of hands had been severed from the body. However, Dr Dolman has always denied that he had any knowledge of their removal and there is no evidence that he had any such knowledge, which is not something about which he is likely to be mistaken. It is much more likely that he did not study the documents relating to Mr Faldo in quite the detail with which they have been studied in this inquiry, assuming, which is by no means certain, that the document was indeed in the coroner’s file on 25th August when he opened the
inquest into the death of Mr Faldo. Moreover, if Dr Dolman had been aware
that hands were being removed, he would have discussed it with the police at the
time because he did not insist upon fingerprint evidence in every case in order to
be satisfied as to identification. In all the circumstances I see no reason to reject
Dr Dolman’s evidence in this regard and I find on the balance of probabilities
that Dr Dolman was not present at any discussion about removing of hands on
the afternoon of 20th August or at any time thereafter and that he was unaware
of the authority that Dr Knapman had given.

6.7 Dr Knapman accepts that the effect of what he said to the senior police officer on
20th August was to authorise the removal of hands where that was considered
necessary. It is, however, important to bear in mind that at the time of this
meeting no bodies had been recovered which had become seriously decomposed
by prolonged immersion in water. Thus the time had not yet arrived for any
actual decision to be taken to remove the hands of any particular body.

6.8 Authority was required from Dr Knapman before any hands could be lawfully
removed because at common law he has a right to possession of the body. It is
likely that Dr Knapman gave authority because (a) it was anticipated that bodies
would be recovered from the river in a decomposed state such that visual
identification would be regarded as unreliable, (b) the opinion of Dr Shepherd
was that in those circumstances fingerprints should be taken and if necessary the
hands would have to be removed to enable prints to be taken at the laboratory
and (c) such a procedure had been followed before with the authority of
Dr Knapman. In the course of his oral evidence Dr Knapman candidly accepted
that he did not anticipate any ‘outrage’ at what he regarded as ‘a necessary evil in
order to identify people.’ He envisaged that it could be upsetting but considered
that it would be understood to be necessary.

6.9 Little if any mention was made at the discussion on 20th August of identifying
bodies by reference to dental records. Dr Knapman was obviously aware that
dental records could be used for identification purposes, but it seems likely to me
that on 20th August 1989 he focused attention on the use of fingerprints to
identify those bodies which were not suitable for visual identification. However,
the use of dental records as a means of identification was discussed between

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1 R v Bristol Coroner ex parte Kerr [1974] QB 652 at 658-9. See also the discussion of the role of the
coroner in part two below.
Dr Knapman and, probably, DI Raison, at a further meeting on 22\textsuperscript{nd} August before Dr Knapman returned to Devon.

6.10 Thus in the contemporary report of a police strategy meeting on 22\textsuperscript{nd} August at 2.20 pm DI Raison is recorded as reporting that the coroner had asked for dental records of all victims to be obtained and that he had given authority for SO3 (the branch of the MPS concerned with identification) to remove hands and take them to the lab for identification. Since Dr Dolman was unaware of anything to do with the removal of hands ‘the Coroner’ must be a reference to Dr Knapman. On 24\textsuperscript{th} August DI Raison is recorded as saying that ‘the Coroner wanted 100% identification of the bodies before he would be satisfied. This means dental and fingerprint identification.’ Since it is clear from the inquests opened by Dr Dolman in relation to those bodies unsuitable for visual identification that he did not require both dental and fingerprint identification, it is probable that the coroner being referred to is again Dr Knapman. DI Raison must have been referring to what he understood to have been the wish of Dr Knapman expressed earlier in the week before he returned to Devon. This reported opinion by Dr Knapman is echoed by his remark in his supplementary statement provided to this inquiry, namely: ‘It was also a necessary imperative to be as sure as possible in the identification process.’

6.11 Having regard to this evidence it is clear that at the meetings on 20\textsuperscript{th} and 22\textsuperscript{nd} August Dr Knapman did not address the question whether the removal of hands was being authorised even if dental records were in the course of being obtained. Indeed, he left the police with the impression that he required identification by both dental records and fingerprints because he wanted (as DI Raison put it) ‘100% identification’. In his oral evidence Dr Knapman told me that he assumed that hands would not be removed in circumstances where identification could be achieved by dental records. However, in the light of the contemporaneous evidence and of his written evidence I cannot accept that that was a conscious assumption on his part at the time because I do not think that he gave any specific consideration to the question.

6.12 If he had thought about it or his attention had been drawn to that question, namely whether he was authorising or would authorise the cutting off of hands when dental records were in the course of being obtained, it seems likely that he would have said that he did not expect the removal of hands to be carried out without waiting to see if a positive identification could be obtained by means of dental records. That is, I think, especially so in relation to a body which had been
provisionally identified by clear matches of ante mortem and post mortem data. It may be noted that prior to the MARCHIONESS disaster Dr Knapman had authorised the removal of hands from bodies recovered from the river, but in such cases it was his practice to grant authority only where all other attempts to identify the body had failed. When Dr Knapman said in evidence that he ‘assumed’ that removal would not take place in circumstances in which dental records were likely to be available in the near future, I think he must have meant that he would have assumed that to be the case if he had thought about it, because I have reached the firm conclusion that he did not actually consider the question at the time.

6.13 Dr Knapman accepted that he did not inform those present on either 20th or 22nd August that he had made the above assumption. As stated above, that is in my opinion because he had not consciously made such an assumption. Dr Knapman accepted that he ought to have made clear what limitations there were (or ought to have been) on the extent of the authority he was granting, that it would have been sensible to have done so and that the decision should have been reached on a body by body basis. If he had done so, it is likely that DCS Purchase or DI Raison, when responding to the request to remove hands on 23rd August, would have considered whether removal was appropriate in circumstances where dental records were in the course of being obtained. If Dr Knapman had made clear on 20th August that he was giving only limited authority to remove hands and stressed the importance of obtaining dental records it is likely that the concerted efforts by the police which were made to obtain dental records on 23rd August would have been made on 21st August. In that event it is likely that many dental records would have been in the possession of the police on or before 23rd August when the first request to remove hands was made.

6.14 Before Dr Knapman left for Devon on 22nd August he discussed the question of identification with Dr Dolman. However, he did not inform him of the authority that he had given on 20th August to remove the hands. In evidence he accepted (to my mind correctly) that in circumstances where Dr Dolman was taking over from him as coroner in a major disaster such as the MARCHIONESS good sense required him to have informed Dr Dolman of the fact that he had given that authority and its extent. It was suggested that Dr Knapman ought not to have returned to Devon at all but remained and acted as coroner throughout. I do not, however, criticise Dr Knapman for returning to Devon, but for returning to Devon without advising his deputy Dr Dolman of the authority he had given.
In making the above findings I have taken particular account of the following evidence. In paragraph 25 of his affidavit sworn on 6th January 1993 Dr Knapman described what he called the five criteria generally employed to assist in the identification process. They were visual identification, clothing, personal items (such as jewellery), teeth and fingerprints. In paragraph 26 he said this:

The decisions which were taken in relation to the identification of the victims of the MARCHIONESS disaster were as follows:

a. The Police would use all five criteria if possible.

b. With those bodies which were found on the MARCHIONESS it was likely that three criteria would suffice – namely visual identification, personal items and clothing.

c. With those bodies which were not recovered from the MARCHIONESS and which would be likely to surface only when putrefaction and bloating meant that they would float, the following would apply:

   (a) visual identification would be unreliable, perhaps impossible, and cause distress for relatives so that it should not be used; and

   (b) in circumstances where it was impossible to take adequate fingerprints from the bodies without removing the hands of those bodies to the Fingerprint Laboratory, those hands should be removed.

d. A file would be drawn up for each deceased person and when the Identification Officer was satisfied as to identification, he would bring the file to me or my Deputy.

It is to my mind striking that there is no reference in paragraph 26 of that affidavit to the use of dental records instead of fingerprints. I recognise that it was sworn in a different context and for a different purpose and that Dr Knapman gave evidence that his affidavit was incomplete and was intended to give a chronological account of what happened rather than a detailed and complete account of the identification criteria which he required. However, Dr Knapman there attempted to describe the identification criteria which he
required at the time and, if he had consciously contemplated in 1989 that dental records might be used instead of fingerprints I am sure that he would have said so in his affidavit. When he swore his affidavit he had a recollection of what the criteria which he required were, whereas when he gave evidence in this inquiry he said he had little if any recollection of the meeting in question. It is not surprising that Dr Knapman now has no clear recollection of what was said on 20th August, over 11 years ago. He would have had a much better recollection in 1993. If he had intended on 20th August 1989 to accept a dental match instead of fingerprints he would be likely to have remembered it in 1993 and included that fact in his affidavit.

6.17 The first reference in the minutes of the police strategy meetings to a requirement for dental records occurs not in the notes of meetings on 21st August but in the notes of the meeting on 22nd August. In an unsigned statement, but one corrected in pencil by Det Supt Lewis, reference is made to a meeting with Dr Knapman on 22nd August at which the identification criteria were discussed. The manuscript and computerised records of the action taken to obtain dental records are dated no earlier than 23rd August. The transcript of the inquests opened by Dr Knapman on 22nd August records that DCS Purchase informed Dr Knapman that it was anticipated that over the next few days bodies would rise to the surface which would have to be recovered and identified. It is therefore probable that a further discussion as to the means by which such bodies would be recovered took place on that day.

6.18 Before Dr Knapman returned to Devon he discussed the identification criteria with Dr Dolman, but he did not mention the authority which he had given on 20th August for the removal of hands. As a result Dr Dolman, although acting ‘for his coroner’2 whilst Dr Knapman was away in Devon, did so in ignorance of that authority. It was of course that authority which led to the removal of hands on 24th and 25th August.

6.19 On Friday 25th August, after a number of bodies had been identified by dental evidence and by matching ante and post mortem data, it appears that Dr Dolman must have been asked whether he would accept such evidence without the need for fingerprint evidence because on the afternoon of Friday 25th August he opened the inquests on seven victims without the need for fingerprint evidence. The earliest of these inquests was opened at 2.30 pm, Dr Dolman having been

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2 See section 7(1) of the Coroners Act 1988.
engaged on medical work in the morning. The hands removed on 25th August were received at the laboratory at 3.10 pm on that day and so must have been removed earlier in the day. Thus the change of approach between Dr Knapman and Dr Dolman was not apparent until the afternoon of Friday 25th August and probably too late to lead to a stay on the removal of hands.

6.20 In all these circumstances I am firmly of the view on all the evidence which I have read and heard that the authority to remove hands was in effect given by Dr Knapman on 20th August and confirmed by him on 22nd August before he returned to Devon. The police were left with the impression that Dr Knapman required fingerprints to be taken in every case and that, if it was necessary to remove the hands in order for fingerprints to be taken, that should be done. It was for that reason that, as indicated further below, when the senior police officers were advised by the fingerprint experts that it was indeed necessary to remove the hands in order to take fingerprints, they in effect regarded themselves as instructed by the coroner to permit it.

The Fingerprint Officers and the Decision to Remove the Hands

6.21 There were two police fingerprint officers at the mortuary, Mr Robin Viner and Mr Anthony Strong, both of whom gave oral evidence. Mr Viner attended Westminster mortuary on 21st and 22nd August. His responsibility was to obtain fingerprints from the deceased. His duties (and those of his team) were no wider than that. It was no part of their responsibility to consider the necessity for taking fingerprints as opposed to, say, dental records. During the afternoon of 22nd August a number of bodies that had been retrieved from the river arrived at Westminster mortuary. Mr Viner examined one or more of those bodies that afternoon. He then spoke with Mr Strong and asked him to attend on 23rd August, which he did. Mr Viner believes that he also attended the mortuary briefly on the morning of 23rd and examined bodies 2601 to 2604, together with Mr Strong. They formed the view that those bodies were not suitable for fingerprinting at the mortuary and that the hands would need to be removed and taken to the laboratory at Amelia Street.

6.22 A request, which is evidenced by a contemporaneous note, was then made by either Mr Viner or Mr Strong (they could not now remember which) for permission to remove the hands from those bodies that could not be fingerprinted in the mortuary. As appears below, this request was made to the police team in the mortuary, probably to DI Raison. The answer that was given
was that the coroner had given his permission for the hands to be removed if that was necessary in order to obtain prints, although Mr Strong could not recall either whether permission was given immediately or the terms in which it was given. Mr Viner told the inquiry that his instructions to Mr Strong were to make a decision on each individual body. Body nos. 2605 to 2617 were examined by Mr Strong and his colleague Mr Bell on 24th August. The examination included the physical appearance of the bodies and the condition of the hands. Mr Strong’s evidence was that after each examination, he sought separate confirmation that the hands could be removed from that body although I have some doubt as to whether his recollection is correct because Mr Viner said in evidence that he would not have expected there to have been specific requests since they had already been told that if it was necessary they had permission to remove the hands.

6.23 A manual and instructions existed in 1989 setting out the procedures to be followed by fingerprint officers in cases where hands were to be removed. The instructions required the permission of the coroner to be obtained. Mr Viner was not familiar with the manual but he appears to have been familiar with the principles contained in the manual and applied them. In particular, he was fully aware of the importance of obtaining permission from the coroner before hands could be removed.

6.24 In fact the request was not made directly to the coroner. It was not made either to Dr Knapman, who of course by this time had returned to Devon, or to his deputy Dr Dolman, who was now the coroner. It is likely that it was made to DI Raison who was in charge of the mortuary police team. The coroner’s officer Mr Robert Rumbold recalled overhearing DI Raison saying on about Wednesday 23rd August that the coroner had given permission. The permission to which he must have been referring was the permission given by Dr Knapman on 20th August (and confirmed on 22nd August) as explained above. It was not any permission given at any time by Dr Dolman.

6.25 The inquiry has not had the benefit of evidence from DI Raison and so it is not clear from whom he learned that permission had been given by the coroner. However, it is clear from Dr Dolman’s evidence that DI Raison did not learn it from Dr Dolman. Equally, it is clear from the evidence of both coroner’s officers, Mr Rumbold and Mr Roger Foster-Smith, that he did not learn it from them. It is therefore likely that he learned it from a senior police officer, probably DCS Purchase whom Dr Knapman recalls being at the meeting on 20th August. There
has been no evidence from DCS Purchase but on the available evidence it seems very likely that, when faced with the request of the fingerprint officers, he informed them that the coroner had authorised removal of hands if they (as fingerprint experts) thought that that procedure was necessary in order to take fingerprints. As I see it, the only realistic alternative possibility (albeit much less likely) is that the original authority was given to DI Raison and not to DCS Purchase, in which case it was probably he who so informed the coroner’s officers and not DCS Purchase.

6.26 It was in these circumstances that the police permitted the removal of the hands. Before doing so, they gave no consideration to the question whether it was necessary to do so, having regard to other means of identification in any particular case. They simply acted on the basis of what they perceived to be the authority (and in effect the instructions) of the coroner. In short they acted on the basis that, as DI Raison put it at a strategy meeting on 24th August (quoted above), ‘the Coroner wanted 100% identification of the bodies before he would be satisfied; this means dental and fingerprint identification’. They therefore permitted the removal of the hands on a blanket basis and did not consider the question whether or not the hands should be removed on a case by case basis.

**Conclusion**

6.27 For the reasons which I have tried to give, my conclusion is that the reason why the hands were removed is that Dr Knapman authorised their removal on 20th August 1989 if it was necessary for hands to be removed in order for fingerprints to be taken. He in effect confirmed that authority on 22nd August. He gave the authority to the police, without limiting it in any way. Because it was the coroner who had to be satisfied as to the identity of each of the deceased, the police regarded that authority as amounting to an instruction to the same effect. Accordingly, when the fingerprint officers expressed the view that it was necessary to remove the hands of those bodies which were recovered from the river, the police permitted removal of the hands in accordance with that authority. They did not consider each body separately on a case by case basis having regard to other forms of identification which were or might shortly be available.

6.28 I consider below the various criticisms which have been advanced against Dr Knapman, the MPS, the fingerprint officers and others. I also consider the circumstances in which the bodies were released because in some cases the hands
which were removed were not returned with the bodies. The relatives were not told about the removal of the hands, with the result that they did not discover the truth until much later. However, before considering this part of the inquiry further, it is convenient to focus on some of the evidence given by members of the families of the deceased.

7. **Evidence from the Families**

7.1 Evidence given by the parents of those who died has been of particular value to the inquiry because it contains, not only a factual account of what occurred in particular cases, but also a vivid illustration of some of the concerns and problems which have arisen, which are relevant to both the past and the future.

7.2 Margaret Lockwood-Croft is the mother of Shaun Lockwood-Croft. She visited the mortuary on Friday 25th August and wished to see her son, not only for the purposes of identifying him, but also for the purpose of viewing him and being with him as part of her grieving process. She was not able to see her son. She was told that the coroner had set out approved methods of identification but was not told what they were. By not being given more information as to what steps were being taken to identify her son she felt (in my judgment entirely understandably) as if her son no longer belonged to her and that those in authority were only prepared to let her know matters which they judged she needed to know. For this reason and with great force she stressed the need for full, accurate and honest information to be made available to relatives, perhaps especially in the form of leaflets available through the police liaison officers and at coroners’ courts explaining the procedures to be followed.

7.3 This need was echoed by Peter Bourke and Shirley Bourke, the father and stepmother of Jane Bourke. Shirley Bourke spoke of feeling ‘very much on the outside’ by reason of not being given information as to the procedures which would be followed, particularly with regard to identification. Sally Smith, Jane’s mother, described how she learned much later from a reporter that the hands of 25 deceased had been cut off. She expressed in moving terms the devastating effect that had on her. What particularly shocked her was the knowledge that her daughter’s body had been in the river for a few days without losing a limb, only to have her hands severed when her body reached the mortuary.
7.4 Mrs Smith also underlined the importance of the relatives’ police liaison officer. She described the officer as the ‘life line’ from whom information and comfort should be obtained. However, in 1989 the role of the liaison officer was still in the early stages of development. Thus Eileen Dallaglio, the mother of Francesca Dallaglio, told me that, while her liaison officer was polite and listened to what she told him, he was not a means by which she could obtain information.

7.5 Angela Bensemann, the mother of Dean Palmer, described the distress and shock on learning for the first time at the inquest in 1990 that a post mortem had been carried out on her son. In my view understandably, she saw no reason why Dean’s father, who identified his son, should not have been told about the post mortem.

7.6 Mrs Dallaglio also raised an important matter concerning the registration of the date and place of her daughter’s death. The entry in the register of Births, Marriages and Deaths gave the date and place of death as 23rd August 1989 and the River Thames, Poplar, whereas she correctly observed that her daughter had died on 20th August 1989 and not at Poplar. It appears that it was not uncommon at the time to enter on the form, not the date and place of death, but the date and place of life being pronounced extinct. For my part, I cannot understand how it can be right to enter any information other than that required by the form, namely the actual place and date of death, once it has been established.

7.7 Lucy Garcia is the mother of Elsa Garcia. Like Mrs Lockwood-Croft she wished to see her daughter and identify her. She visited the Coroner’s Court in Horseferry Road daily and made that request, but she was told that her daughter would be identified by other means. She was offended that a mother was not allowed to see her daughter. Although she was aware that her daughter’s dental records were being sought, she was not told that an attempt was to be made to identify her daughter by fingerprints. As in the case of all the relatives, she was not told that her daughter’s hands had been severed in order to take fingerprints. In her case a veil of secrecy also hid from her, until this inquiry was well underway, that her daughter’s hands had not been reunited with the body but had lain in a refrigerator in the Westminster mortuary until their presence was reported in August 1993 to Dr Knapman who then authorised their destruction. I shall return to this in section 10 below. After that information had been revealed to her she made a further and most moving statement to the inquiry.
which must have convinced all who heard it that if hands have to be severed from a body for the purposes of identification it must only be as a means of last resort.

7.8 Judy Wellington, who is the mother of Simon Senior, fairly asked why, in circumstances where she had been told that the identification of her son was 98% certain but would be confirmed by reference to dental records, it was necessary to sever her son’s hands from his body. She was especially upset about the removal of his hands because he had been an artist and played the bass guitar.

7.9 I wish also to mention the evidence of Linda Ali, the mother of Julie Hunt. Ms Ali did not give oral evidence but submitted a written statement. After her daughter’s body had been identified and delivered to the funeral director, Ms Ali wished to view the body of her daughter and dress it for the funeral. The funeral director dissuaded her from doing so and, when pressed, informed her that her daughter’s body had no hands. This information naturally caused her considerable distress and she resolved to investigate with the assistance of solicitors why the hands had been removed. She was told that the hands had been removed for the purpose of taking fingerprints. This came as a considerable shock to her because the description of Julie’s clothing which she had given matched the clothes which had been returned to her, because her daughter’s Barclaycard bearing her name had been found in a pouch attached to her belt and because there was also found in the pouch a Fiat car key, precisely where Ms Ali had told the police it would be.

7.10 On 30th August 1989 DCI Collins and two other officers went to see Ms Ali and (as was entirely appropriate) apologised to her for what had happened. They promised to make arrangements for the return of her daughter’s hands. They also requested her not to take the matter any further because she was the only relative who knew that hands had been removed and that, if the fact of removal were to become public knowledge, additional distress would be caused to other families. She initially acceded to that request but keeping the matter secret caused her additional distress because she felt isolated from the other grieving parents. This feeling of isolation became worse and worse as time went on. She described the loss she had suffered, coupled with the knowledge that her daughter’s body had been mutilated and the misery caused by having to keep the matter secret, as an unbearable burden. Eventually, when discussion at a meeting of the MAG turned to the question of possible confusion over the identity of bodies, she felt that the time had come to disclose what she knew about the
methods used to identify the bodies. That was probably in late 1991 or very early 1992 at the latest.

8. Availability of Dental and Other Evidence of Identification

8.1 The most striking aspect of the procedures used to identify the bodies recovered from the river, save for bodies numbered 2600 and 2626, is that hands were removed from the bodies on Thursday 24th and Friday 25th August when the dental information used to identify many of them was in the course of being obtained. The dental records of at least 17 bodies had been obtained by 0930 on 25th August. Of those 17 bodies, 14 had had their hands removed on 24th August. Of the bodies whose hands were removed on 25th August, there were three in respect of whom dental records had been obtained. Identification using the dental records was made on 25th, 29th and 30th August.

8.2 In the case of the 25 bodies recovered from the river whose hands were removed on 24th and 25th August it is plain that they were not removed as a last resort. Although the available evidence does not enable me to find the precise time when dental records were received during the week following the disaster it is very likely, having regard to the fact that the records of 17 bodies had been obtained by 0930 on 25th August, that hands were removed from some bodies notwithstanding that dental records relating to those bodies were either in the mortuary or were in the course of being brought to the mortuary. There is no evidence that anyone on 24th or 25th August paused to think whether it was appropriate to remove hands notwithstanding the possibility of identification being established by means of dental records. Indeed (as already indicated) it is I think clear that no-one did.

8.3 The MAG and MCG went further and submitted that in two cases hands were removed after Mr Sims had identified the bodies by dental records. The first case was that of Hannah Harris. She was positively identified by Mr Sims on 25th August, which was the very day on which her hands were removed. For the reasons given in paragraph 3 of the introductory note to Annex C, it is likely that the hands were removed shortly after 1230. When the inquest into her death was opened on 31st August, she was formally identified by reference to the dental match made by Mr Sims and by reference to clothing and jewellery found on her
body which matched a description given by a survivor Dowie Jones. A manuscript note on the victim information form records that her sister was informed that the body of Hannah Harris had been identified at 1125 on 25th August. It is said that this refers (a) to the dental match and (b) to a time of 1125 am. I am not, however, sure that the identification refers to evidence of a dental match. It could refer to an identification made on the basis of a match between the clothing and jewellery found on the body and the description given by the victim’s sister and recorded on the victim information form. Nor is it firmly established that the information was given at 1125 am. The MAG and MCG say that the time is likely to have been 1125 am rather than 1125 pm because it is improbable that Mr Sims was working late into the night and unlikely that the police officer would have telephoned the deceased’s sister late at night. It seems to me more probable than not that the time refers to 1125 am but since I am not satisfied that the subject matter of the information related to a dental match I am not persuaded that that the dental match was made before the hands of Hannah Harris were removed.

8.4 The second case was that of Howard Dennis whose hands were removed on 25th August, the very day on which, following his formal identification as a result of a dental match, his inquest was opened at about 16.30. It was submitted on behalf of the MAG and MCG that, having regard to the time required to prepare the paperwork for the coroner, including Mr Sims’ report on the dental match, to give notice to the next of kin of the opening of the inquest and to arrange a visit by the police liaison officer, the dental identification of Howard Dennis must have preceded the removal of hands. It is certainly possible that this is what happened but in the absence of firm evidence it is not possible to be more specific than to find that the hands of Howard Dennis were removed either at about the same time as, or shortly before or shortly after, a dental identification was made.

8.5 The precise time does not, however, seem to me to matter. The important point is that hands were not being removed only as a last resort, but were being removed in all cases. As a result, hands were removed notwithstanding that dental records were being obtained or had been obtained or, possibly in one case, just after a dental match had been made. There was no system in place by which the progress being made to identify victims was reviewed when a request was made by the fingerprint officers to have hands removed, so that a judgment could

3 In the case of Simon Senior, his mother Judy Wellington was informed that the police were 98% certain of the identification but required dental records to be sure. It is possible that this was also the nature of the notification given to Hannah Harris’ sister at 1125.
be made as to whether or not removal was necessary as a last resort. As appears below, it is my view that such a system should have been put in place. However, no such system was in place and as a result there was clearly no consideration on 24th and 25th August as to whether the removal of hands was necessary as a last resort.

8.6 Had there been such a system and consideration given to that question it is very likely that the judgment would have been formed that removal was not necessary. A decision would have been taken to wait and see whether the preliminary identification made by means of what had been found on the bodies could be confirmed by matching dental records. Dr Knapman said in his oral evidence to this inquiry that ‘if... a decision-maker knew that some dental records were on their way, manifestly, I think he should just have left it for 24 or 48 hours’. Having regard to the distress that removal of hands would be likely to cause to the next of kin, this would in my opinion clearly have been the correct approach. If that approach had been adopted in the case of the 11 bodies which were identified by dental records on 25th August, their hands would not have been removed. It was probably for that reason that Dr Knapman agreed (in my view correctly) that in the case of many of the 25 bodies whose hands were removed pursuant to his authority those removals were unnecessary ‘given that dental records were very close to hand’.

8.7 Further dental matches were obtained on 29th, 30th and 31st August, that is after the Bank Holiday weekend. If the last resort test had been adopted, it is most unlikely that a decision would have been taken that it was necessary to remove the hands of bodies in respect of which a dental match had not been obtained on Friday 25th August. Dental records in respect of some were already available and the post mortem data in respect of almost all enabled a preliminary identification to be made. Indeed, in respect of three bodies, Jane Bourke, Michael Carew and Peter Jaye, the coroner (Dr Dolman) approved their identification based upon such data on 30th August. The only possible reason for removing hands before the weekend would have been if a delay of a few days would (or perhaps might) have led to the inability to take good fingerprints should that prove necessary.

8.8 The inquiry received evidence from two fingerprint experts, Mr Bruce Grant and Mr Peter Swann. They were asked whether ‘a delay of up to a week would be unlikely to make much difference to the ability to obtain fingerprints’. They replied that ‘provided the body is preserved and friction ridge detail is present on the hands at the point of preservation then finger and palm impressions should
be able to be obtained.’ In all the circumstances it seems probable that if what I regard as the correct question had been asked, namely, was removal of the hands necessary as a last resort, no hands would have been removed on 24th or 25th August. Indeed, given the approach of Dr Dolman to identification, it seems to me to be more likely than not that, even in the case of each of the bodies which were in fact identified by fingerprints, the match of ante and post mortem data would probably have been acceptable to the coroner, as it was in the case of the three bodies mentioned above.

9. The Correct Approach to the Removal of Hands

9.1 As the evidence provided to this inquiry has clearly shown, the removal of hands can cause extreme distress to the relatives of the deceased. As part of their grieving process, some relatives will wish not only to see the body of their loved one but may also wish to touch or hold the body. In particular they may wish to hold the hand of their loved one. It is clear to me having heard and read the evidence in this inquiry that hands ought not to be removed for the purposes of taking fingerprints unless, having regard to the absence of other sufficient means of identification, it is necessary to do so as a last resort. This seems to me to be the appropriate criterion for parts of the body which are visible and symbolic of the deceased’s affection and abilities, which undoubtedly include hands.

9.2 I note in passing that it does not seem to me to follow that it is the appropriate criterion for the testing of blood or other samples or perhaps for the removal of other parts of the body. I am not sure that I am strictly concerned with this topic, but I shall briefly refer to it below.4

9.3 I recognise that perceptions are very different today from 1989, but I have reached the clear conclusion that, if proper consideration had been given in August 1989 to the question in what circumstances hands should be removed for identification purposes the same conclusion would have been reached, namely that hands should only be removed for identification purposes as a last resort.

4 Invasive procedures may be needed not as part of the identification process but as part of the investigation into the cause of an accident or into the cause of death. My terms of reference, and hence the comments I make, are concerned with identification procedures only.
9.4 As I see it, the question whether the hands of a particular deceased should be removed should have been considered on a case by case basis and not on a blanket basis. In each case all should have depended upon what other identification evidence was available. Thus if, at the moment that the question was asked, dental records were known to be on their way and/or were likely to be available in the near or comparatively near future, the hands should not have been removed. In order to ensure that decisions were taken on that basis, a proper system should have been set up requiring appropriate collation of the information so that the decision would never be made on the basis of anything other than all the information available at that time.

10. The Release of the Bodies and the Failure to Return Hands

10.1 Attention was given during the inquiry to two aspects of the mortuary’s procedures, first, the delivery to the funeral director of the correct body and secondly, the return of the severed hands to their bodies. The first arose because when the funeral director attended at the mortuary to collect the body of Simon Senior the body initially removed from the refrigerator was not that of Simon Senior. The second arose because the hands of Simon Senior and Julie Hunt were not reunited with their bodies when the bodies were given to the funeral director. Further, as I have already mentioned, it was discovered during the inquiry that the hands of Elsa Garcia had not been reunited with the body of Elsa Garcia.

10.2 The mortuary recorded not only the number accorded to each body by the MPS but also gave each body a further number used by the mortuary (‘the mortuary number’). These numbers were recorded on a mortuary action report form in relation to each body. In addition the number of the refrigerator in which the body had been stored was also recorded. The refrigerator door bore the police body number. Once a body had been formally identified by the coroner, a certificate recording the identification and releasing the body for burial or cremation was given by the coroner’s officer to the mortuary. This information was given orally and then the certificate was usually attached to a clipboard hanging on the door which connected the mortuary with the offices of the coroner’s officers. Periodically the mortuary staff would remove the certificates.
Thus the mortuary staff were able to note the identity of a body against the MPS and mortuary numbers of the body.

10.3 Despite that system, when Christopher Wickenden, a funeral director, arrived to take delivery of the body of Simon Senior, the mortuary technician initially removed a body from a refrigerator which was not that of Simon Senior. In response to a question from Mr Wickenden as to how it was known that the body was that of Simon Senior the technician checked the number of Simon Senior’s body in a book and realised that he had removed the wrong body. The correct body was then delivered to Mr Wickenden.

10.4 It is not possible to say why the mistake was made. Fortunately it was corrected. Further concern as to whether the mortuary delivered the correct bodies or had a system for ensuring that the correct bodies were delivered was generated by the discovery that in relation to two bodies the mortuary action reports recorded the wrong name against the MPS and mortuary number. However, examination of the original mortuary action reports shows that the two reports for bodies numbered 2901 and 2902 must have been placed in the wrong order so that when the identities of those bodies had been written on the mortuary action reports from a list of the identified bodies given in numerical sequence the names of bodies 2901 and 2902 had been interchanged. I am satisfied that this was a clerical error and did not lead to the wrong bodies being given to the funeral directors. This is because the mortuary book which I was shown during my visit to the mortuary and which was subsequently produced to the inquiry correctly recorded the names of the bodies against their correct MPS and mortuary numbers.

10.5 Although I am satisfied on the available evidence that the correct body was released in each case, it is obviously of the greatest importance that there should be in place a system which eliminates as far as possible the scope for error. In this regard I note that the systems presently in force in the Westminster mortuary are a considerable improvement upon those in place in 1989. I discuss this in more detail in part two below.

10.6 It is clear that in 1989 there was no satisfactory system in place in the mortuary for ensuring that severed hands were returned to their bodies before the bodies were delivered to the funeral director. Thus Mr Wickenden observed that the hands of Simon Senior were missing when he or his staff were preparing the body
for viewing at his premises. He had to return to the mortuary to collect them. I have already recounted how Ms Ali learnt that the hands of her daughter had not been reunited with the body of her daughter. As already stated, the police promised to make arrangements for the return of Julie’s hands so that there is no reason to think that they did not do so.

10.7 Returning briefly to the position regarding Elsa Garcia, it emerged during the course of the hearings that some time after the disaster a pair of hands was found in a bag at the bottom of one of the freezers at Westminster mortuary, having lain there since 1989. The hands were identified as being those of Elsa Garcia because the bag containing the hands was labelled with the number 2614, which had been the police number allocated to the body which was identified as Elsa Garcia. Dr Knapman was informed of this discovery at the time and ordered the discreet disposal of the pair of hands. There was some question as to when this occurred, however I am satisfied that it occurred in 1993, as Dr Knapman recalled and as set out in a note to Dr Knapman prepared by Elizabeth Riley, one of his coroner’s officers.

10.8 It is to my mind a shocking feature of the case that it was possible for a pair of hands to be left undiscovered in the mortuary, not just for months, but for years. The reason for the failure to return the hands with the bodies was that no record was kept at the mortuary of which bodies had had their hands removed and, it seems, a simple check was not made before bodies were delivered to the funeral director. The system has since been changed and this omission has been remedied, save possibly with regard to the retention of tissue samples.5

11. Death Certificates

11.1 I have already set out the concerns which Mrs Dallaglio understandably felt with regard to the inaccurate recording of the time and place of Francesca’s death in the register of Births, Marriages and Deaths. In my view the place and time of death should have been stated correctly on the certificate. It was accepted by Dr Knapman that they did not have to be recorded by reference to the date upon which a doctor pronounces life extinct. As I understand it, the register can in

5 See section 35 below.
appropriate circumstances be amended and, for my part, I can see no reason why it should not be amended in the case of Miss Dallaglio.

12. Criticisms

**Dr Knapman**

12.1 Many criticisms have been made of Dr Knapman’s conduct and I have reached the conclusion that some of them are justified, but I would like to stress that I have no doubt that he at all times acted in good faith. I entirely accept his evidence that he acted throughout with the best of intentions. Moreover, although Dr Knapman was very experienced as a coroner he had had no experience of dealing with an incident on the Thames, which had led to many deaths. Nor had anybody else, since the last tragedy on the Thames leading to many deaths was in the nineteenth century. Nevertheless good sense suggests that he could and should have acted differently in a number of respects, which I shall set out below.

12.2 Before I do so, I should refer to a submission on behalf of some of the families that Dr Knapman’s conduct and attitude to the removal of hands was reckless and/or displayed a gross disregard for the feelings of the relatives of those who died. For my part I do not think that it is fair to characterise Dr Knapman’s approach as reckless. As I see it, his failure was to give insufficient consideration to the likely feelings of the families in what was a most distressing situation.

12.3 His approach seems to me to give rise to legitimate criticism, even viewed through 1989 spectacles. If Dr Knapman had applied the principle of last resort identified above, as in my view he should have done, it is much more probable than not that the decision to remove hands would not have been taken and the distress caused by the discovery of the fact of removal would have been avoided.

12.4 As already indicated, on 20th and 22nd August Dr Knapman gave no actual consideration to the question whether the removal of hands should take place in circumstances where dental records were in the process of being obtained. No

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6 The collision between the BYWELL CASTLE and the PRINCESS ALICE which occurred on 3rd September 1878.
bodies unsuitable for visual identification had yet been recovered and no request
to remove hands had yet been made. It is likely that Dr Knapman stressed the
importance of seeking to identify bodies by both dental records and by
fingerprints. The reason why hands were removed from bodies when the dental
records which were used to identify the bodies were being quickly obtained was
the absence of any proper system whereby consideration was given on a case by
case basis to the question whether it was necessary to remove the hands of the
decased having regard to the other information available and likely to become
available in the reasonably near future.

12.5 Dr Knapman correctly accepted that it would be unsafe to leave to a fingerprint
officer a decision whether in all the circumstances the hands should be removed
since he would know only about fingerprints and not about other means of
identification such as dental records. However, Dr Knapman does not appear to
have given consideration to this question at the time. He regarded co-ordination
as a matter for the police. It was, he said, ‘a Metropolitan Police operation’. I
regret that I am unable to agree.

12.6 Dr Knapman’s failure to tell the police that he did not authorise removal, unless
a review of the progress being made with other identification evidence showed
that removal was necessary as a last resort, was the cause of there being no
proper system in place. It was suggested that Dr Knapman was also to be
criticised for not ensuring that there was a proper system in place. The
assumption which underlies this suggestion is that Dr Knapman as coroner had
the necessary executive power to put in place an appropriate system. The
proceedings at an inquest are inquisitorial: see section 11 of the 1988 Act, which
provides that the coroner shall examine the witnesses. One of the issues a coroner
is charged with determining at an inquest is the identity of the deceased: see
section 11 (5)(b)(i) of the 1988 Act. However, save for a power to direct a post
mortem or special examination of the body (sections 19 and 20) and a power to
order the exhumation of a body (section 23), the Act does not provide the
coronor with any general investigative powers or any power to direct the work of
the police or other personnel involved in investigating the identity of the
decased.

12.7 In these circumstances, as I see it, there is no basis for the assumption underlying
the criticism of Dr Knapman that he failed to ensure that there was a proper
system whereby information was collated and reviewed so that when a request to
remove hands was made a judgment could be made as to whether the removal
was necessary as a last resort. In my opinion the criticism of Dr Knapman which is made out is not a failure to ensure that a proper system of collation was put in place, but a failure to give proper consideration to the question in what circumstances the removal of the hands should be authorised. He thus failed to consider what authority he should give to the police and how that authority should be limited. If he had he should (and no doubt would) have limited that authority to a case of last resort, as for example where there was no reasonable prospect of a dental match being made in the reasonably near future.

12.8 Dr Knapman was also criticised for failing to ensure that there was a proper system for ensuring that the hands were reunited with the body before delivery to the funeral director. This criticism again assumes that the coroner had the necessary executive power to set up an appropriate system. He did not (and does not) and therefore cannot be criticised for failing to ensure that there was in place an appropriate system. However, where authority was given to remove hands it ought to have been made clear that the hands were to be returned to the body before the body was delivered to the undertaker. That is because failure to return the hands to the body was (and is) likely to cause shock and grief. Such a direction seems to me to be a consequential requirement of permitting the removal of hands and ought therefore to be considered by the coroner as an adjunct to the authorisation of their removal. This was accepted by Dr Knapman, although he correctly pointed out that he had no executive control over the mortuary personnel.

12.9 It seems that Dr Knapman did not address the question of the return of hands but trusted that the mortuary personnel would operate a safe system. Unfortunately the system in operation in Westminster mortuary at the time was inadequate in the respects described above. If Dr Knapman had made it clear that hands must be reunited with their bodies, as he ought to have done, it seems to me to be more likely than not that the mortuary would have kept a record of those bodies from which hands had been removed. In 1989 the mortuary did not keep such records and it may well be that their absence led to the hands of Elsa Garcia, Julie Hunt and Simon Senior not being reunited with their bodies when delivered to the undertaker.

7 Under present practice (see below) the Identification Commission (usually chaired by the coroner) will consider matters such as whether invasive procedures are necessary as a last resort and will contain amongst its members those with the necessary power to ensure that an appropriate system of collation and co-ordination is in place.
12.10 Dr Knapman was further criticised for failing to inform the families in a timely and sensitive manner as to the standard procedures likely to be followed and in fact being followed with regard to identification. In particular it was said that he ought to have informed the families of the likelihood of post mortems being carried out and of the possibility that hands might be removed for fingerprinting purposes. As a result of Dr Knapman’s failure to do so it was said that he kept the families in the dark and allowed them to suffer the shock and distress of finding out about these matters later by chance.

12.11 It is clear from the evidence in this inquiry that the relatives of those who have perished in a disaster should be informed in a timely and sensitive manner of the procedures likely to be used to identify the victims. In the present case the relatives were aware only that identification by means of dental records was to be attempted (because their assistance in locating such records was required) and that visual identification was not to be used (because requests to identify visually were refused). It appears that they were not made aware that post mortems were to be or had been conducted or that fingerprints were to be or had been taken, except in the case of those four victims who were identified by fingerprints. Such information as they received was provided not because of a conscious decision to keep the relatives informed but as a by-product of the means used to identify the bodies recovered from the river.

12.12 It was not the practice of Dr Knapman in 1989 to inform relatives that a post mortem had been carried out. Rule 7 of the Coroners Rules 1984 (‘the 1984 Rules’) provided for relatives who had informed the coroner of their desire to attend or be represented at a post mortem to be notified of the date, hour and place at which the post mortem was to take place. There was no evidence that any such desire was expressed, although there was equally no evidence that any relative knew or was told that a post mortem had been directed or requested by the coroner. Nor was it his practice in 1989 to inform relatives that hands had been removed. He considered that it would be unnecessary and inhumane to do so.

12.13 There has been a considerable change in approach since 1989. Thus Dr Knapman agreed that good practice in 2000 required that relatives be informed as soon as possible that a post mortem is to be or has been carried out. This is because an open and honest approach is now recognised to be right in principle. Where an Identification Commission\(^8\) chaired by a coroner reaches the conclusion that the

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\(^8\) See part two below.
removal of hands is necessary as a last resort, relatives should be (and no doubt are) informed of that decision in as humane and sensitive a manner as possible. The wishes of those who do not wish to know should of course be respected, but save in such cases the principles of openness and honesty require that the information be provided humanely and sensitively. If that approach is not followed there is the risk that the information will be revealed at a later date giving rise not only to shock and distress but also to allegations that the authorities, and in particular the coroner, have acted in an arrogant and insensitive manner. The point was expressed in this way by Mrs Lockwood-Croft:

I think it is paramount that you have honest, accurate information at all times. Secrecy sort of goes on to doubts and doubts give fears and fears become, start off as, molehills and then mountains. That could be avoided by being honest. A lot of the problems that have occurred in the MARCHIONESS disaster is the simple fact we were not given information, and then you feel, ‘What are they covering up? What are they really hiding from us.’ That could have all been averted by honest communication on a daily basis . . .

That seems to me to be an entirely understandable point of view.

12.14 In view of the practice or ‘culture’ which prevailed in 1989 I do not consider that it would be fair to criticise Dr Knapman for his failure to provide the relatives with information as to the identification procedures. I am pleased to say that since then that practice has come to be regarded as wrong in principle.

12.15 Finally, Dr Knapman was criticised for giving instructions that relatives should not identify or view bodies which were recovered from the river. This criticism is based upon the view expressed by Dr Knapman on 20th August to the effect that in cases where visual identification was not possible other evidence would be required, namely, fingerprints. As already stated, in due course bodies were recovered from the river (on 22nd and 23rd August) and brought to the Westminster mortuary. The view was formed by those attending the post mortem that the bodies were not suitable for visual identification and this was recorded on the victim identification forms prepared by the police. Some of the mothers who gave evidence said that they were refused permission to see the body of their son or daughter. Thus Mrs Lockwood-Croft said that she wanted both to identify her son and to see him and be with him. She said that when she expressed her wish, she was told by the coroner’s officer Mr Rumbold that she could not do so.
Mr Rumbold had no recollection of such a request at the mortuary. However, DC Jonathan Walshe, who (as already stated) was appointed to act as a relative liaison officer, recalled being requested by Mrs Lockwood-Croft to view her son's body. He said that he had received instructions from DCI Collins, who was head of the relative liaison team, that the bodies with which he was concerned were not suitable for viewing. He said that he told Mrs Lockwood-Croft that she could not view the body for identification purposes because the coroner would not accept such evidence and that she should not view the body for the purposes of grieving.

12.16 Dr Knapman considered that in every case the body could be viewed at the premises of the funeral director, which was of course true. By that stage the body was no longer in the possession of the coroner and he had no power to give or refuse permission to view at the premises of the funeral director. But before then the body was in the mortuary in his possession and he therefore had authority over it. Since 1989 the facilities at the Westminster mortuary for relatives to view the body, to be with it and to touch it have been improved. This reflects the more open attitude which now prevails in these matters. I have little doubt that in 1989 Dr Knapman did not consider what if any direction it would be appropriate for him to give with regard to relatives who requested to view the body.

12.17 For this reason I do not think that Dr Knapman gave instructions that relatives should not view the body of their loved one at the mortuary, but he did make it clear that he would not accept evidence of visual identification in the case of those bodies which were recovered from the river after a long period of immersion. It is likely that the coroner's officers and police liaison officers, acting from the best of motives, namely to avoid distress to relatives, sought to dissuade from viewing those relatives who expressed a wish to view. It is quite possible that such officers used language which suggested that viewing was prohibited rather than ill-advised; to do so would be more likely to achieve what they thought best, namely, that a loving parent would not be distressed by the sight of their child's decomposing body. I am, however, quite satisfied that DC Walshe and the other family liaison officers acted throughout in what they perceived to be the best interests of the relatives and in such a way as to minimise the distress which they were bound to feel.

12.18 In all the circumstances, and having regard to the standards in 1989, I do not think that it is fair to blame Dr Knapman in this respect. The position today is quite different. It is to be expected that, following an incident involving loss of life, some relatives will visit the mortuary in order to see the body of their loved
As matters are perceived today, a coroner ought therefore to consider how requests to view should be dealt with and give appropriate directions since the body is in his possession. Good sense and regard for the feelings of the relatives require that this matter be addressed carefully and sensitively. There may well be a need for appropriate counselling before viewing takes place and some may decide not to view when the condition of the body has been explained to them with due sensitivity. But in principle the request of a relative to view the body, if maintained after appropriate counselling, should be respected.

The Police Officers

12.19 The MAG and the MCG criticised DCS Purchase, Det Supt Lewis and DI Raison. In their closing submissions counsel for the MAG divided the many criticisms initially advanced by the MAG and MCG into two broad categories. They were first a failure to seek dental records before 23rd August and, secondly, a failure to co-ordinate the identification process and the information which was being obtained in order to ensure that hands were only removed as a last resort.

12.20 In circumstances where Dr Knapman did not stress the importance of dental records on 20th August but instead emphasised the need for fingerprints, I do not consider that the police officers can fairly be criticised for not seeking to obtain dental records until after Dr Knapman had referred to them on 22nd August before returning to Devon. Of course they could have started to obtain dental records before then but since it was the coroner’s decision as to what identification evidence was to be accepted it seems to me that it was reasonable for them to follow his lead.

12.21 None of the police officers who have been criticised has given evidence. However, as already stated, it is clear that no consideration was given by any police officer to the question whether it was appropriate to remove hands in circumstances where dental records were in the course of being obtained. The MAG and MCG submitted that, although Dr Knapman failed to inform the police officers that he did not authorise the removal of hands in circumstances where identification by dental records was likely to be possible in the near future the police officers ought to have decided to follow that policy themselves.

12.22 I have already said that what probably happened on 23rd August when the request was made by the fingerprint officers for the removal of hands was that DCS Purchase informed them that the coroner had authorised the removal of
hands if the fingerprint officers took the view that that procedure was necessary in order to take fingerprints. Dr Knapman accepted that he authorised removal if that was considered necessary and in his affidavit in 1993 he said that the decision he took was that ‘where it was impossible to take adequate fingerprints from the bodies without removing the hands of those bodies to the Fingerprint Laboratory those hands should be removed.’ In circumstances where authority for the removal of hands had to come from the coroner, where that authority had been given without any limit being placed on it with regard to the possibility of identification by dental evidence and where there was pressure to identify the bodies swiftly and accurately I do not consider that DCS Purchase (or either of the other two senior officers, Det Supt Lewis and DI Raison) can fairly be criticised for not adding his own limitation to the authority given by the coroner.

12.23 One of the tasks of the police was to collate and match the information necessary to identify the victims. The judicial identification of bodies was of course exclusively the role of the coroner but the task of obtaining evidence from which bodies could be identified lay with the police. Thus from an early stage one of the police officers was put in charge of identification and the daily minutes of the police ‘strategy’ meetings report on the progress made in identifying the bodies. Given the number of bodies to be identified, the task could be expected to be complex and detailed. There was a clear need for the information being obtained in respect of each body to be collated and reviewed so that, if and when decisions had to be taken in relation to a particular body (such as the removal of hands, the possible need for which had been identified on 20th August), the appropriate police officer would be readily able to see what progress had already been made in identifying the body and would be able to reach an informed decision or, if the consent of the coroner had not been obtained, place the appropriate information before him.

12.24 The fact that hands were removed on 24th and 25th August when dental records either had been or were in the process of being obtained is both striking and alarming. It is clear that no police officer organised a review of the identification process for the purpose of a decision whether or not to remove the hands of a particular deceased. On the other hand, as described above, the ante and post mortem data were in the process of being obtained and compared. There is no evidence to suggest that the police did not have a perfectly good system for collating and matching the relevant material. Indeed, it seems to me to be likely that if they had been asked for relevant information in order to enable a decision to be made in a particular case on the basis of all the material which had been
collected, they would have been able to provide it. The problem was not any failure by the police to put an appropriate system in place, but a failure to consider the question whether hands should be removed on a case by case basis having regard to all the circumstances.

12.25 I do not regard that as a culpable failure on the part of the police, but a failure on the part of the coroner to give them clear authority limited in the way which I have described earlier. For that reason the police were under the impression that the coroner required 100% certainty and that he wanted both dental and fingerprint identification. It is possible that other police officers might have acted differently and, for example, queried with Dr Dolman\(^9\) whether the removal of hands was really required. It does not follow that the failure of DCSPurchase to question the apparent requirements of Dr Knapman on, say, 24\(^{th}\) August was unreasonable and therefore worthy of criticism.

*The Fingerprint Officers*

12.26 Mr Viner and Mr Strong were the two fingerprint officers charged with taking fingerprints from the bodies. Each had had many years’ experience of such work with the MPS. Neither could be criticised for failing to consider whether the removal of hands was appropriate in circumstances where identification by dental evidence was imminent because their sole function related to the taking of fingerprints and deciding how that could best be done. But it was said that their evidence did not establish any strong or sufficiently compelling need to remove hands in order to take fingerprints.

12.27 In 1989 it was preferable to obtain good impressions from all ten digits. There were two reasons for this. First, the checking of fingerprints against police records was only partly computerised and it was more difficult to obtain a match without good impressions from all ten digits. Secondly, fingerprints (known as latent prints) taken from, say, the home of a deceased might only be partial. It was therefore necessary to have a full good set of impressions in order to improve the prospects of a match and was standard practice to do so. It was also desirable to obtain prints from the palms. The police fingerprint laboratory at Amelia Street had no facilities for the storage of bodies. Accordingly, if the obtaining of fingerprints required laboratory techniques, either the digits or the hands had to be severed. Severing of separate digits would have created a risk of mistakes.

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\(^9\) Assuming he was available. His own records indicated that he was at a Magistrates' Court on the morning of Thursday 24 August and possibly at Cannon Row police station later that day.
being made in that the digits might be mis-described by the technician carrying out the severing operation. It would also not have enabled palm prints to be taken.

12.28 The techniques which were actually used to obtain prints from the hands which were removed were inflation of the bulb using a hypodermic syringe and removal of loose skin (epidermis) using a scalpel. Eight of the pairs of hands were then cast and the remainder were printed with ink. The hands required considerable preparation and effort to put them into a condition in which they could be inked and printed. The experts were agreed that the use of syringes and scalpels were laboratory procedures. Casting does not necessarily require a laboratory but in this case the casting was carried out on the hands that were in the worst condition and thus those which required the greatest preparation (ie. injection and use of scalpel).

12.29 The expert instructed by the MCG and the MAG agreed that he would not consider even attempting to obtain prints in a mortuary in severe cases of decomposition and maceration where the friction ridge surfaces were in such a poor state that his assessment of the situation tells him that it would not be possible to obtain any useful impressions in the mortuary.

12.30 Taking fingerprints takes about an hour in the case of a body in good condition, whereas in this case the hands were not in good condition. Mr Viner had had personal experience of spending up to three days obtaining a set of fingerprints from a pair of severed hands. The condition of the hands was such that the fingerprint officers would have had great difficulty in obtaining prints in situ. If it had been necessary to take prints in the mortuary without removing the hands, it would have taken hours or possibly days per set of hands. None of the available techniques was suitable for the mortuary. It was not a borderline decision. The hands were examined by four fingerprint officers (namely Mr Viner, Mr Strong, Mr Poulley and Mr Bell) and they all formed the view that removal of the hands was necessary. It would have been impracticable to make separate attempts to take prints from each of the bodies in those circumstances.

12.31 In these circumstances, no criticism falls to be made of these officers. They carried out their role as they were required to. It was not their responsibility to determine whether fingerprints were required or whether other means of identification were readily available.
12.32 Current practice has materially changed since 1989 in two respects. First, removal of hands for the purpose of obtaining fingerprints is now very infrequent. In 1989, 39 sets of hands (excluding those of the MARCHIONESS victims) were surgically removed from bodies held in London mortuaries in order to obtain fingerprints. However, between 1996 and 1999 the average was only three sets per year. The reduction is attributable, among other developments, to advances in DNA techniques and improved computer technology for fingerprint searching and identification (thereby enabling checks against police records to be made using lesser quality prints).

12.33 Secondly, the procedures to be followed in cases where it may be necessary to sever hands have been developed since 1989. It is now necessary for the written consent of the coroner or his representative to be obtained in each case where it is proposed to sever hands from the body of a deceased person and a form has been produced for this purpose.

*The Coroner’s Officers*

12.34 Criticisms were made of the coroner’s officers, Mr Rumbold and Mr Foster-Smith, by the MAG and the MCG. Essentially the criticism was that they too ought to have collated the identification evidence and considered whether in circumstances where identification by dental evidence was likely and imminent it was appropriate to remove hands.

12.35 The coroner’s officers in the Westminster Coroner’s Court are not employed by the coroner but work for his benefit. They assist him in various matters including the identification of bodies. In the case of a major transport accident such as the collision between the MARCHIONESS and the BOWBELLE, where the police are involved in investigating the accident and in identifying the victims, the coroner’s officers provide assistance to the police. Thus, for example, in the present case they assisted in obtaining dental records. They also provided a channel of communication between the police and the coroner. When the police considered that they had identified a body they provided the evidence to the coroner’s officer who then enquired of the coroner whether the type of evidence provided was sufficient. If it was, the coroner’s officer prepared a file of evidence for the coroner who, if he was satisfied that the evidence proved the identity of the body, opened the inquest, adjourned it and then released the body for burial or cremation. In this and in other respects the coroner’s officers played an important role but there was no evidence that it was their duty either to decide what
identification evidence the police should seek or what identification evidence was acceptable for the purposes of identification.

12.36 Mr Rumbold first learned that permission had been granted for the removal of hands by overhearing DI Raison inform someone of that in the office of the coroner’s officers on Wednesday 23rd August. He also learned by observation of a ‘white board’ in the same office that the hands of certain bodies had been removed. Information concerning the bodies was placed on the white board, which was a rudimentary means of recording some of the action taken in relation to each body. For example the letter H in the first column indicated that the hands of the relevant body had been removed. However, it was not complete because it does not appear that it recorded that dental records had been obtained. There can I think be no doubt that the police maintained much more complete information at Cannon Row where it was being collated.

12.37 Although Mr Rumbold told me in his oral evidence that, if he had been aware that it was proposed to remove the hands of a body which had been identified, he would have told the police that there was no need to remove the hands, there is no basis upon which it can be said to have been his responsibility to monitor the steps being taken to identify a body.

12.38 Mr Foster-Smith was another officer on duty during the week commencing 21st August. Like Mr Rumbold he learned that permission for the removal of hands had been given at some time during that week and also observed from the white board in the offices of the coroner’s officers that the hands of some bodies had been removed. Although he had had experience of requests for the removal of hands from bodies recovered from the Thames in circumstances where all other methods of identifying the bodies had failed, he had no involvement in the request to remove hands from bodies recovered from the river following the MARCHIONESS disaster.

12.39 The criticisms advanced of the coroner’s officers assumed that their duties required them to consider what steps were appropriate in the search to identify the bodies which had been recovered. I do not consider that that was part of their duty and I therefore reject the criticisms which were made against them.
Dr Dolman

12.40 As stated above, I accept Dr Dolman’s evidence that he was not made aware either that Dr Knapman had authorised the removal of hands or that hands had in fact been removed. The MAG submitted that, since he was the coroner in the absence of Dr Knapman, he ought to have taken steps to have informed himself as to what was going on and checked that all was in order. It was said that, if he had done so, he might have learned that which Dr Knapman had failed to tell him. I do not consider that this is a fair criticism of Dr Dolman. He had been briefed by Dr Knapman before the latter returned to Devon, but he had no grounds for suspecting that an important piece of information had not been passed on to him. On Wednesday 23rd August he opened a number of inquests and so would have learned much about how the identification process was proceeding. On either that day or the next he visited Cannon Row police station ‘to see what was going on, to make sure I was ‘au fait’ with what was going on’. On Friday 25th August he opened further inquests and accepted identification based upon dental evidence and in one case fingerprints. He did not learn at that stage that hands had been removed. While an interrogation of the coroner’s officers or of DCS Purchase or DI Raison would have revealed that which Dr Knapman had not told him I do not consider that Dr Dolman can be criticised for not conducting such an interrogation.

The Pathologists

12.41 Criticisms initially advanced against Dr Shepherd and Dr Patel, who was the other pathologist, were withdrawn. I agree that no criticisms can be made of the pathologists.

Westminster Mortuary

12.42 Although no formal criticisms were advanced at the opening of the inquiry as to the procedures at Westminster mortuary, the evidence gave cause for concern in three respects. First, so far as the removal of hands is concerned, it seems to me that the mortuary is to be criticised for not having had in place at that time a proper system to ensure that hands were reunited with the bodies before they were released to the undertakers. As stated above, however, Dr Knapman ought to have made clear that the hands were to be returned to the body before the body was delivered to the undertaker. If he had done so, it is more likely that the mortuary would have kept a record of those bodies from which hands had been removed.
12.43 Secondly, with regard to the delivery of bodies to the undertakers, the system was far from satisfactory. It nearly led to what would have been a most unfortunate and distressing error. Thirdly they had no satisfactory system for ensuring that body parts did not remain in the mortuary for an excessive period of time, as evidenced by the discovery of Elsa Garcia’s hands after more than three years. In all the circumstances it seems to me that the mortuary is properly to be criticised in these respects.

13. Conclusions

13.1 In part four below, I set out a fairly detailed summary of my conclusions in part one of the inquiry. It is therefore unnecessary to do so here as well, save perhaps to say this with regard to the principal question which was the subject of part one of the inquiry. The hands of 25 of those who lost their lives as a result of the collision were cut off in order that they could be taken to a laboratory for fingerprints to be taken. The central issue is why the decision to remove the hands was made.

13.2 The coroner, Dr Knapman, returned to London on 20th August 1989 from his holiday in Devon and stayed until 22nd August when Dr Dolman took over. Before Dr Knapman left to return to Devon, he authorised the police to permit the removal of hands if it was necessary to do so for fingerprints to be taken. He left the police with the impression that, in the case of bodies which were subsequently recovered from the river, he would insist on both dental and fingerprint identification evidence. As a result of what he said to them, the police reasonably thought that he required fingerprint evidence in every such case.

13.3 Accordingly, when the fingerprint officers inspected the hands of those recovered from the river and formed that view that, if fingerprints were to be taken, the hands would have to be removed, the police permitted the hands to be removed. They are not in my view to be criticised for doing so because they were acting with the authority (and in effect on the instructions) of the coroner, Dr Knapman. I have reached the conclusion that Dr Knapman should not have given that blanket authority, but should have instructed the police that they were to consider each case separately and only remove the hands if it was necessary to do so as a last resort, having regard to other information that was available at
the time the decision was made or that was likely to become available in the reasonably near future.

13.4 If Dr Knapman had given the police only that limited form of authority, it is more likely than not that none of the hands would have been removed and a great deal of distress avoided.
14. Introduction

14.1 Paragraph 2 of the terms of reference requires me to review and report on the procedures currently followed to establish the identity of victims following accidents similar to the MARCHIONESS disaster. There have been very few, if indeed any, accidents in which the identification procedures have been similar to those used in the aftermath of the MARCHIONESS disaster. Accordingly, the sensible interpretation of paragraph 2 seems to me to be to review and report on procedures used following major transport accidents generally. These procedures are, in essence, similar to those used to establish the identity of victims following any major disaster in which there is loss of life.

14.2 There has been a striking number of major transport and other disasters in this country in the last 15 years, including the HERALD OF FREE ENTERPRISE, Hillsborough, Lockerbie, Clapham and Kings Cross, to name but five. The aftermath of each has required the identification of tens, if not hundreds, of victims. The effect of the death of the victims is naturally devastating to families and friends. As the evidence in part one of this inquiry has shown, the effect of unsuitable or insensitive identification procedures and of the way relatives are treated can have profound long-term consequences.

14.3 The inquiry has received numerous submissions, written and oral, both from individuals and organisations with a part to play in the identification process and from those who have been bereaved as a result of major disasters. I have also been provided with copies of articles, theses, reports, guidance documents and training manuals. A list of all those who have contributed and a list of all of the material received are contained at Annex A. With the assistance of the inquiry team, I have tried to consider all of these materials in the preparation of the report.

14.4 Almost entirely thanks to the hard work of Samantha Leek, a document was circulated in hard copy and posted on the inquiry’s website on 8th December 2000 setting out the inquiry’s understanding of the procedures currently followed to establish the identity of victims of major transport accidents. Readers of the
document (which I shall call the ‘procedural document’) were invited to comment on it and on the suggested recommendations set out in it. A number of written responses were received by the inquiry and on 18th December a public meeting was held in order to give anyone interested an opportunity to make oral submissions or comments both on the procedural document and on the way forward for the future. I am extremely grateful to all those who sent in submissions and who contributed at the meeting. As already stated, a list of those who attended forms part of Annex A.

14.5 This part of the report is based largely on the information set out in the procedural document. The inquiry team has tried to correct such errors as there were in it, but thanks to the thorough way in which it was prepared, very few were pointed out to us. I have also added such further information as was provided to the inquiry. If there are any errors of fact, they are entirely my responsibility and I apologise for them.

14.6 In the meantime, on 19th October 2000 a letter was sent out to all the coroners in England and Wales, asking them to provide information, *inter alia*, as to their current practices regarding identification, their relationship or proposed relationship with the police in the case of a disaster and the way in which they deal or would deal with bereaved families in cases where the need to identify a deceased arises. We also asked them if they would welcome further training as to how to deal with a mass disaster situation or guidelines as to identification. I am pleased to say that a large number of coroners responded to the letter, for which I am grateful. The responses have been of great assistance. A list of all those who responded is at Annex A.

14.7 I hope that as a result of the combination of written information and oral submissions I have been able to form a realistic understanding of the way in which victims of major disasters are identified today, although I recognise that it is quite impossible to form a complete picture of the situation without having been involved oneself. With regard to my recommendations for the future, I hope that I have managed to balance the requirements of those agencies involved in the identification process (police, coroners, pathologists etc) against the needs of the bereaved.

14.8 The evidence shows that a great deal of work has been done and (as I said in paragraph 4.3 above) that lessons have been learned over the past 11 years since
1989. I would like to mention in particular the continuous work undertaken by the Association of Chief Police Officers (‘ACPO’) and the MPS, both of which organisations have made every effort to learn lessons from each major incident in which they are involved. I would specifically like to pay tribute to the work undertaken by the MPS working group led by Detective Chief Superintendent Barry Webb, which undertook a review of casualty bureau procedures, family liaison arrangements and identification processes following the Ladbroke Grove rail crash.

14.9 The working group produced a report dated 30\textsuperscript{th} March 2000 which I have annexed at Annex F since it seems to me to make a number of extremely sensible suggestions and recommendations, all of which have been accepted by ACPO and are currently in the process of being implemented, whether by incorporation into the 2001 ACPO Emergency Procedures Manual or otherwise. As will become clear, I wholeheartedly endorse all of the recommendations made by DCS Webb and his team and am pleased to note that the police service is progressing the recommendations.

14.10 The procedures currently followed to establish the identity of victims of major transport disasters vary from coroner to coroner and between police authorities. Emergency planning and disaster management are undertaken on a local rather than a national level, although some national organisations such as the police service issue national guidelines and co-ordinate training on a national level.

14.11 In the aftermath of any major disaster the identification of victims involves a large number of individuals, organisations and agencies. The relationship between them depends to a significant extent upon pre-planning and the establishment of defined roles. In what follows I shall try to focus upon that relationship, but begin with the roles of those principally involved.

15. **The Role of the Coroner**

*The Office of Coroner*

15.1 Since it is the coroner who is ultimately responsible for the identification of deceased victims of disasters, it seems appropriate to consider first the nature and role of the coroner. In doing so, I shall throughout refer to the coroner as
'he', but only for ease of reference and not because I assume that all or most coroners are male. On the contrary, I am aware that many coroners are female and I intend no discourtesy to anyone.

15.2 I recognise that in recent years there has been a considerable amount of literature on the role of the coroner. Some of it is listed among the material in Annex A. It includes the Bristol Royal Infirmary Interim Report dated May 2000 ('the Bristol Report') and the Royal Liverpool Children’s Inquiry Report, published to Parliament as recently as 30th January 2001, ('the Alder Hey Report'). As will be seen in part three below, my experience in this inquiry and my reading of the Bristol and Alder Hey reports have persuaded me that it is time for a detailed review of the role of the coroner by, say, the Law Commission, in order to consider in what form the office should continue and to propose a statutory scheme which would codify the powers, duties and responsibilities of the coroner (and indeed others involved in the identification of the deceased) so that they can all be found in one place and be readily comprehensible to all.10

15.3 The coroner is an independent judicial officer who is appointed by the local authority but who can be removed from office only by the Lord Chancellor 'for inability or misbehaviour in the discharge of his duty’11 or by the court upon conviction for corruption, wilful neglect of duty or misbehaviour in the discharge of his duty. The appointment, powers and duties of the coroner are regulated by the 1988 Act and the 1984 Rules. They are not, however, wholly to be found in those two places. Thus in R v Bristol Coroner, ex p Kerr [1974] QB 652, where the Divisional Court was considering the extent of the coroner’s right to possession of a body, Lord Widgery CJ said at 658E:

The reason why there is so little authority on the point no doubt is because the coroner’s office is a very ancient one, and many of the principles on which his rights are based are principles of common law which have never been challenged in recent years.

Since 1974 interested relatives have been more inclined to challenge what have been said to be the powers of coroners and it is partly for this reason that it seems to me that the time has come to put them on (and only on) a coherent statutory basis.

10 See further paragraphs 29.2 et seq below.
11 Section 3(4) of the 1988 Act.
The only qualification required for appointment as a coroner\textsuperscript{12} is that the individual concerned has been qualified as a solicitor or barrister for five years or is a legally qualified medical practitioner of not less than five years’ standing. The Home Office, which is responsible for the law relating to coroners, has provided evidence to the inquiry that any person appointed as a coroner may take up his post without any formal training. There is no statutory requirement for coroners to undergo training or achieve particular qualifications in law or practice. As set out at page 56 of Annex B to the Bristol Report on the removal and retention of human material and set out in a Home Office submission to this inquiry, neither the Home Office nor any other government department has any statutory responsibility for setting educational or training standards for coroners, although the Home Office has provided regular study opportunities for coroners to attend on a voluntary basis.

Most of the submissions received from coroners have stated that they would welcome further or compulsory training. Mr Victor Round, who attended the 18\textsuperscript{th} December meeting on behalf of the Coroners’ Society, expressed the view that there should be a statutory requirement for coroners to undergo training before taking up their posts or that it should be a term of the appointment of any coroner that he should undergo appropriate training. He said that the Coroners’ Society felt that training should be compulsory. Indeed, I have been informed by Veronica Hamilton-Deeley, HM Coroner for Brighton and Hove in a letter dated 12\textsuperscript{th} December 2000 that at the last AGM of the Coroner’s Society a resolution was passed urging the Home Office to provide coroners with more training. I have made recommendations regarding the training of coroners in paragraphs 29.17 to 29.18 and in recommendations 6 and 7 below.

\textit{The Duty to Identify and Possession of the Body}

Where there is reasonable cause to suspect that a deceased person has died a violent or unnatural death, or has died a sudden death, the cause of which is unknown, the coroner within whose district the body lies is under a duty to hold an inquest.\textsuperscript{13} In these circumstances, it is almost inevitable that an inquest or inquests will have to be held after a major disaster.

The duty to identify the victims of major disasters in practice falls to the coroner. No-one suggested the contrary. One might have expected that duty to be clearly

\textsuperscript{12} Section 2(1) of the 1988 Act.
\textsuperscript{13} Section 8(1) of the 1988 Act.
stated in the 1988 Act but there is no clear and explicit statutory provision to that
effect. The duty is not set out as a free-standing duty imposed upon the coroner
by the 1988 Act, but is to be inferred from the fact that by section 11(5) of the
1988 Act and rule 36(1) of the 1984 Rules the matters to be established at an
inquest are who the deceased was, when, where and how he died.

15.8 Section 11(5) provides, so far as relevant to identification:

An inquisition –

(a) shall be in writing under the hand of the coroner and, in the
case of an inquest held with a jury, under the hands of the
jurors who concur in the verdict;

(b) shall, set out, so far as such particulars have been proved –

(i) who the deceased was; . . .

The inquisition is thus the document signed by the coroner or the jury. It is
accepted by everyone as implicit in section 11(5) that since the inquisition must
set out who the deceased was, the coroner must be satisfied as to the identity of
each deceased. Strictly, the effect of section 11(5) seems to me to be that it is for
the jury to be so satisfied where an inquest is held with a jury and for the coroner
to be so satisfied where there is no jury.

15.9 The reference to identification of the deceased is somewhat oblique both in the
1988 Act and the 1984 Rules. However, in practice everyone recognises that the
coroners must be satisfied as to identification before the inquest begins, so that
there will be no difficulty about it at the inquest itself.

15.10 The legal principle that there is no property in a dead body or in parts of a dead
body is enshrined in English common law, although there are a number of
exceptions to it. One of those exceptions is the coroner’s right to possession of
the body of the deceased for the purpose of his coronial functions until those
functions are completed or he otherwise loses jurisdiction: R v Bristol Coroner ex p Kerr [1974] QB 652. Since one of those coronial functions is identification of

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14 See also rule 4.
15 See also Jervis on Coroners 11th Edition (paragraph 6–10).
the deceased, it follows that the coroner is entitled to possession of the body, *inter alia*, until the identity of the deceased has been established. In this regard I note the comments made in the Bristol Report as to the question of whether human material belongs to anyone and as to the ‘no property’ rule stating that:

> It is no hyperbole to describe the law in this particular area as both obscure and arcane.

It seems to me that this is an apposite description of the law, not only relating to the so-called ‘no-property rule’ but also as to the duty to identify and the powers and duties of coroners generally. I return to this point in paragraph 29.2 to 29.14 and in recommendations 1 and 2 below.

**The Coroner and Identification Procedures**

15.11 Whether there is a single death, or many deaths in the case of a major disaster, the decision as to the criteria to be accepted for identification in practice lies with the coroner, even where there will be a jury at the inquest. It is thus in practice for him to decide in each case whether he is satisfied on the evidence presented of the identification of an individual. In the case of a single death, it is likely that the coroner’s officer or officers will make enquiries as to the identity of the deceased, possibly with the assistance of the local police.

15.12 The procedures followed to establish the identity of victims of major transport disasters will inevitably be similar to those followed whenever there is serious loss of life following any major incident, whether in the context of transport or otherwise. The ease with which the identity of the victims can be established will naturally depend on the nature of the incident.

15.13 The procedures followed to establish the identity of those on board a plane, where the names of the passengers should be known, will thus be different from the procedures followed in what is known as an ‘open’ disaster such as a bomb explosion in a busy store in the middle of a city. Although the task of identifying ‘who’ is likely to have been involved will not be the same in these two very different cases, many of the technical procedures will be similar. Because of the scale of the task in a major disaster, it is in practice the police who set up the structures and facilities required to ascertain the identity of the victims even though the ultimate decision as to the identity lies with the coroner (or jury). See Paragraph 98.
below for a discussion on the Identification Commission which is now (and has for some years been) set up in each disaster and on which the coroner sits with senior members of the police and other professionals.

15.14 With regard to the relationship between the coroner and the police, Leonard Gorodkin, the coroner who assumed jurisdiction for the deceased in the Manchester Airport Disaster, said at a conference organised by the Emergency Planning Society in 1999 (‘the EPS Conference’):

When a disaster occurs the police of course are immediately involved . . . with the emergency services. . . . But after that initial response and when it is appreciated that there are deaths, the police also investigate on behalf of the coroner. The coroner will normally be contacted pretty quickly and as soon as he gets to know he should get to the scene and liaise with the senior police officer to make the decisions about the inquiry.

15.15 In his book ‘Coroner’s Courts: a Guide to Law and Practice’ (1st edition 1999), Christopher Dorries sees the function of the coroner and his relationship with the police as follows:

In a major disaster, as with any death, the coroner has responsibility for the body until such time as it is released to the relatives. He must arrange for the body to be recovered from the place of death and for it to be kept in a proper manner until any necessary post-mortem and forensic examination can take place, so that the body is properly identified and that any evidence of crime is preserved for the police to deal further with. There must be liaison with the relatives. Eventually the body, and connected property, must be released for disposal to those lawfully entitled . . . this responsibility must be exercised in coordination with the police, who will not only be performing many of these tasks for the coroner but will also be treating the event as a major crime until the contrary is shown.

15.16 He summarises the preparation required for a disaster by saying that the coroner must ensure that:

he has his own written procedures in place to initiate a proper response to disaster by his own office;

[his] responsibilities and needs are properly considered by those preparing disaster plans for the community (eg. police and social services);
the identification, establishment and staffing of a temporary mortuary (with sufficient facilities to handle a large number of casualties) can take place smoothly at short notice;

there are proper systems in place, understood by all those involved, to deal with the recovery of the bodies;

procedures can be set in progress which will end with a positive identification of each body;

the responsibilities of the coroner and of the police are understood by both sides and that there are suitable liaison arrangements in place.

No-one suggested that that did not accurately state the current position. Clearly much of this preparation must take place in conjunction with the police and other agencies.

16. The Role of the Police

16.1 As stated before, in the course of this inquiry I have had great assistance from both the MPS and from ACPO. They have both sent detailed submissions to the inquiry and have answered thoroughly the numerous questions asked of them throughout the period of the inquiry. Deputy Chief Constable Alan Goldsmith, the Chairman of the ACPO General Policing Committee’s Standing Sub-Committee on Emergency Procedures, has provided a submission (‘the ACPO Submission’) to the inquiry dated 29th September 2000. Also both DCS Webb and Chief Inspector Mick Free attended the meeting on 18th December and made valuable contributions to the debate.

16.2 An important part of the work done by the MPS and ACPO to which I referred in section 14 above, has been the improvement of the processes of identification after a major disaster. In particular, considerable care is now taken to treat relatives with the respect which they both require and deserve in what must be a most distressing time for them. As already indicated in the context of DCS Webb’s working group, the police procedures are kept under continual review such that, although I shall make a number of recommendations in part three
below. I do not pretend that (for the most part) they are original suggestions. On the contrary, most of them are already in prospect thanks to ACPO, the MPS, DCS Webb, Chief Inspector Free and countless others.

16.3 The role of the police in the aftermath of any major incident is set out in detail in the ACPO Emergency Procedures Manual 1999 (‘the ACPO Manual’) and in a 1994 MPS document entitled ‘The Identification of the Deceased following Mass Disaster’ (‘the Identification Manual’). When I considered these matters briefly in the course of my final report in the TSI I annexed part of the ACPO Manual and the whole of the Identification Manual as Annex G. In order that this report should be free-standing I annex the same material as Annex G to this report because it seems to me to be of particular importance to an understanding of present procedures. I understand that the ACPO Manual is currently undergoing revision and that the 2001 edition is likely to be published shortly. As stated above, the numerous recommendations of DCS Webb and his team relating to identification, family liaison and casualty bureaux will be incorporated into the new edition.

16.4 In addition to those documents, the Home Office has produced a document entitled ‘Dealing with Disaster’ which contains guidance to those organisations which would be likely to be involved in the aftermath of a major disaster. This document does not replace the guidelines and manuals aimed at the individual emergency services and other agencies, but presents best practice and draws on lessons learned from real incidents and exercises. The inquiry has also been provided with a document entitled ‘Dealing with Fatalities During Disaster’, which is a report produced in October 1994 by a National Working Party chaired by the Civil Emergencies Adviser to the (then) Home Secretary. In addition, individual police forces have their own disaster plans prepared in conjunction with local authorities’ emergency planning departments and often with the local coroner and local pathologists.

16.5 In any major incident, the tasks of controlling and co-ordinating the operation to recover bodies and the collation of information for the purpose of identification in practice fall to the police service from an early stage. According to the ACPO submission, where there are casualties and loss of life, in addition to the collation and dissemination of casualty information, the police see their primary responsibilities as being:
control of the remains of the deceased, identification of the remains and release of remains to next of kin, with the consent of the coroner.

The police are of course also responsible for the investigation of any new crime or possible crime which may have been committed.

16.6 Essentially, the police will be involved in the removal of bodies, body parts and property from the scene, transporting them to the mortuary or temporary mortuary, collating, documenting and matching the post mortem and ante mortem information and providing family liaison services for the families of the deceased.

16.7 It is a striking feature of the role of the police after a major accident that (except perhaps in connection with the investigation of crime) the responsibilities described above do not derive specifically from any statute or statutory instrument. The police simply assume that their role includes the exercise of those responsibilities and no-one suggests that they should not have them. So far as identification is concerned, the legal position is that when the police are dealing with a suspicious death they work on behalf of the coroner because it is he who has both the responsibility for identification (as explained above) and the right to possession of the body until his coronial functions have been fulfilled. Matters within any criminal investigation not overlapping with the coroner’s jurisdiction will of course be pursued without reference to him.

16.8 The control of the remains of the deceased and identification are naturally matters for the police because they may be of importance in a criminal investigation, but quite apart from that, they are among those tasks for which the police have naturally assumed responsibility as the agency best able to carry out the necessary work. As to the release of the remains to the next of kin, the MPS are of the view that responsibility in that regard sits more appropriately with the coroner and/or mortuary staff but that this is an issue which can and should be considered in each disaster by the Identification Commission. I agree that this is indeed a matter which could (and should) sensibly be considered by the Identification Commission because the appropriateness of who is responsible for the release of bodies or remains will depend, among other factors, upon the location of the casualty, whether the bodies are held at a public mortuary or temporary mortuary, the number of fatalities and the resources available both to the local police and to the coroner. However, as appears further below, it is in my
view desirable that responsibility for the custody and release of body parts should be determined as part of a pre-ordained protocol, so that in any particular case the Identification Commission only has to consider the problems which arise in that case.

16.9 Whatever decision is reached as to where the responsibility for these matters lies, it is of paramount importance that the division of responsibility is made clear to all those involved. I shall return to this point below in the context of the Identification Commission and the role of a senior officer, whom it is intended should be designated Senior Investigation Manager (‘SIM’). As appears below, he or she will have an important role, which will include discussing the division of roles and responsibilities with both the coroner and other members of the Identification Commission.

**Relationship between the Police and the Coroner**

16.10 It is evident that the relationship between the police and the coroner will depend not only upon the individual coroner and police force, but also upon the nature and extent of any co-ordination and contingency planning which has taken place between the coroner, the police, the local authority and other relevant agencies before any major incident occurs. The contribution made to the inquiry by the secretary of the Coroners’ Society, Michael Burgess, is to much the same effect. Police forces have their own procedures in place for the management of a major incident, including the recovery and identification of bodies, but the extent of the involvement of the coroner in the process depends largely upon the individual coroner.

16.11 The evidence given in part one of this inquiry highlights the importance of pre-planning between the local coroner, police force and local authority emergency planning department. It is vital that each agency knows, not only what its role will be in the event of a disaster producing numerous fatalities, but also the role of each of the other organisations involved. This will involve working out who is responsible for collation of information, recording of information, documenting the procedures, contact with families, making of key decisions at every stage and release of bodies or remains.

16.12 The importance of pre-planning is recognised by the Royal College of Pathologists, whose document ‘Deaths in Major Disasters – the Pathologist’s Role’ states:
Because of the recent increase in the number and variety of major disasters, it is now generally recognised that the planning of emergency procedures, including training programmes, is a matter of great importance and urgency.

Before considering the important role of the Identification Commission and the proposed role of the SIM it is convenient to set out briefly the way in which information is collated and matched for the purposes of identification. Since these tasks are essentially undertaken by the police, I shall consider them in this section. I shall also consider the Identification Commission and the SIM in this section because the SIM post will be held by a senior police officer and the police are central to the Identification Commission.

**Collation and Matching of Ante Mortem and Post Mortem Information**

16.13 In order to establish the identity of the victims of any disaster, a match has to be established between ante mortem information and post mortem information (whether of bodies or body parts). Ante mortem information is all of the information known about the deceased before he or she died. This will include information such as what he or she was known to be wearing at the time of the incident, jewellery and personal effects known to be worn or carried at the time of the incident, dental records, fingerprint information (either latent prints lifted from, say, the home or car of the deceased or prints held by the police where the deceased had a criminal record), known surgical procedures and more recently, samples of DNA which might be found at the deceased’s home or elsewhere. Post mortem information is information ascertained from the (as yet unidentified) body which has been found: this will include what is found on the body, including jewellery, clothing and personal effects, scars, tattoos, body piercing, dental charting, fingerprints and DNA.

16.14 In the case of a ‘closed’ disaster, where the identity of those in a particular place is known, clearly it is easier to collate the ‘ante mortem’ information with which to match the post mortem information than in the case of an ‘open’ disaster. In the case of an ‘open’ disaster, hundreds, often thousands of people will think that a friend, relative or acquaintance was or might have been involved. This may also be so in the case of a closed disaster although in such a case it will be much easier to establish with some certainty who was involved.
16.15 In either case a casualty bureau is set up by the police: see Section 14 of the ACPO Manual in Annex G. This is a police operation which will usually be set up within a very short space of time after the disaster has occurred. The ACPO submission sets out the role of the casualty bureau as follows:

... to provide a central contact and information point for all records and data relating to persons who have been, or who are believed to have been, involved in an incident. There are three fundamental tasks in this process, namely obtaining relevant information on the persons involved or potentially involved, the processing of that information and then the provision of accurate information to HM Coroner, to the senior investigating officer, and to relatives and friends.

16.16 Essentially a casualty bureau comprises four units: (a) missing person enquiry unit; (b) casualty information unit; (c) collation unit; and (d) general message unit. The ACPO submission sets out the function of these units as follows:

The missing person enquiry unit is responsible for receiving incoming enquiries from members of the public on designated telephone lines, for assessing the likelihood of involvement, for recording details as required and for passing them to the collation unit.

The casualty information unit is responsible for recording incoming casualty data from police documentation teams at hospitals, at the scene and at survivor reception centres. Once recorded the casualty information is passed on to the collation unit.

The collation unit is responsible for matching information from the missing person enquiry unit and the casualty information unit. Where a match is made the information is passed on to the general message unit.

The general message unit is responsible for informing enquirers when a match has been made, notifying persons on behalf of casualties and making other general enquiries as directed.

16.17 The ACPO submission states that the post mortem data is recorded on Disaster Victim Information (‘DVI’) forms developed by Interpol (the International Criminal Policing Organisation) for use by all member countries. Air Commodore Cullen of the Department of Aviation Pathology states that, while the Interpol DVI form is ideal for the investigation of the identification of a single
unknown body, such as the unknown victim of a murder, it is not easy to use when there are multiple victims. His department therefore devised its own form which has been adopted with some modifications by the MPS and is known as MPS form 3140.

16.18 As a result MPS form 3140 is a practical form used for the identification of victims of disasters. Air Commodore Cullen accordingly recommends that it be used in all disasters in the United Kingdom. ACPO has confirmed to the inquiry that form 3140 is less complex than the DVI form and that it was used at Ladbroke Grove with success. The inquiry was informed that there was to be a meeting of the ACPO Major Disaster Advisory Team on 5th December to discuss the question of body file forms and that the comments of Air Commodore Cullen would be noted. The ACPO Major Disaster Advisory Team did in fact discuss the question of body file forms on 5th December and the inquiry has been informed that further work is being undertaken to move this issue forwards.

16.19 Once post mortem and ante mortem information has been collated, the missing person list which has been compiled by the casualty bureau (and narrowed down as much as possible to a list of those persons likely to have been involved in the incident) can be compared against the bodies recovered. The forms containing all of the information about the (as yet unidentified) victims are compared with all of the information known about the missing persons.

The Identification Commission

16.20 The purpose of the Identification Commission is to ensure that all the relevant information is collated and evaluated. It is, in effect, a committee responsible for establishing the identity of each deceased. It is set up at an early stage and usually comprises the following:

- Overall Incident Commander
- Incident Officer
- Senior Investigating Officer
- Supervising Pathologist
- Ante Mortem Co-ordinator
- Mortuary Documentation Officer
Administrative Officer

and where applicable:

Odontologist

Other pathologists

Fingerprint Experts

Other specialists – eg. jewellery etc.

16.21 The role and functions of the Identification Commission are set out as follows in the ACPO Manual (see also the Identification Manual):

(a) Liaison with the Coroner – The Overall Incident Commander will be responsible for evidence presented to the Coroner. Police MUST liaise with the Coroner to formulate identification criteria and evidential requirements.

(b) Controlling the running of the Mortuary – through the Mortuary Documentation Officer and the Mortuary Duty Officer.

(c) Confirming the appointment of a supervising Forensic Pathologist with the Coroner – where several pathologists are working it is advantageous for one of them to act in a supervisory capacity.

(d) Recording and Evaluating post and ante mortem data – receiving information from both post and ante mortem teams generating and collating enquiries.

(e) Compiling identification evidence for submission to the Coroner and any other inquiry.

16.22 Any information received by the casualty bureau is passed to the Identification Commission. The ACPO Manual states that the Identification Commission will examine each prospective identification against the evidence presented by the post and ante mortem teams until all victims have been identified or enquiries exhausted.
16.23 The Identification Commission also works closely with the coroner. The Home Office publication ‘Dealing with Disaster’ and the Identification Manual state that the coroner chairs the Identification Commission and set out the functions of the Identification Commission as including ‘the compilation of evidence which will lead to the positive identification of the deceased, and controlling the running of the mortuary.’ The ACPO Manual does not specifically state that the coroner chairs the Identification Commission, although it is (as I understand it) the practice for the coroner to discuss with the police (and other members of the Identification Commission, usually the supervising pathologist and forensic odontologist) the criteria which he would accept (and thus expect the jury to accept) for a positive identification. It is, after all, ultimately a matter for the coroner what criteria should be accepted for a formal identification. It is for him to decide in each individual case whether he is satisfied on the evidence presented of the identification of an individual.

16.24 The inquiry was informed by the MPS in a letter dated 5th December 2000 that the omission of any reference in the ACPO Manual to the coroner chairing the Identification Commission was deliberate. The reason was that the ACPO Emergency Procedures Sub-Committee had considered the matter and had concluded that the variation in the levels of experience of coroners around the country is so great that it would be inappropriate for the coroner automatically to head the Commission. The present view of the MPS is, however, different. In a letter dated 14th December 2000, it expressed the view that the coroner should always be the head of the Identification Commission, working with appropriate support from other commission members, particularly where the coroner lacks experience.

16.25 This was one of the matters discussed on 18th December and it was I think the view of most of those present that in principle it is desirable that the Identification Commission should be chaired by the coroner, but that (in common with most of the questions which were debated) there should be no inflexible rule because circumstances vary greatly and it might be appropriate for someone other than the coroner to chair the commission in a particular case. That seems to me to be a very sensible approach. Thus in general the coroner should be chairman of the Identification Commission, but there may be unusual circumstances in which that would not be appropriate. In such a case, as I see it, it must be for the coroner, no doubt in consultation with the overall incident commander, to decide who should take the chair.
16.26 The Identification Commission has now been successfully used on a number of occasions. One further question which was both canvassed in submissions and debated on 18th December was the size of the Identification Commission and whom it should comprise. Various people made submissions that, in addition to those people listed above who would normally form part of the Identification Commission, numerous others including mortuary staff (and in particular the mortuary manager), a member of the Forensic Scientific Services or other forensic scientific adviser, clergy and family liaison co-ordinators should sit on the Commission. At the meeting on 18th December DCS Webb expressed the view that the Commission should be ‘as small as possible in terms of core players’ and should include those people listed in the ACPO Manual as ‘core players’. He accepted, however, that if there were any particular difficulty further experts could be called upon to assist or to attend meetings.

16.27 In response to concerns expressed on 18th December that the families’ interests were not represented on the Identification Commission, DCS Webb explained that the SIM (as to whose role, see paragraphs 16.30 to 16.34 below) would sit on the Commission and that he would liaise closely with the family liaison co-ordinator. DCS Webb reported that this structure was used following the Ladbroke Grove rail crash and that he anticipated that the family liaison co-ordinator would speak to the SIM about any issues of concern being raised by the families of the victims.

16.28 DCS Webb reported that at Ladbroke Grove the officer who in effect performed the role of SIM had a number of meetings with the families himself in order to ensure that he was receiving all the information he required. Thus he was able to take the information and put it before the Identification Commission.

16.29 It seems to me that it is indeed sensible for the Identification Commission to be limited to the ‘core players’, as suggested by DCS Webb and as set out in the ACPO Manual, so that it does not become unwieldy, but that there should be flexibility as to who sits on the Commission in any given circumstance. All should depend on the circumstances of the particular case. Thus, in each situation the Commission would comprise those people set out in the ACPO Manual together with the coroner and the SIM. Further members of the commission could then be co-opted as and when necessary.
**The Senior Identification Manager**

16.30 As set out in detail in part one, the facts of this case demonstrate both the importance of collation of ante mortem and post mortem information and the importance of ensuring that the responsibility for that collation should be clearly defined. It became increasingly clear during the course of the evidence heard in part one that no-one was responsible for deciding on a case by case basis whether it was necessary to go to the extreme lengths of removing the hands of a deceased in the light of the other information which was available or likely to be available in the near future. The essential lessons to be learnt from this case are that each deceased must be considered as a separate case and that, before any step is taken which is likely to cause distress to relatives, such as the removal of hands, the person making the decision what evidence should be presented to the coroner should have available to him all the ante mortem and post mortem information that has been obtained. That is only possible if the information obtained is collated in a systematic manner and presented to the decision maker.

16.31 In this regard, following the Ladbroke Grove rail crash, DCS Webb and his team recommended the creation of the post of SIM. The recommendation is that the SIM, who would be a Detective Superintendent or Detective Chief Superintendent, would have overall responsibility for the identification process and would provide the link with the Senior Investigating Officer (‘SIO’) regarding the investigation process.

16.32 DCS Webb amplified this at the hearing on 18th December and explained that in a major disaster information about the deceased comes from the casualty bureau, family liaison officers (‘FLOs’), coroner’s officers, the mortuary team and the incident room. He anticipated that the role of the SIM will be to pull together the information, evaluate it and report to the Identification Commission on the identification status of each of the deceased, how far the procedures have progressed and what remains to be done in order to satisfy the identification criteria. This is an eminently sensible recommendation, which I fully endorse. The SIM creates a bridge between the coroner and his staff on the one hand and the police on the other and, together with the FLOs, forges a crucial link between the police and the bereaved and survivors.

16.33 Thus as I understand it the SIM will be responsible for the collation of information in the case of each deceased in order to ensure on the one hand that the process of identification proceeds with reasonable despatch, because of
course families of those whom they fear may have lost their lives want to know the true position, and on the other hand that the process is done efficiently and that no untoward decisions are taken. If there had been a SIM in 1989, it seems most unlikely that this inquiry would be taking place today. On the basis of the experience in this case, of the written submissions I have read and of the discussion on 18th December, I fully support the appointment of a senior police officer as SIM in future cases of major disaster. As I see it, in addition to his responsibilities to his superiors in the police, he will be responsible to the Identification Commission and, through it, to the coroner.

16.34 I should also note that at the hearing on 18th December DCS Webb stated that within the ACPO Major Disaster Advisory Team there are currently four officers with sufficient training and expertise to enable them to give advice as to the role of the SIM. In this regard DCS Webb himself gave advice to the SIO following the Ladbroke Grove rail crash. He said that one of the proposals that he is to make to ACPO in the near future is that a number of officers around the country (probably in the region of 40) should be trained in the role of SIM in order to be able to perform that role in the event of a disaster. Subject to any questions of funding, that seems to me to be a very sensible idea.

17. What Happens to the Body?

17.1 The first exercise to take place in any disaster situation is the location of bodies and body parts. This is undertaken by the police with the assistance of the fire brigade and possibly with the assistance (or advice) of pathologists. For example, after the MARCHIONESS disaster this involved searching the Thames continuously for a number of days. In the Paddington disaster this involved, inter alia, a slow-moving line search along the track and its surrounds to locate bodies and body parts. When bodies or body parts are located they are labelled and/or numbered, probably photographed in situ and taken to the temporary mortuary, which is described in section 18 below. The police have devised a system for labelling bodies and body parts in such situations and ensuring that records are kept of the precise location in which they are found.
17.2 It is essential that the police establish evidence of continuity regarding the movement of bodies, body parts and property from the time of finding, through the identification process and up to the time of release to the family.

17.3 The collection of post mortem data is a multi-disciplinary team effort. Any body or body part found at the scene of the accident is placed in a body bag and transported to an appropriate site for examination, usually the temporary mortuary. All body parts recovered are separately bagged and numbered and taken to the temporary mortuary.

17.4 It is important that there is no confusion during any stage of the identification process as to the identity of each body or body part. Establishing the continuity of the body, body parts and property is therefore vital. A police officer is usually responsible for accompanying the body or body part from the scene of the incident to the temporary mortuary where it is usually passed to another police officer. This is all documented and statements are usually taken which will enable the history of a body or body part to be traced from the time it is found and numbered until it is identified and matched with a name.

17.5 Bodies found at the scene are not searched in situ but are removed and taken to the temporary mortuary. Property found on a body is not removed at the scene but is labelled and placed in the bag with the body. Such property may well be of assistance in the identification process. Likewise, whilst property found near a body should be labelled and its position marked, it should not be placed with a body in case it does not belong to that person. This could create confusion. The ACPO Manual states:

Property required for evidential purposes or to assist in the identification of victims will be labelled, its position marked for inclusion on the overall plan, placed in individual bags and handed to a property team for recording and storage.

17.6 On arrival at the mortuary there is a full examination of the body, which involves police, pathologists and photographers. Each item of clothing or other property found on it is described and recorded. It is then removed, numbered and retained. The body is normally photographed, both clothed and undressed, front and back. There is an external physical examination by the pathologist. In addition to noting the injuries the pathologist notes the physical features which may aid in identification. These include race, height, weight, build, eye colour, hair colour
and details, whether ears are pierced, whether make-up is worn, scars and deformities, tattoos etc. In some cases there is an autopsy or post mortem, during which the pathologist will look for evidence of disease and injury in order to determine the cause of death and to assist in the investigation of the accident, but which may also assist in identification. Radiological examination may reveal the presence of metallic implants within the body which may be compared with ante mortem records. These may include artificial hip joints, plates used to stabilise fractures and other signs of surgical intervention. Once the pathologist has concluded his examination, the odontologist makes a full dental charting. Fingerprints may then be taken. Every piece of information is recorded and every piece of evidence (such as clothes, jewellery and personal belongings) is kept as an exhibit.

17.7 All information obtained is passed to the Identification Commission for matching with the ante mortem information received by the casualty bureau, FLOs, the incident room and other sources.

17.8 The body is kept in refrigerated conditions at the mortuary or temporary mortuary until it has been formally identified and the coroner has authorised its release for burial or cremation. The body is then released to those entitled to it. The responsibility for release of the body and for ensuring that it is in a proper state and complete may be different depending upon whether it is in a mortuary or temporary mortuary. I return to this below.

18. **The Temporary Mortuary**

18.1 A ‘temporary mortuary’ refers to premises temporarily converted to a full mortuary facility where bodies are subject to a post mortem examination and identification procedure. This facility is required because, while hospital or public (local authority) mortuaries often have a capacity to store bodies in excess of what would normally be expected, different considerations apply in the case of a major disaster (transport or otherwise):

- there are often considerable numbers of body parts (particularly in the case of high speed impact or explosion) which have to be stored separately, thus taking up far more space than would be usual;
• the procedures involved in identification of body parts or mutilated bodies require more space than would normally be required;

• the viewing facilities at a normal mortuary are likely to be inadequate for the number of victims of a major disaster;

• there will inevitably be intense media interest and heightened security may be required in order to prevent journalists and others from gaining access;

• normal mortuary business has to continue despite the disaster.

18.2 A Home Office document entitled ‘Emergency Planning Guidance to Local Authorities’ advises:

in a Major Accident in which large numbers of people [are] killed existing public mortuaries may be insufficient and buildings suitable for temporary use should be earmarked.

18.3 The ACPO Manual states:

It is important that a temporary mortuary is set up correctly at the outset and it is strongly recommended that one or more suitable venues are pre-planned in each police force area. Pre-planning should always be undertaken jointly with the Local Authority, Coroner, Pathologist(s) and other specialists and whilst each organisation will make a necessary contribution, funding is the responsibility of the Local Authority as part of its duty to service the Coroner.

18.4 The nature and characteristics required of a building designated to be used as a temporary mortuary and the specific facilities and materials required are set out in detail in ‘Dealing with Fatalities during Disasters’, which examines the need for common practices when dealing with fatalities during disasters.

18.5 I have received copies of temporary mortuary plans from several coroners around the country. Dr Shepherd provided the inquiry with a copy of the Temporary Mortuary Plan for Surrey. He told me that the plan had been prepared as a result of numerous meetings organised by the Surrey County Council Emergency Planning Office and that advice had been received from the police, the coroner, pathologists and others for the purposes of preparing the
He also stated that there had been a ‘walk through’ of the facilities which had been attended by, *inter alia*, the police, the coroner, victim support groups and members of the church. I attach the plan as Annex H, albeit without its appendices, because it seems to me a most valuable document.

18.6 The plan specifies that the SIO will lead a designated temporary mortuary management team which is set up to provide the logistical and administrative support to ensure the smooth running of the temporary mortuary. It also specifies that Surrey Police will manage the arrangements for the reception and documentation of the deceased and their property into the mortuary and ensure that the instructions of the coroner are followed with regard to the final release of the deceased in liaison with the appropriate coroner’s officer and the relatives of the deceased. The plan defines clearly the respective roles of the police, the coroner, the supervising pathologist, the social services, the emergency planning unit, the Identification Commission and various other agencies which might become involved. I commend the plan to any person or organisation involved in contingency planning for a major disaster and suggest that all local authorities prepare similar contingency plans for a major disaster involving numerous fatalities.

18.7 It seems to me to be important that part of the pre-planning for a temporary mortuary should include consideration of the question who is responsible for the custody of each body while it is at the temporary mortuary and who is to be responsible for its delivery to the relatives or whoever is entitled to it after all relevant processes have been completed. For example, is it the police or the local authority who is to have custody of the body? Who then is to be responsible for ensuring that the correct body is delivered, that the body is (so far as possible and appropriate) complete and that the relatives (or as may be) are properly informed of or offered information about any respects in which it is not complete?

18.8 In this regard the position at a temporary mortuary appears to be as follows, although I am not sure whether this describes the situation throughout the country. The ACPO Manual states that one of the primary responsibilities of the police on behalf of coroners is the release of the body or remains to the next of kin with the coroner’s consent. So far as I can see, there are no details in the body of the Manual as to precisely what this means. A temporary mortuary will be staffed mainly by police officers with civilians being brought in if necessary but under the control of the police. In the section of the Manual on job descriptions, the roles of the ‘Identification Commission – Officer in Charge’ include ‘establish mortuary..."
procedures through Mortuary Documentation Officer’ and ‘brief mortuary staff’ as to areas of responsibility and procedures’. The Mortuary Documentation Officer is to ‘identify areas of responsibility in liaison with funeral directors’ and ‘provide the Overall Incident Commander with regular situation reports’.

18.9 ‘Dealing with Fatalities during Disasters’ states that:

the police are responsible for security of bodies and property in their capacity as officers of the coroner’s service. They are also responsible for the collation of identification data and the general management of the temporary mortuary.

18.10 Most of the procedures set out in the ACPO Manual and other disaster manuals assume that the post mortem and identification processes will take place at a temporary mortuary and in that case the operation is run and managed by the police from start to finish. Other individuals and agencies will be involved but it is essentially a police operation. Thus, in these situations it would seem that the police have de facto responsibility for the bodies and remains until their release is authorised by the coroner. It does not, however, appear that any person or organisation has the specific responsibility for ensuring that the correct body goes to the correct family or undertaker, that the body is released intact or as to the condition of the body.

18.11 The Surrey Temporary Mortuary Plan (at Annex H) refers to the coroner releasing the body to the family through a funeral director. It specifies as follows:

When the coroner releases the deceased to relatives, Surrey Police will ensure that the deceased are logged out of the mortuary.

Surrey Police will ensure that the instructions of the Coroner are followed with regard to the final release of the deceased in liaison with the appropriate Coroner’s officer and the relatives of the deceased. When encoffining is complete and identification has been carried out, they will ensure that the Police Liaison Officer and Social Services Officer attached to each family are informed.

18.12 The position thus appears to be that each body which is brought into a temporary mortuary is in the custody of the police from the time of arrival until physical
release to the relatives or whoever is entitled to receive the body. I see no difficulty with such an arrangement, provided that it is clear in advance who has custody of the body and who is responsible for ensuring that the correct body goes to the correct family or undertaker, that the body is released intact or as to the condition of the body. If there are indeed any parts of the country where there is any doubt about who has any of those responsibilities, they should be clarified before a major disaster occurs.

19. The Mortuary and Mortuary Staff

19.1 There may be cases of major disaster in which an existing mortuary is used. For example, the local authority mortuary in a particular area may be sufficiently large and well situated for it to be able to accommodate the bodies in the aftermath of a disaster and there may not be so many bodies or body parts as to overwhelm it. By way of example, Westminster mortuary was used after both the MARCHIONESS disaster and the Ladbroke Grove rail crash. Even in such cases, the practices followed after a major disaster are likely to differ from those followed in the ordinary cases dealt with on a day-to-day basis. The main differences are that in a disaster situation post mortem procedures must be carried out on a number of deceased within a short space of time and the identification processes are likely to be complex and undertaken by a team of police officers and other professionals.

19.2 The inquiry has received little information concerning the general workings of local authority mortuaries around the country, since this has not been the main focus of the inquiry. However, in his submission on behalf of Westminster City Council, James Butterfield has given a detailed description of the procedures followed to track a body through the mortuary. I include that description as Annex I (albeit without its annexes) so that it is not necessary to set out the substance of the procedures here, save perhaps to say this.

19.3 Elaborate procedures are now in place for logging a body into the mortuary and ensuring the documentation of any procedures or processes carried out on a body until the time of release. A Mortuary Action Report (‘MAR’) records the history of the body during the time that it is at the mortuary. A number of cross-checks have been put in place to ensure that there is no confusion as to the
identity of bodies and the inquiry has been informed that the system at Westminster has now been computerised. In this regard I would like to repeat what I said in part one, namely that the system at Westminster mortuary is now radically different and greatly advanced compared with that in operation in 1989.  

19.4 Mr Butterfield says that the disaster situation differs dramatically from the everyday situation. He describes how, in a disaster situation, a large number of unidentified bodies are likely to arrive at the mortuary in quick succession. Although an MAR is raised for each body, this bears no name at the outset. As set out above, the bodies arrive in body bags to which a police number is attached. The police number is recorded on the MAR. Although the mortuary staff give the body a separate mortuary number and add the name of the body to the MAR and other mortuary records (including the fridge, office board, toe-tags etc) once it has been identified, in a disaster situation the police produce their own records dealing with all matters relating to identification of the deceased.

19.5 Mr Butterfield says that in the past, as for example during the MARCHIONESS disaster, the mortuary tended to ‘cede’ detailed record keeping to the police once they became involved. That was not the case following the Ladbroke Grove rail crash and Mr Butterfield suggests that it should not be the case in the future. He suggests that while the principal task of identification falls to the police, it is important that the mortuary manager is fully aware of all the procedures affecting bodies in his ‘care’.

19.6 I agree. It seems to me that it is important in the case of a disaster producing numerous fatalities that the mortuary staff and the police communicate and co-ordinate their respective roles, so that each group knows exactly what the other is doing. The co-ordination between the agencies applies equally to the issue of documenting the procedures, reuniting body parts and the release of the correct remains to the next of kin. Mr Butterfield recommends that the procedures for the release of bodies should be tightened up.

19.7 He recommends in particular that the mortuary staff should receive authority directly from the coroner certifying:

- that an undertaker had been issued with the requisite certificate, and

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17 But see section 35 below.
that the coroner himself is satisfied that the body is suitable for release.

Any procedures which are designed to avoid the release of an incomplete body or to avoid the release of a body to the wrong family are to be welcomed.

19.8 As in the case of the temporary mortuary, it is important that it should be clear who has custody of the body and who has the responsibility for releasing it, for ensuring that the correct body is released, that the body is (so far as possible and appropriate) complete and that the relatives (or as may be) are properly informed of or offered information about any respects in which it is not complete. Whereas in a local authority mortuary under normal circumstances the body will be physically handed over to the undertaker by mortuary staff, a disaster situation could give rise to confusion as to whose responsibility this is. The usual mortuary staff will be present at the mortuary and the coroner’s officer will be present, but the police will be undertaking many of the procedures. In these circumstances it seems to me to be of particular importance to ensure that the responsibilities of each should be pre-planned and set out in precise terms so that there is no confusion in the course of the aftermath of a major incident as to whose responsibility it is to do what.

19.9 Once a major incident has occurred and an Identification Commission set up, these are all matters to be co-ordinated by the commission and, with the introduction of the SIM they are matters for him or her to deal with in conjunction with the coroner and the mortuary manager if the bodies are dealt with at a local authority mortuary or with the police officer or civilian who has been appointed to manage the temporary mortuary.

19.10 Under normal circumstances it is the role of the mortuary staff to process bodies through the mortuary, including recording any information about the body and documenting any processes carried out on the body. At Westminster mortuary, MARs are completed on each body coming into the mortuary which record details about the individual bodies. Mortuary staff are also expected to prepare the body for post mortems, assist the pathologist during a post mortem, replace the organs following the post mortem, stitch up the body and prepare the body for the funeral directors.
20. The Coroner’s Officers

20.1 Under normal circumstances the coroner carries out his functions with the assistance of a coroner’s officer or officers. The duties of the coroner’s officer are set out as follows in Jervis on Coroners: 18

The coroner’s officer may visit the scene or place where the body lies; alternatively he may receive a report from police attending the scene. . . . In either event he will commonly have to make the actual arrangements for removal of the body to a mortuary or other suitable place, . . . The duties of the coroner’s officer will also include searching for evidence relevant to the inquest, interviewing potential witnesses and dealing with lawyers and others representing interested parties. If a post mortem examination is made, he may have to notify persons who have a right to be informed of this. If an inquest is to be held, the coroner’s officer, on the direction of the coroner, will notify the interested persons and will summon the witnesses and the jurors (if a jury is required). He will probably also organise the actual sitting of the court, acting as a mixture of usher and clerk of the court.

In his relations with members of the public the coroner’s officer will come into contact with relatives of deceased persons in times of stress and often in very difficult circumstances.

20.2 In his statement for part one of the inquiry Mr Foster-Smith, one of Dr Knapman’s coroner’s officers, said that he dealt with identification of the deceased, carried out administrative work, took statements, presented the cases, fielded enquiries by relatives both in person and by telephone and undertook such other tasks as the coroner required. Naturally, the role of the coroner’s officer will be different in the case of a major disaster since the police will be undertaking many of the functions normally carried out by the coroner’s officer.

The Role of the Coroner’s Officer after a Major Disaster

20.3 It became clear during the course of the evidence in part one of the inquiry that there was confusion following the MARCHIONESS disaster as to the respective roles of the mortuary staff, the coroner’s officers (and his staff) and the police. That confusion was apparent in particular in relation to the liaison with families,

the release of the bodies and the question of viewing the bodies while they were at the mortuary.

20.4 At the hearing on 18th December, the MCG questioned whether there remained a role for coroners’ officers in dealing with families following disasters because of the existence of the FLO. At the hearing, I also expressed doubt as to whether there was room for the traditional coroner’s officer during the identification process since the point of contact with the family would be the FLO and the Identification Commission would make the major decisions. Mr Round, who spoke on behalf of the Coroner’s Society, expressed the view that in most disaster situations the coroner’s officers would still be required to ‘run the shop’ and maintain the everyday work of the coroner’s officer. He recognised (as indeed is the case) that FLOs almost take over the role of coroner’s officers if they are available, but said that the coroner’s officers can assist with local contacts, including morticians, suppliers and undertakers.

20.5 Elizabeth Riley, who is and has for many years been one of Dr Knapman’s coroner’s officers (and who gave very valuable assistance to the inquiry) stated at the meeting on 18th December that coroner’s officers had much to offer since they had a great deal of expertise in dealing with relatives and indeed many of them now come from the caring professions. She said that it was the belief of the coroner’s officers in post at the time of the MARCHIONESS incident that one of the reasons why problems occurred was because the coroner’s officers were used as court officers and played no part in the identification processes and the dealing with relatives. Mrs Riley hoped that this had been recognised and said that the coroner’s officers had been much more proactive in dealing with the relatives following the Ladbroke Grove rail crash.

20.6 It seems to me that this is an area (like others) where flexibility is important. Thus the roles of the coroner’s officers and staff and of the mortuary staff are likely to vary greatly depending on the size, nature and location of the disaster, the resources available to the coroner and the police, the experience of those concerned and perhaps even the idiosyncrasies of the coroner concerned.

20.7 As I see it, good sense suggests that in any disaster the lead should be taken by the police and that the SIM and FLO co-ordinator, acting in conjunction with the coroner, should lay down clearly the role to be played by the coroner’s officers and mortuary staff so that there is no confusion. As with most of these situations,
the crucial factor is co-ordination between the agencies so that everybody knows who is responsible for what. Since the police are now the most likely to be trained for coping with the aftermath of major disasters and have experienced senior officers available to supervise and advise, it should be for them to lay down the structures needed for the identification processes and the liaison with the relatives. For example, it is clearly of importance that the relatives are not bombarded with questions and requests from all angles and that duplication of questioning is avoided.

21. The Pathologist

21.1 The role of the pathologist is set out in full in the second edition (2000) of the Royal College of Pathologists’ document entitled ‘Deaths in Major Disasters – the Pathologist’s Role’. Where there is more than one pathologist involved in the aftermath of a disaster, one pathologist will be designated supervising pathologist. As set out above, the supervising pathologist will sit on the Identification Commission with the coroner and senior police officers. So far as identification is concerned, the pathologist is expected to assist, liaise with, cooperate with and supply information to the other members of the Identification Commission. This includes advising on the type of identification that is feasible.

21.2 The Surrey Temporary Mortuary Plan referred to above sets out the role of the senior supervising pathologist as follows:

Surrey Police and the Senior Supervising Pathologist will decide if it is necessary for the Senior Supervising Pathologist to visit the scene of the incident with the Coroner.

Once it has been decided to open a temporary mortuary, the Senior Supervising Pathologist will liaise with the Coroner and Police over the call-out of pathology staff, radiologists, odontologists and mortuary staff and equipment.

The Senior Supervising Pathologist will supervise the post mortem examinations.

The Senior Supervising Pathologist will hold regular meetings with the Coroner and Police to discuss the information concerning
identification and cause of death for each victim, so that the relevant bodies can be released from the mortuary to next-of-kin when the documentation is complete.

Before the start of post-mortems, the Senior Supervising Pathologist will endeavour to meet with religious representatives of the various faiths to discuss the mortuary process, in order to minimize conflict with any religious beliefs or practices.

21.3 Those principles also seem applicable to the situation where the work is carried out at a local authority mortuary. They seem to me to give a clear overview of the role of the pathologist. I should add that I say no more about the role of the pathologist in this report, not because I do not appreciate its importance after a major disaster, but because I am concerned only with identification and not with the very many other problems which can arise.

22. Methods of Identification

22.1 The methods of identification used in any particular disaster depend on the nature and circumstances of the incident. The Identification Commission discusses with the coroner the criteria which will be accepted by him for a formal positive identification. As stated above, ultimately, the coroner decides what will be accepted in order for a positive identification to be made.

22.2 There are a number of means by which the identity of an individual can be established. These include visual identification, fingerprints, dental charting, DNA, physical characteristics including ante mortem surgical procedures, jewellery, clothing and personal property. It goes without saying that some of these methods of identification are more reliable than others.

22.3 The ACPO submission states that:

the most reliable primary evidence of identification comes from personal characteristics such as DNA profiles, fingerprints or dental records. Secondary evidence can be obtained from the circumstantial items such as jewellery and clothing found on the body and personal property within the clothing.
Thus, comparisons of post mortem fingerprints, dental charts and DNA samples with ante mortem information provide objective methods of identification. The use of ‘secondary’ evidence may leave room for error and misinterpretation because it is reliant upon subjective judgment.

**Visual Identification**

The terms ‘visual identification’ and ‘viewing the body’ are often used interchangeably and thus confused. The distinction between the two expressions is an important one, which should not be trivialised. Visual identification is the process by which a relative establishes the identity of a victim by looking at the body and confirming that it is a particular missing person. Viewing the body is the process whereby a relative, friend or other person is permitted to look at, hold or spend time with the deceased, once the identity has been established and confirmed by other means.

Much has been written on the subject of both visual identification and viewing the body. With regard to visual identification, the weight of the submissions of those professionals regularly involved in the identification process, (coroners, pathologists, police officers, odontologists), suggests that this method of identification is notoriously unreliable. This is the case not only where the body is damaged by reason of fire, water, decomposition, trauma or other means but perhaps even where the body is intact and in good condition. This is not to say that viewing the body should not be permitted in such cases (see below).

Air Commodore Cullen states in his submission:

> I feel strongly that visual identification should only be used as a confirmatory method once the body has been restored by the undertakers. On many occasions I have come across mistakes in visual identification.

Professor Michael Green (an Independent Consulting Forensic Pathologist) says that in the days when physical identification was a requirement in coronial investigation, he frequently saw mistakes made by distressed relatives.

The Royal College of Pathologists’ Forensic Pathology Sub-Committee submits as follows:
visual identification by relatives may not be reliable even where the facial features are well-preserved. That is not to say that viewing of a body by relatives should ever be disallowed, such a prohibition having a potentially negative effect upon those relatives.

22.10 The Royal College of Pathologists’ document ‘Deaths in Major Disasters: the Pathologist’s Role’ states:

Formal visual identification is fraught with possible errors, enhanced by the distressed state of the bereaved. Identification by direct visual means should therefore not be carried out as a routine, but should perhaps be reserved for those cases in which the relatives positively wish to view the body. Bodies exhibiting substantial facial trauma should not be identified visually.

22.11 The submission of the British Association of Forensic Odontologists (‘BAFO’) expresses astonishment that any UK authority would use ‘subjective’ methods of identification without corroboration, citing the misidentification by visual methods of victims of the massacre in Luxor. It further suggests that subjective recognition should never be accepted unless all else fails, since it is too prone to error.

22.12 Dr Derek Clark, a member of BAFO, who has been involved in the identification of victims of a considerable number of disasters, writes:

Relatives are under intense emotional stress and have an overpowering desire to regain the body of a close relative and their powers of discrimination may become distorted. This results in a strong tendency to identify any body, even in the absence of any real likeness, rather than admit that visual identification could not or should not be made.

22.13 Professor Bernard Knight in his work ‘Forensic Pathology’\(^{19}\) writes:

Even in perfectly fresh bodies, recognition may be difficult because of alterations in the features caused by death. It is a common occurrence in mortuary viewing rooms for a close relative, even a parent or spouse, to have doubts about – or even to deny or mistakenly agree to – the identity of the deceased person. Though distress and emotion play a part, changes in the features may be profound. Hypostasis, contact flattening, oedema, muscle flaccidity and pallor may all combine to distort the face.

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\(^{19}\) 2\(^{nd}\) edition (chapter 3).
Recognition in the living is partly a dynamic process, aided by facial muscle tone and especially eye contact and movement, all of which are absent in the corpse.

22.14 Given the importance of establishing with certainty the identity of the deceased, the factors set out by the professionals regarding the difficulties of visual identification and the fact that ‘objective’ rather than ‘subjective’ means of identification are inevitably more accurate, it is clear that visual identification should be accepted with caution and, if possible, only where other confirmatory means of identification are available. This is particularly so where the bodies have been subjected to any form of trauma or high impact or have been immersed in water for any length of time.

22.15 The importance of getting it right first time cannot be overemphasised. Misidentification will inevitably be distressing for the family of a missing person. Further, in a mass disaster situation, the misidentification of one body will inevitably lead to the misidentification or non-identification of at least one other body. The knock-on effects may be far reaching.

22.16 Viewing of the body is dealt with in section 23 and paragraphs 29.35 to 29.39 below and is the subject of recommendations 27 to 30. It is important to recognise that where visual identification is not appropriate the family should nevertheless be given the opportunity to decide whether to view the body. It may well be that in cases where families have complained that they were not permitted visually to identify the body, if they had subsequently been given the opportunity to view the body the complaint would not have been made.

**Dental Charting**

22.17 Of all human material, dental tissues are the most likely to remain intact following physical trauma. Where a body has been subjected to extreme heat, the use of dental evidence is of prime importance, due to the inherent strength of teeth and their protected location within the body.

22.18 Dental identifications are made by comparing the missing person’s ante mortem dental records with the post mortem examination of the teeth of the victims. Dr Derek Clark\(^\text{20}\) has said that this has been the most successful method for a

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\(^{20}\) In an article entitled ‘Victim Identification in Marine Disasters’ in the Australian Coastguard Journal and in J Br Assoc Immed Care 1991: 14(3).
number of years. He qualifies this by saying that the success rate of dental identification will vary considerably depending on the nature of the accident, the nationality and country of residence of the victims, the incidence of dental treatment and the availability of good dental records.

22.19 It is generally agreed that in cases where a body has been subjected to extreme heat or mutilation, dental charting is one of the most reliable methods of establishing the identity of an individual. This will, however, depend upon the ability to obtain the dental records of the deceased, the accuracy of the records and the nature of any dental work which has been undertaken.

22.20 I understand that in some situations the jaw of the deceased has to be removed in order for x-rays to be taken or for accurate charting to be carried out. In such cases, consideration should of course be given to the need for carrying out such procedures in circumstances which are likely to be distressing for the relatives of the deceased. As in the case of removal of hands for fingerprinting, procedures involving mutilation of the body, and in particular parts of the body which are visible, should only be undertaken as a last resort. I discuss the removal of hands and other body parts below.

**Fingerprints**

22.21 The matching of fingerprints is an objective and accurate means of establishing the identity of a body, where ante mortem information is available. It is said\(^{21}\) that:

The most reliable method of identification is fingerprinting since no two sets are alike and the technique provides rapid conclusive identification.

22.22 The Identification Manual, which was published in 1994, recommends that the taking and use of fingerprints should not be restricted even if other means of identification appear possible, since there are many recorded instances of wrong visual identifications being corrected by fingerprint identification.

22.23 The ACPO Manual echoes this and states as follows:

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\(^{21}\) Dr Derek Clark: ‘Disaster Victim Identification’.
Even when the soft tissue of fingers and hands are damaged by fire or water, techniques are available to attempt to obtain impressions. In the UK relatively few fingerprints are held on file but there are several other ways that comparison prints can be obtained, for example at possible home addresses, places of work, documents, motor vehicles and, in the case of foreign nationals, from the respective countries’ national fingerprint bureaux. As well as using fingerprints to identify the deceased, it should be remembered that the perpetrators of the act that caused the disaster may, themselves, have been killed by it. Therefore with the consent of the Coroner, the fingerprints of all deceased persons must be taken in order for them to be compared with any marks.

22.24 There can be little dispute that it is of benefit to have fingerprints from all of the victims of major disasters, for both identification and investigative purposes. The ACPO submission states that the taking and using of fingerprints is an extremely reliable method and even when soft tissue of fingers and hands is damaged as a result of the incident, by fire or water, techniques are available to obtain impressions. Fingerprint impressions are taken by trained fingerprint experts who, other than in the MPS, are trained at the National Training Centre for Scientific Support to Crime Investigation (‘NTCSSCI’). The NTCSSCI has produced to the inquiry part of a training manual entitled ‘Fingerprinting Cadavers’. This document sets out in detail the methods which may be used to take fingerprints from the deceased including those which may be used when the deceased has been immersed in water for long periods of time, exposed to fire, decomposed or exposed to dry air.

22.25 The document referred to above contemplates that in certain situations the condition of the hands may be such that satisfactory fingerprints can only be obtained following the removal of the hands. The main difficulties and the conditions most likely to necessitate the removal of hands from cadavers in order to utilise specialist techniques in a laboratory environment are: maceration, desiccation, charring and advanced decomposition. Bruce Grant, in his statement to the NSI, has produced a spreadsheet showing the reduction in the number of hands and feet removed from 1993 to 1999 for the purposes of printing by the MPS.

22.26 From the documentation received by the inquiry it appears that there has been a dramatic reduction in the removal of hands for the purposes of fingerprinting.

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22 Assistant Director in the SO3 Directorate of Identification, Special Operations Department, MPS. Head of the MPS Fingerprint Bureau.
over the last decade. As indicated in paragraph 12.32 in part one, whereas 39 sets of hands (excluding those of the MARCHIONESS victims) were removed in 1989, between 1996 and 1999 the average was only three per year.

22.27 With regard to the removal of hands, the training manual ‘Fingerprinting Cadavers’ states as follows:

If, due to their condition, it is necessary to remove [the hands] for specialised treatment:

(a) There must be a properly designed and controlled facility in your Force for dealing with them.

(b) Hands can only be removed with the permission of the CORONER, not the Coroner’s Officer. It is recommended that a formal written request is made by the Officer in the case. The removal should be performed by the pathologist or pathology technicians.

(c) Hands must be conveyed in approved secure packaging.

(d) HANDS SHOULD ONLY BE REMOVED IF ABSOLUTELY NECESSARY.

Police procedures now sensibly require the consent of the coroner to be in writing.

22.28 Air Commodore Cullen states that the necessity for removal of hands or feet is rare. He states that he has never known it happen in an accident which he has investigated and that fingerprinting is of use mainly with victims of those countries where fingerprint records are the norm, such as the United States, Korea and Japan.

22.29 Professor Michael Green states that throughout the first 20 years of his career as a pathologist it was standard practice among the police forces with whom he worked in the United Kingdom (and the Australian police forces with whom he worked), to remove hands in cases where fingerprinting was necessary and the body had been immersed in water for some time. He states that he would have thought that it would now only be necessary to remove hands for fingerprinting in very rare circumstances and submits as follows:
It has now been agreed, in the Sheffield, Bradford and Leeds areas at any rate, that if such a removal is being considered the Coroner’s authority must be obtained by telephone first. The pathologist then notifies the Coroner in writing . . . immediately the autopsy has been concluded and a list of the organs and tissues retained, and the reasons for this retention, are incorporated into the written report which is sent to the Coroner.

22.30 Dr Ian Hill\(^23\) states in his submission to the inquiry that:

Fingerprints have not been used extensively in major accidents in the UK. They are excellent ways of proving an identity, but they present many difficulties, not the least of which is the added trauma to the families and friends of the victims . . . In the UK it is largely those with a criminal record who have had their fingerprints taken and stored. Therefore, if there is to be a possibility of making a match, the homes of the victims have to be searched so that comparison prints can be taken. This seems to me to be a wholly unnecessary intrusion, which is bound to exacerbate grief. Moreover, as identifications have been successfully carried out in a variety of disasters, without the need to use fingerprint evidence, the rationale for going to such lengths seems obscure. Teeth will provide just as good a result and if dental evidence is added to other forms of identification, such as clothing, belongings, appearances and medical findings, then the value of fingerprints fades dramatically.

... In the Zeebrugge accident many of the victims had been submerged in the sea for many weeks. We were asked to remove hands for fingerprinting but refused. A member of the team, not a policeman, successfully demonstrated that fingerprints could be taken without removing the hands. I have never encountered a situation when it has been necessary to remove the hands for fingerprinting.

22.31 The current practice appears to be that hands are now only removed in cases in which all other methods of identification have failed to produce results and satisfactory fingerprints cannot be obtained other than in a laboratory situation. The ACPO Emergency Procedures Manual and the police training manual make clear that any requests for specific forensic procedures regarding bodies or body parts, including the taking of samples, organs or limbs, must be made to the coroner. It is anticipated that the coroner will exercise his discretion having

\[^23\] Senior Lecturer and Honorary Consultant in Forensic Medicine at King’s College, London.
received advice from all concerned and particularly those on the Identification Commission. However, it seems to me that the position essentially remains as I stated it in section 9 above in the context of part one of the inquiry. In any case in which a request is made for the removal or severing of a body part or other mutilation of a body, the coroner should only authorise it as a last resort. It should only be authorised after a consideration of all the other information that has been obtained and is likely to be available in the near or comparatively near future. In short it should only be authorised if it is necessary in all the circumstances of the case.

22.32 It may well be that the same conclusion can be reached by reference to articles 8 and/or 9 of the European Convention of Human Rights (‘the Convention’). I shall consider those articles briefly in section 24 below after a discussion of viewing the body. It is convenient to consider them at that stage because article 8 is at least potentially relevant both to the circumstances in which it is permissible to remove body parts and to the right of a family member to view the body.

22.33 As appears below, it is my view that, just as the 1988 Act and the 1984 Rules make provision for post mortems, so the powers and duties of coroners in this regard should be put on a clear statutory basis. Indeed it is my view that all the powers and duties of coroners should be exposed to a detailed and comprehensive review and a detailed statutory code enacted so that everyone may know what they are. In particular, I see no reason why the powers and duties surrounding the issue of removal or retention of body parts for the purposes of identification should not be placed on a statutory basis so that all concerned know where they stand.

**DNA**

22.34 Professor Bernard Knight in ‘Forensic Pathology’ writes that one of the most revolutionary advances in identification in recent years is the so-called ‘DNA profiling or fingerprinting’. This is a technique in which ‘virtually unique sequences of bases in the DNA strands or chromosomes are used to compare one blood or tissue sample with another, and to investigate genetic relationships’.

22.35 The submission of the Forensic Science Service (‘FSS’) states that the use of DNA profiling is particularly effective if the victims’ bodies have been subjected to severe trauma, fire or have been subjected to decomposition either through the length of time taken to recover the body or prolonged immersion in water. The
FSS booklet called ‘DNA – Present & Correct’ details the techniques and usage of DNA profiling in criminal and civil casework. The submission highlights the speed with which results can now be achieved by stating that following the Ladbroke Grove train crash the results of the DNA analyses were generated within 48 hours of the receipt of the body samples in the DNA unit and only three of the body tissue samples failed to yield a DNA profile. The submission goes on to state that ‘it took several more days to carry out the appropriate comparisons and confirm the identifications of the victims.’

22.36 The ACPO Manual states as follows:

In many circumstances DNA profiling is a powerful tool in confirming identity. The following points must be taken into account, however:

- DNA profiling can only be successfully used when close blood relatives are available to compare a comparison sample with samples taken from the bodies.

- Obtaining such control samples may well cause distress to relatives and the decision to use this method may be considered appropriate when all other methods have proved fruitless.

- The length of time taken to analyse samples.

- The result may prove a non paternal/maternal relationship.

The technique may be helpful in reuniting body parts and assist in accurately establishing the number of victims.

22.37 From the submissions and articles received it seems that DNA profiling in the case of an unidentified body still tends to be used as a last resort and only if other methods of identification have failed to produce results. However it is more frequently used to match body parts with each other. A number of submissions have suggested that, while the cost of DNA matching has come down substantially in recent years, it is still considerably more expensive than other methods. Further, the potentially distressing nature of the procedure seems to militate against its use.
22.38 However, the Forensic Science Service DNA expert, Dr Kevin Sullivan has commented as follows:

In response to paragraph 3 in the Terms of Reference, I would suggest that a DNA profile could easily be obtained from a deceased, but of course this would have to be compared against swabs taken from the next of kin. Obviously speed of testing would be a priority in such circumstances; testing as premium samples should enable a result to be obtained within 48 hours of receipt. Actually taking controlled samples from the family would be distressing, but I suggest far less so than the current methodology of cutting the hands from a deceased person.

22.39 Professor Michael Green states that:

not only can DNA be obtained from literally less than a dozen cells but even in material which has been exposed to natural degradation over many years successful DNA profiling can be carried out . . . It follows from this that DNA was not a feasible option for identification in 1989. It would now be the method of choice.

22.40 The MPS Submission to the Thames Safety Inquiry states that developments in DNA technology since 1989 now enable positive identification to be obtained (in most cases) quickly and simply and without removal of body parts. The inquiry has been informed by the MPS (letter dated 14th December) that at Ladbroke Grove DNA was used as the primary method from day one of the operation and that in a future mass disaster similarly involving separation of body parts it is likely that the same approach would be taken.

22.41 My reading of all the material which has been presented to the inquiry has led me to the conclusion that DNA is an extremely valuable tool in the identification process and that every effort should be made to make it both quicker and cheaper.

23. Viewing the Body

23.1 Where a body is not judged suitable for visual identification the family or loved ones of the deceased may nevertheless still wish to see or be with or hold the
deceased. To many people this is an integral and vital part of the grieving process since it enables them to accept that the person has died. As appears below, it is at least arguable that article 8 of the Convention affords relatives a right to view the body because it provides by article 8(1) that ‘everyone has the right to respect for his family life, his home and his correspondence’. However, whether that is so or not, I am firmly of the opinion that all relatives should be offered the opportunity of viewing the body. As I understand it, that view is widely accepted because relatives are in fact given that opportunity at present.

23.2 After a major disaster it is not uncommon for the body of the deceased to have been seriously damaged, whether by fire, prolonged immersion in water, trauma or mutilation. In such situations those in ‘authority’ may feel that it is best for the family not to see the body since it would be too distressing. However, over the years it has become recognised that ultimately it is for the bereaved to decide whether or not to view the body (or body parts). It may well be appropriate for the bereaved to be advised as to the condition of the body and the pros and cons of seeing it, depending on the condition of the body. Fortunately FLOs are now trained how to handle situations of this nature and are in a position to liaise with counsellors and religious advisors if necessary.

23.3 In this regard I note that the Temporary Mortuary Plan for Surrey states:

in circumstances where the family insist on viewing the body or remains against police advice, the police should consult with Social Services and the appropriate faith community representative.

The plan also sets out appropriate circumstances for viewing of the body, which seem to me to be very sensible, subject to two considerations.

23.4 The first is that it recommends that viewing takes place once the body has been released by the coroner and at the premises of the funeral director to whom the body has been released but recognises that this may not always be possible. In many cases, however, the bereaved will understandably want to see the body as soon as they can, if only to confirm for their own peace of mind that the identity is correct (in situations where visual identification is not suitable). The document states that a helper (accredited by social services) should be available to any next of kin viewing a body and that the helper should describe the condition of the body before they see it and accompany the next of kin, should they so wish.
23.5 The second consideration relates to photographs of the deceased. The plan specifies that care should be taken to ensure that:

The procedure is conducted in such a manner that the witness is unable to see or hear any of the activity connected with the temporary mortuary process.

There is a reception area near to the viewing area where the bereaved can be briefed. When possible, the needs of the next-of-kin should be established prior to viewing so that arrangements can be made.

Access to the viewing area is not through the main temporary mortuary.

Within each Chapel of Rest only one body is viewed at a time in private. Where possible there should be separate entrances for the deceased and the bereaved.

The body is presented for identification in a manner which preserves the dignity of the deceased and minimises stress for the person making the identification.

A suitable area is available where composure can be recovered. Water, tea and coffee should be available. Lavatories should be close by.

It also recommends that photographs of dead bodies should only be used where they are essential to assist the identification process. It seems to me, however, that those involved should be flexible as to whether to use photographs since it might be less distressing and easier for some bereaved to have an idea of what to expect before they actually see the body.

23.6 As with most of the other topics discussed in this report, pre-planning seems to me to be of crucial importance. Thus it is important for the local coroner, coroner’s officers, police, social services and other agencies involved to have considered this type of situation before it arises and to have put plans into place before the event. It is also important to make sure that the various agencies are in agreement about issues such as viewing the body in order to avoid giving families mixed messages or creating confusion. Having heard the evidence in part one it is easy to understand how the bereaved can be given the impression that they are
not entitled to see the body when in fact they are simply being advised against it in order to protect them. Confusion of that kind must be avoided.

24. European Convention on Human Rights

24.1 By section 1(1) and (2) of the Human Rights Act 1998, which came into force on 2nd October 2000, articles 8 and 9 of the Convention have effect as part of English law. Although no-one referred to the Convention during the course of the NSI, it is I think appropriate to consider articles 8 and 9, especially since the Alder Hey Report considers them in a similar context.24 It is convenient to consider the two articles separately.

Article 8 – ‘Right to Respect for Private and Family Life’

24.2 Under article 8(1) of the Convention, ‘everyone has the right to respect for his private and family life’. The Alder Hey Report suggests that it might be argued that the funeral and burial or cremation of a member of one’s family are among one of the most important and sensitive parts of family life and that to invade a family’s privacy at such a time by withholding part of the deceased’s body without consent is a denial of respect. This argument would apply equally to the removal of body parts for the purpose of identification and subsequent failure to reunite them with the body. Further it might also be considered that the forbidding of a family member to view their deceased relative would be in breach of the rights of the family member under article 8.

24.3 The balancing provision in article 8(2) provides:

There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of . . . public safety, . . . for the protection of health or morals, or for the protection of the rights and freedoms of others.

The phrase ‘in accordance with the law’ means that any interference by a public authority with family life must have a basis in domestic law.

24 See pages 384 and 385.
24.4 It is not easy to see how article 8(2) could be used as a justification for removal of hands. On the other hand, if the removal of hands is truly necessary in order to identify the body, it might be said that there was no breach of article 8(1). Nevertheless, in the very rare case where removal of hands is justified by necessity, it is at least strongly arguable that a failure to return them to the body and thus to the relatives would be an infringement of article 8(1) and it is very difficult to see (save perhaps in a very exceptional case) how it could be justified under article 8(2).

24.5 As to viewing the body, except for the situation where there is a serious health risk in permitting the viewing of a body, it seems to me that there can be no basis in domestic law for forbidding the viewing of a body. It is perhaps arguable that the right to ‘respect for private and family life’ does not afford a right to view the body of a member of the family. My preliminary view (without knowing what, if any, Strasbourg jurisprudence there may be on the point) is that article 8 does afford such a right but, as already stated, it seems to me that, whatever the true construction of article 8, an individual should have a right to view the body of a close family member after death and it is not for the police, the coroner or anybody else to prescribe whether it is in the person’s ‘best interests’ to do so or not.

**Article 9 – ‘Freedom of Thought, Conscience and Religion’**

24.6 Under article 9(1) ‘everyone has a right to freedom of thought, conscience and religion’. The Alder Hey Report raises the suggestion that it is arguable that where parents’ religious beliefs dictate that a body be buried or cremated as a whole it would be a breach of their freedom of religion under article 9 to deny it, unless there were some important health reason for doing so, such as the spread of infection.

24.7 The balancing provision in article 9(2) provides:

> Freedom to manifest one’s religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

Where a body part has to be removed as a matter of last resort in order to be able to identify a particular individual, it seems to me that, as in the case of article 8(1)
there would probably be no infringement of article 9(1). However, the failure to reunite the body part with the rest of the body or to return it to the family for the purposes of burial with the body, in the absence of any compelling health or safety reason, would probably constitute a breach of article 9(1) and not be justified under article 9(2).

25. Family Liaison

General

25.1 The nature of the treatment of the bereaved and of survivors following any major disaster not only has implications for those who are personally affected but also plays a part in the identification and investigation processes.

25.2 All of those bereaved and survivors who have provided written or oral evidence to the inquiry and whose views have been received by way of submissions or otherwise, have made it clear that they need full, honest and accurate information as to the procedures which are being undertaken in both the identification and investigative processes. Likewise, the police and those organisations involved in these processes have a need for information from the families and friends of the victims.

25.3 Much attention has been paid in recent years to the role of police FLOs who work with families whose relatives have been the victims of homicide or who have died in mass disasters. Ruth Harrison, who lectures and advises on the subject of sudden death and who has advised police forces and trained FLOs nationally, gave evidence to the Ladbroke Grove Inquiry that the Ladbroke Grove crash was a quantum leap in terms of use of family liaison. Her evidence (which I entirely accept) was that in that case the officers played a key role both in giving information to families and as a conduit for information from the families.

25.4 The evidence provided to the inquiry suggests that the use of FLOs has made an enormous difference both to the families of victims and to those involved in the identification process. As a result of the Ladbroke Grove crash, a number of recommendations have been made to the ACPO Emergency Procedures Subcommittee by DCS Webb and his working group: see part three below. Further,
the experiences gained in relation to family liaison as a result of the Ladbroke Grove crash are now used as part of major incident, disaster and civil emergency training. As set out in detail below, it appears from evidence provided to the inquiry that there is now greater co-operation between the police and local authorities (and in particular social services) with regard to the provision of counselling and long-term support.

25.5 The inquiry has been informed that there are currently 272 fully trained FLOs in the MPS and that the target is for a minimum of 500 by the end of 2001. The initial training for FLOs consists of a six day course. There are in addition about 2000 MPS officers who have had ‘awareness training’ in family liaison which means that they would not be posted as dedicated FLOs but are trained to deal with an emergency situation. Of these, 180 have also received the specialised major incident training and would therefore be particularly useful following a disaster. I have been informed that awareness training on family liaison issues is now a part of basic CID training and the target is for every MPS officer to have received this training by the end of 2001.

25.6 Further, the inquiry has been informed that there has been development on a national level regarding the provision of family liaison services within all provincial police forces. The national training of FLOs is based upon Chapter 9 of the Murder Investigation Room Standardised Administration Procedure (‘MIRSAp’) Manual, which is a National Crime Faculty document approved by ACPO. While this manual was designed specifically to be used following a murder, it anticipates that FLOs would be used for any incident in which they were considered to be of assistance. This would include any mass disaster. The manual sets out the aims and objectives of family liaison and defines the respective roles of the SIO, the FLO and the FLO Co-ordinator. The objectives for family liaison strategy include the following aims and objectives:

- That families are treated appropriately, professionally, with respect and consideration given to their needs. This must be reflected at all levels within police structures and due consideration given to any police action which may impact on a family, from media statements made by a Chief Constable to the telephone operator who responds to a query by a family member...
• Ensure that family members are given information about support agencies and that referrals are made to Victim Support and other agencies in accordance with the family’s wishes.

• Securing the confidence and co-operation of a victim’s family can positively impact on the wider issues of community trust and confidence as well as bringing positive benefits to the investigation.

• Gather evidence and information from the family in a manner which contributes to the investigation and preserves its integrity.

• Those performing the role of FLO must always act with the highest degree of professionalism and must carry out their duties with great sensitivity.

25.7 Importantly, the manual recognises that one of the primary concerns of family members is the need for information and that the trauma of bereavement can be compounded by the frustration of not knowing the surrounding facts. It states that ‘the victim’s family must be provided with the timely sharing of all possible information so far as the integrity of the investigation permits.’ It sets out in full the issues which an FLO must address with the family in the early stages and the important questions of viewing, identification and release of the body and disclosure of information to the family.

25.8 The inquiry has been informed by the MPS (in a letter dated 7th December 2000) that FLOs are being trained in all forces and that a national list of co-ordinators is almost complete. The training being implemented is based upon a format developed by Avon and Somerset Constabulary.

25.9 Further, the MPS has furnished the inquiry with a document entitled ‘Metropolitan Police Service Family Liaison Policy & Fundamental Guidelines’, which is due to be published on 12th February 2001. This document sets out in great detail the proposed MPS policy for the management, selection and deployment of family liaison personnel and gives guidelines to all those involved in the provision of family liaison services.

25.10 The document sets out the primary goals of family liaison as follows:
To gather evidence and information from the victim/family in a sensitive manner which contributes to the police investigation/action and preserves integrity.

To provide a documented, two way communication channel between victim/family and police which is fully recorded using the Family Liaison log.

To mitigate, as far as possible, the negative effects of the criminal justice system through the provision of timely information and practical support to the victim/family concerning:

- the investigation/action/procedures, to date and ongoing which may include the interaction with other agencies such as local authorities, media, Coroners Officer etc

- the ongoing processes/procedures of the criminal justice system ie. CPS, Coroner or other statutory bodies interacting in the process

To ensure that victims/family members are given information about support agencies and that referrals are made to Victim Support and other agencies in accordance with the victim/families wishes.

25.11 It is clear that the provision of family liaison has improved beyond all recognition since 1989. One example of this was drawn to our attention by DCS Webb on 18th December, namely that one of the ways in which the police have attempted to move forward in the area of family liaison is that they have invited those who have been bereaved as a result of disasters to speak and deliver presentations at the management of disaster and civil emergency (‘MODACE’) course. It seems to me that this is a productive way forward and creates a partnership, which bridges the gap between those effectively ‘in authority’ and those who are directly affected by the disaster.

**Families Living Abroad**

25.12 The inquiry has been informed by the MPS in letters dated 5th and 7th December 2000 that the support for families of victims who are living abroad forms part of the current MPS policy on family liaison. It is the current policy for an officer to be allocated and to travel abroad or to facilitate the family travelling to the UK
as necessary. The decision as to necessity depends upon a balance of all relevant factors, including the importance of family and community confidence and the public purse. The balancing exercise will vary from case to case and depend on the resources of the particular force. The MPS believes that a similar approach would be taken by all provincial forces, although there is currently no ACPO guidance on this issue. We have also been informed that following the Paddington crash two officers travelled abroad, one to Norway and one to South Africa and that following the recent Hatfield crash, two officers travelled to New Zealand, one with the victim’s body and one to assist with the process of ‘closure’ (on the advice of one of the counsellors and trainers of FLOs). In these cases, whilst the officers who travelled abroad were MPS officers and the relevant force Hertfordshire, the expenses were borne by the relevant train company.

25.13 It appears to me that it would be appropriate for the ACPO Manual and the relevant FLO training manuals to address the question of dealing with relatives living abroad. In response to the procedure document disseminated on 8th December Alan Goldsmith accepted on behalf of ACPO that it would be appropriate for the ACPO Manual to address the question of dealing with relatives abroad. It is his view that there are significant considerations, particularly if one considers the possibility of an air crash involving in excess of 300 foreign nationals, which would create major difficulties for most police forces. Mr Goldsmith has stated that the ACPO Emergency Procedures Subcommittee will consider how this matter may best be addressed. This is an encouraging step forward.

26. Information and Counselling

26.1 One of the main concerns voiced by those bereaved as a result of the disasters in the 1980s is that they felt they were left in the dark and provided with insufficient information as to the procedures that were taking place in the immediate aftermath of the disaster. Many intelligent people felt that they were patronised or treated as though they had lost their capacity to think rationally. At a conference organised by the Emergency Planning Society in 1999, Reverend John Mosey, who lost his daughter in the Lockerbie disaster, said:
The needless refusal of access to information and the subsequent denial of choice can only increase the feeling of impotence and helplessness that overwhelms the bereaved.

At the same conference Dr Mick North, whose young daughter died in the Dunblane shooting, said:

...those in authority must appreciate that the people who have suffered a tragedy do not become incapable of rational thought and action.

26.2 Bereaved or potentially bereaved families are surely entitled to full, honest and, so far as possible, accurate information at all times. In particular, it is of the utmost importance that relatives should be kept fully informed at every stage and that information should be provided in a sensitive way. Even if there is no information to give, families should be informed that this is the case and the reason for it.

26.3 As stated above, the role of the FLO is vital for the flow of information both to and from those bereaved as a result of a disaster. It appears from the submissions received and the oral contributions made on 18th December that those bereaved want both general and specific information.

**General Information**

26.4 Most people who are bereaved as a result of a disaster have no idea what to expect. It is often their first experience of sudden death. They tend to want general information about the following matters, no doubt among many others:

- where a body will be taken once it has been found;
- what happens to a body at the mortuary;
- how the identification process will work and who will be involved in it;
- the role of the coroner and the police;
- what is a post mortem;
– when a post mortem takes place and why;

– what rights the families have regarding the body and the post mortem;

– the right, if any, to view the body;

– when the body will be released;

– what will happen to the body after it has been released;

– what an inquest is and the reasons for it;

– what will happen during the inquest.

26.5 The Home Office has produced a comprehensive pack known as the ‘Homicide Pack’ which contains information for families of Homicide Victims. It contains the following information, leaflets and guides:

– Coping when someone close has been killed (Home Office)

– The Criminal Justice System in England and Wales – A Summary (Home Office)

– List of Useful Contacts (This will have filled in the names of the Police Senior Investigating Officer, the FLO and details of the local Coroner’s Office and Victim Support Scheme. It also includes details of Victim Supportline).

– List of Organisations able to offer help and advice. (This includes bereavement organisations, victim support organisations and self-help groups.)


- Murder and Manslaughter: Information for bereaved relatives and friends (Victim Support)

- Support and Help for Families and Friends of Murder and Manslaughter Victims (SAMM: Support After Murder & Manslaughter)

- Going to Court (Victim Support)

- What to do after a death in England and Wales (Benefits Agency)

- Legal Aid: How to get free or low-cost Legal Help

- Witness in Court (Home Office)

- The Victim’s Charter (Home Office)

- Helping the Bereaved (Cruse Bereavement Care)

- Information about the Criminal Injuries Compensation Scheme.

26.6 This pack was adapted for use following the Ladbroke Grove Rail Crash and was used in conjunction with a leaflet provided by the Red Cross. Ruth Harrison, mentioned above, who co-ordinated the support services provided to the families following the Ladbroke Grove Rail Crash and who advised the MPS on the FLO response, gave evidence to the inquiry that there had been positive feedback from the families concerned.

26.7 The use of the homicide pack was supported by Mrs Lockwood-Croft in her evidence to the inquiry. It was her considered opinion, having researched a number of deaths caused by disasters, that if the pack were to be given to families of victims of disasters, it should be called ‘Information for families of victims of sudden death’. That seems to me to be a very sensible suggestion. Alternatively, a similar pack could be prepared specifically for families of disaster victims. Trevor Cobley, who attended the 18th December meeting on behalf of the Home Office, while pointing out that his unit was not responsible for the homicide pack, accepted that it would be desirable for there to be a similar pack for the families of victims of disasters and that he could see no reason why this could not be achieved.
26.8 In addition to the homicide pack prepared by the Home Office, a number of coroners around the country have prepared their own versions of leaflets explaining the role of the coroner and what can be expected when attending a Coroner’s Court. Local authorities also have their own documentation addressing questions of bereavement and coping with the loss of family members.

26.9 It is clear that a great deal of work has been done over the last few years with a view to ensuring that families of victims of homicide and other sudden deaths are provided with information as to particular procedures. There does, however, appear to be a dearth of information concerning methods of identification and what can be expected during the identification process. It would, in my view, be of great assistance to families who are either bereaved or waiting to find out if they have been bereaved, to have a simple leaflet setting out basic information concerning the identification process. This should explain who is responsible for identification, the involvement of the police and other authorities in the process, how victims are identified, the procedures used and the length of time it may take and why.

26.10 However, as Malcolm Williams, a survivor of the MARCHIONESS disaster and a principal social worker, stated in his oral contribution to the inquiry:

"Leaflets are helpful, but they are not substitutes for personal contact and personal explanation."

I wholeheartedly endorse that view. On the other hand the information packs and leaflets provide valuable general information which the families of the victims are able to read and digest at their leisure.

**Specific Information**

26.11 As set out above, the position at present is that each family will have an FLO who ought to be in a position to provide the family with specific information, for example about the identification procedures, the timing of the release of the body and the timing of the inquest. In addition to the FLO it is anticipated that in the future, in situations where there is a substantial number of victims, there will be an FLO Co-ordinator who will liaise closely with the SIO, the SIM and senior officers in the casualty bureau. It is likely that the SIM will form part of the Identification Commission and will thus be privy to specific information concerning the identification procedures.
26.12 In evidence in part one of the inquiry Mrs Lockwood-Croft, the mother of Shaun who died in the MARCHIONESS disaster, said (in a passage which I have already quoted in part one):\textsuperscript{25}

I think it is paramount that you have honest, accurate information at all times. Secrecy sort of goes on to doubts and doubts give fears and fears start off as molehills and then mountains. That could be avoided by being honest. A lot of the problems that have occurred in the MARCHIONESS disaster is the simple fact we were not given information, and then you feel, ‘What are they covering up? What are they really hiding from us?’ That could have all been averted by honest communication on a daily basis, and if you have a family liaison officer, they are trained in the trauma and everything else, that would be avoided and you would not have the problems with family or survivors.

Access to information and the giving of specific information about the procedures being undertaken are vital to the building up of trust between those people seen to be in authority and those who have been bereaved as a result of or who have survived a disaster. One way in which to break down the barriers is for senior members of the police team such as the SIM, SIO or FLO Co-ordinator to meet with the families to explain what is happening, how long they might have to wait for their loved ones to be identified and explain the investigation and identification processes. Likewise, if the coroner felt able to meet with the families as a group to explain what is happening this would probably help the families in their understanding of the position and lessen their feeling of helplessness.

26.13 Many of these changes have been brought about as a result of a considerable amount of work put in following previous disasters by the members of the ACPO Emergency Procedures Sub-Committee, who are to be applauded for the advances. It is clear that lessons are constantly being learned and that procedures are modified and updated accordingly.

**Provision and Co-ordination of Counselling.**

26.14 While the FLOs are responsible for communication with the bereaved and survivors and provide a conduit for information flowing both to and from them, the value of effective and co-ordinated counselling services in the aftermath of a disaster and during the identification process cannot be overstressed. The inquiry has been provided with a report by Ruth Harrison which is an ‘Analysis of the

\textsuperscript{25} Paragraph 12.13.
support requested by bereaved families and survivors in the immediate aftermath of the Ladbroke Grove Railcrash. ’I have annexed a copy of this report at Annex J because it gives to the reader an idea of the nature of the services and co-ordination which might be required in the aftermath of any future disaster. The report focuses on the needs of the bereaved and survivors who contacted the support services set up by the MPS in the aftermath of the crash and concentrates on the support identified and recorded by the multi-agency team established following the incident.

26.15 The report concludes that the key aspect of the provision of services was the pivotal role played by the co-ordinators of the multi-agency trauma and bereavement services, who together with the police FLO Co-ordinator, employed the multi-agency approach led by the FLOs and which linked all the agencies.

26.16 It is suggested in the report that the partnership between police and other agencies provides an effective model for future emergency plans and operations. There has been no suggestion that this is not the case and seems to me to be a very sensible way forward. Once again, co-ordination between the various agencies and an appreciation of who is to undertake which role appear to be key factors in the successful provision of FLO and counselling services in the aftermath of a disaster.
Part Three: The Future

27. General Approach

27.1 It is clear from the above discussion of all or almost all the topics which I have considered in part two, that many lessons have been learned from the disasters of the late 1980s. Since that time there has been an increasing awareness in most police forces, local authorities and other organisations involved in dealing with the aftermath of disasters, of the importance both of contingency planning and of putting in place appropriate arrangements for dealing with the bereaved. It is now correctly recognised that failure to do so can have far reaching implications.

27.2 I would like to stress (if I have not done so already) that I include in the list of those who have made great advances many of those who were involved in the events of August 1989. Thus, in addition to the police, to whom I have referred extensively in part two, I include both Dr Knapman (and his officers and staff) and the Westminster mortuary.

27.3 Paragraph 3(1) of the terms of reference requires me to advise on what, if any, additional procedures should be followed when the need to identify victims arises following similar accidents. Under paragraph 3(2) I am asked to advise on the procedures for the notification and involvement of the next of kin in cases when it is necessary to establish the identity of such victims. The purpose of the exercise is specifically to minimise distress to the families of the victims of any disaster. Since both sub-paragraphs have the same aim in mind and since there will inevitably be an overlap between the recommendations, it seems sensible to me not to try to separate the recommendations into two groups but instead to make recommendations by theme.

27.4 It seems to me that in order to minimise the distress inevitably suffered by relatives and friends of victims of major disasters as a result of the identification process, there are a number of general principles which should be kept in mind throughout. They may be summarised in this way:

(1) provision of honest and, as far as possible, accurate information at all times and at every stage;
(2) respect for the deceased and the bereaved;

(3) a sympathetic and caring approach throughout; and

(4) the avoidance of mistaken identification.

27.5 I have recently seen a document entitled Advice from the Chief Medical Officer dated January 2001 written in the light of the Bristol and Alder Hey reports and the evidence given in those inquiries. As stated in paragraph 14 of chapter 1 of the Advice, its purpose was to recommend comprehensive changes to current practice with regard to the removal and retention of organs and tissues and to recommend comprehensive changes which will ensure:

– a proper respect for the person who has died and the surviving relatives;

– the compassionate treatment of bereaved families;

– the provision of clear information and full explanation by clinicians on the purposes of organ and tissue removal and retention;

– effective participation by families in taking key decisions so that any agreement to such procedures is freely given;

– that, with the support of the public, the benefits of greater understanding of disease through research, audit and teaching, using retained tissue and organs after death, will help future generations of patients.

27.6 I am not of course concerned with the particular problems which faced the Alder Hey inquiry or which the Chief Medical Officer was addressing, but there is a significant overlap between those problems and the ones which I have been considering.26 Thus the approach to the bereaved should be essentially the same.

27.7 I note in this regard that in paragraph 14 of chapter 5 the Chief Medical Officer set out a number of guiding principles as underpinning his recommendations regarding the removal, retention and use of human organs and tissue from post mortem examination. As I see it, four of them in particular also apply to the

26 See further section 28.
situation where the identity of an individual deceased is in issue. They are as follows:

- **Respect:** treating the person who has died and their families with dignity and respect.

- **Understanding:** realising that to many parents and families their love and feelings of responsibility for the person who has died are as strong as they were in life.

- **Information:** much better information is required, both generally by the public and specifically for relatives who are recently bereaved, about post mortems and the use of tissue after death.

- **Cultural competence:** attitudes to post-mortem examination, burial and the use of organs and tissues after death differ greatly between different religions and cultural groups; health professionals need to be aware of these factors and respond to them with sensitivity.

27.8 I respectfully endorse that approach and would only add this with regard to the importance of information. Families of those who have recently died should be offered full information at every stage, but not all families may wish to be given it. They must therefore be offered appropriate counselling so as to decide whether to receive the information or not.

28. **The Alder Hey and Bristol Royal Infirmary Inquiries**

28.1 The Bristol and Alder Hey reports and the Advice from the Chief Medical Officer referred to above all address the question of the removal and retention of human material and make recommendations for the future. Although the removal and retention of human material in those inquiries were from children
and were not for the purpose of identification, nevertheless (as just stated) many of the principles which have been considered and the recommendations made apply equally to the removal of body parts for the purpose of identification. The first recommendation of the Bristol Report was that:

The ruling principle in the removal, retention, use and disposal of human material must be respect for the dead child and for the concerns and, to the extent allowed by law, the wishes of the parents.

As stated above, that principle applies equally where an adult has died. The strength of feeling about how the dead are treated cannot be overstated.

28.2 A number of the recommendations in the Bristol and Alder Hey reports focus on the removal of human material and the carrying out of the post mortem for the purpose of establishing cause of death. In major disasters it is likely that one of the functions of the post mortem will be to document any internal injuries or noteworthy features in order to assist in the identification process. It is also possible, in rare cases, that a jaw might have to be removed in order to make a dental chart or that parts of the hand might have to be removed for fingerprinting or, now more frequently, that material needs to be removed in order to carry out DNA profiling. I therefore recommend that any consideration of the recommendations made in the Bristol and Alder Hey reports should take into account those possibilities.

28.3 For example, recommendations 20 and 58 respectively in the Bristol Report state:

The Coroner’s post mortem should be understood as having been concluded when the pathologist indicates his findings on the cause of death to the Coroner.

It should be put beyond doubt that the pathologist, in conducting a Coroner’s post mortem, acts as the agent of the Coroner and thus may neither remove nor retain human material except for the purpose of establishing cause of death.

Since the Bristol inquiry was not considering the possibility that material might have to be removed for purposes other than establishing cause of death, those recommendations do not encompass such a possibility, whereas this inquiry has
shown that it might be necessary to remove body parts for the purposes of identification.

28.4 From the material that I have seen it appears that the need to remove body parts for the purpose of identification is diminishing, partly by reason of technological advances in the area of fingerprinting and partly because of the development in DNA profiling. That does not mean, however, that consideration should not be given to the test to be applied when such a need does arise. The use of tissue and other human material for the purpose of identification by means of DNA profiling is also likely to increase.

28.5 The test which should be applied to the removal of body parts such as hands (or jaws) in my view remains that stated above, namely that body parts should not be removed for the purposes of identification except where it is necessary to do so as a last resort.

28.6 As to the removal of tissue and other human material for the purposes of DNA profiling the position seems to me to be somewhat different. It is of prime importance that bodies should be identified as soon as reasonably practicable and that mistakes should not be made. A mistaken identification is likely to cause untold distress. DNA profiling has become a more important method of identification in recent years and it seems to me that, while samples for DNA purposes should only be taken where it is necessary, the test cannot be that of last resort, as in the case of the removal of body parts such as hands (or jaws). The reason is that the removal of tissue or other material for that purpose seems to me (and I think to others) to be less distressing or offensive than the removal of, say, hands or jaws. I should perhaps add that it is important that the obtaining of material as a comparator for DNA purposes should be done in as sensitive and compassionate a way as possible.

28.7 There is at present no statutory regulation of the removal of body parts or other human material for the purpose of identification, despite the fact that there is statutory regulation (however inadequate) of the post mortem process. It seems to me that consideration should now be given to regulating the removal from deceased persons of any human material, whether it be body parts, tissue or organs, for any purpose, including identification. I return to this in the recommendations below.
29. Discussion and Recommendations

Introduction

29.1 In this section I shall refer briefly to the main reasons for making particular recommendations, but only in so far as it seems sensible to add to what I have said in part two. I stress that many (perhaps all) of the recommendations are not my ideas but those of others. If I do not identify the true originator of any particular idea, I apologise. It is also important to note that much of the ground has been traversed by the Bristol and Alder Hey inquiries. In so far as the recommendations they make overlap with the issues raised in this inquiry, I see no difference in approach between us and I support their views.

Coroners

Review of Powers and Duties

29.2 This is a topic in respect of which there is a good deal of overlap between the inquiries. As stated in paragraphs 15.2 and 15.3 in part two above, it is my view that the law in this area is arcane and needs both updating and supplementing to reflect the obvious concerns expressed during the course of this inquiry and the Bristol and Alder Hey inquiries.

29.3 The passage from the judgment of Lord Widgery CJ in *R v Bristol Coroner, ex p Kerr* [1974] QB 652 at 658E quoted in paragraph 15.3 above demonstrates that it is not possible to ascertain the powers and duties of a coroner by simply looking at a statute or statutory instrument. That seems to me to be profoundly unsatisfactory, especially since the common law is in some respects far from clear. In the course of the inquiry Nigel Jacobs, junior counsel for the MAG, prepared a paper dated 15th December 2000 on ‘Property Rights in the Body’. I annex it to this report as Annex K, not in order to express a view on any of the legal questions discussed in it, but in order to demonstrate the areas of the law which require further consideration. I also draw attention to Annex B of the Bristol Report which contains a detailed discussion of the legal position.

29.4 In paragraph 15.10 I quoted a sentence from paragraph 98 of the Bristol Report where the law relating to property in a body was described as ‘both obscure and arcane’. My attention has also been drawn to the Report of the New Zealand Law Commission on ‘Coroners’ dated August 2000. The report proposed a number of reforms as a foundation for improved investigation of deaths,
understanding patterns of sudden death and demonstrating greater sensitivity to
the values of its different cultures. In the preface to the report the authors
summed up the position by citing a submission which read:

Just as we changed our birth practices in the second part of the
20th century, we need to change our death practices in the first half
of the 21st century.

29.5 In the light of the reports of the Alder Hey and Bristol inquiries and my own
experience in conducting this inquiry, I entirely agree. I was also interested to
note the concern expressed by coroners in New Zealand as to their lack of
training and the fact that no training is, or has ever been, provided to coroners
upon appointment, in contrast to the position of other judges. The report makes a
number of recommendations regarding the role of coroners which in my opinion
merit consideration by anybody reviewing the law and role of coroners in this
jurisdiction.

29.6 For example, in paragraph 243 the Commission states that families should be
able to look to the Coroners Act in New Zealand to ascertain their rights in the
coronal process. In my opinion, the same should be true here. Also, in
recommendation 24 the Commission recommended that ‘the Coroners Act be
amended to give the deceased’s family, with the consent of the Coroner, the
option of viewing and touching the deceased prior to the post-mortem
examination’. Again that seems to me to be very sensible, as do a number of other
recommendations which I commend to the Law Commission or other body
entrusted with the responsibility of reviewing this whole area of the law.

29.7 The Bristol Report included this passage in a part of the report which was
considering the lawfulness of practices at Bristol:

Coroners, in effect, operate fiefdoms. They exercise considerable
discretion and display little uniformity of practice as regards, for
example, the proper disposal of human material removed for the
purpose of coroner’s post mortem, once the cause of death has
been established.27

The report later made a number of recommendations under what it described as
‘Option 1’, which contemplated a code of practice but not a change in the law.28

27 Paragraph 59.
28 Paragraphs 131 to 175.
and a number of recommendations under ‘Option 2’, which contemplated a change in the law. 29

29.8 The recommendations included a number of particular recommendations which I would wholly endorse in the light of the evidence in this case: see in particular recommendations 14, 17, 19, 21 and 22. However, in addition the report seems to me to give impetus to a call for a wholesale review of the role of the coroner.

29.9 Chapter 9 of the Alder Hey Report contained a number of detailed recommendations relating in particular to training of coroners and as to post mortems, which seem to me to be very sensible. So too did the Advice of the Chief Medical Officer, but he also recommended a more fundamental and broader revision of the law. Although he did so in the context of the particular problems he was considering, he plainly had in mind a major review of the coroners’ system. 30

29.10 In the light of all the material which I have read and all the evidence which I have heard, I recommend that a detailed review be undertaken as to the role of the coroner by, say, the Law Commission and that a statutory scheme be introduced which codifies the powers, duties and responsibilities of the coroner.

29.11 It may be that I do not need to make this recommendation, because after I had formed the view that it would be sensible to make a recommendation along these lines, the inquiry received a letter from Mr Cobley at the Home Office saying that, in response to the Alder Hey Report, the Secretary of State for Health had informed the House of Commons on 30th January 2001 that the Home Secretary had ‘set in train a review of the coroner system’. A perusal of the statement itself shows that the House was not given any further details and I am not aware of the terms of any further announcement specifying the nature of the review proposed, who is to conduct it or how long it is likely to take.

29.12 In these circumstances it is perhaps appropriate for me to make the recommendation which I had in mind, with apologies if it is now unnecessary. I recommend that the review be as wide ranging as possible and that it cover all the many associated matters discussed in the Bristol and Alder Hey reports and in this (perhaps more limited) report.

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29 Paragraphs 176 to 193.
30 Chapter 4, paragraph 5.
29.13 Any review of the law relating to coroners should include a consideration of the following questions, no doubt among many others:

a. Should there be a general principle that there is no property in a body or a body part? If so, what, if any, exceptions should there be? If not, who should have property in a body or body part, from when and for what purpose?

b. Who should have a right to possession of a body and when?

c. Should personal representatives of the deceased (or others, and if so who) have a right to call for possession of body parts for the purpose of burial or disposal?

d. Who should have possession or custody of a body at a mortuary or temporary mortuary?

e. Who should be responsible for identification of a body? What powers should such a person or entity have?

f. In each case should the powers and duties concerned be laid down by statute or in some other way and, if so, what?

g. What criteria should be adopted or tests applied before human material (including limbs and other body parts) is removed for the purposes of identification?

29.14 As stated earlier, it is my present view that the powers and duties of coroners, including those governing identification, should be clearly stated by statute and, indeed, that the criteria to be adopted before a body part is removed for identification purposes should also be regulated by statute so that everyone knows what the relevant rules are. However, I am aware of the fact that many respondents, including coroners, expressed concern that any new regime should not be inflexible. I agree that it is indeed important that any new rules should have a degree of flexibility because I recognise that no two disasters are the same. Nevertheless it is important that the general principles should be clearly stated.
Removal of Body Parts and other Human Material

29.15 In these circumstances I recommend that, quite apart from the wide review contemplated above, consideration should now be given to regulating the removal from deceased persons of any human material, whether it be body parts, tissue or organs, for any purpose, including identification. In that regard I also recommend that any consideration of the recommendations made in the Bristol and Alder Hey inquiries should take account of the possibility of the removal of body parts or other human material for identification purposes.

29.16 I recommend that it should be made clear that the methods used for establishing the identity of the deceased should, wherever possible, avoid any unnecessary invasive procedures or disfigurement or mutilation and that body parts should not be removed for the purposes of identification except where it is necessary to do so as a last resort. The position is somewhat different in the case of samples taken for DNA purposes.

Guidance to and Training of Coroners

29.17 There is considerable support for a recommendation along these lines. Consideration should be given to requiring coroners to undergo extensive training both before appointment and from time to time thereafter. Such training should be uniform across the country and should include:

a. the identification of unknown bodies in multiple fatality incidents;

b. dealing with bereaved relatives in major disasters;

c. the management of and contingency planning for multiple death disasters; and

d. the likely ethnic, cultural and religious interests of minority and religious groups in case of death.

29.18 I endorse the recommendations made by Michael Burgess, secretary to the Coroners’ Society, in a submission dated 4th December 2000 that:

31 Paragraph 28.7.
32 Paragraph 28.2.
33 Paragraphs 28.5 and 28.6.
34 Paragraphs 15.4 and 15.5.
a. while the actual methods for establishing the identity of the deceased person should in any particular case be left to the coroner, the Home Office should issue guidance on the criteria and suitable methods which might be used;

b. such guidance should be kept under regular review and there should be consultation with such persons or organisations as the Home Office may from time to time determine; and

c. the guidance should take account of advances in scientific knowledge and available techniques.

**Coroners and Coroners’ Staff**

29.19 Many members of the families and others have stressed the importance of being given honest and accurate information at all times.\(^{35}\) In these circumstances I recommend that coroners and coroners’ staff should meet with families or family groups to explain the identification and other procedures to be followed. They should also keep relatives informed of the progress of the identification process.

**Police**

29.20 The recommendations made by DCS Webb and his working group, following their review of casualty bureau procedures, family liaison arrangements and identification procedures in the aftermath of the Ladbroke Grove train crash, cover many of the areas with which the inquiry is concerned and are wholeheartedly endorsed by the inquiry. As set out above,\(^{36}\) the inquiry has been informed that ACPO has approved all of the recommendations and that production of the ACPO Emergency Procedures Manual 2001 is currently in progress. Where the recommendations do not require an amendment to the ACPO Manual, the particular recommendation is being dealt with by way of training or otherwise. The recommendations and the principles upon which they are based are set out in full in the report\(^{37}\) of the MPS working group led by DCS Webb dated 30\(^{th}\) March 2000 at Annex F and are, in summary, that consideration should be given to the following matters:

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36 Paragraphs 14.8 and 14.9.
37 Paragraph 14.9.
a. incorporation into the ACPO Manual of a Pro-Active Unit as an integral part of the Casualty Bureau;

b. inclusion in the ACPO Manual of the Ladbroke Grove Casualty Bureau MISPER grading system as a specific example of good practice;

c. incorporation into the ACPO Manual of a proposal that two FLOs be assigned to the Casualty Bureau;

d. highlighting within the ACPO Manual the need for timely quality control to be introduced within Casualty Bureau;

e. reviewing the format of MISPER reports to ensure they highlight key aspects in completing individual reports and are compatible with the HOLMES II screen;

f. commissioning research by ACPO to maximise the IT opportunities presented by the introduction of HOLMES II;

g. the creation of a Senior Identification Manager post to have overall responsibility for the identification process;

h. inclusion in the ACPO Manual of the removal of body parts as a component of the identification process;

i. inclusion in the ACPO Manual of the need for careful documentation of all procedures undertaken at the mortuary;

j. arranging a meeting between representatives of the ACPO Homicide Working Group, Emergency Procedures Sub Committee and Race and Diversity Portfolio with a view to discussing Family Liaison in incidents of major disaster;

k. including in the ACPO Emergency Procedures Manual and draft Family Liaison Guidelines a paragraph that highlights the crucial role the FLO has in assisting the identification process;
1. the ACPO Manual highlighting Family Liaison team leaders as good practice;

m. the ACPO Manual highlighting the long term benefits of the family viewing the body if at all possible;

n. developing the concept of partnership between police and bereaved families within the ACPO Emergency Procedures Manual;

o. incorporation into the ACPO Manual of a section which covers good practice regarding the involvement of independent advisers;

p. inclusion in the ACPO Manual of advice concerning the need for enhanced bereaved family information packs to be prepared as part of the advance planning process;

q. inclusion in the ACPO Manual of a paragraph highlighting that good practice has shown that hotel accommodation provides the most suitable environment for family liaison;

r. inclusion within the ACPO Manual of a section on the benefits of FLOs viewing a photograph of the body with which they are dealing;

s. inclusion in the Family Liaison Chapter of the ACPO Manual of a section on Family Liaison Logs;

t. inclusion in the ACPO Manual and Draft Family Liaison Guidelines document of a reference to the equipment needs of FLOs;

u. inclusion in any nationally designed FLO course of media training and an awareness of Casualty Bureau functions.

As stated above, I do not pretend that these recommendations are mine but I endorse them and support the work being undertaken by the police in this regard. I shall include them among the list of recommendations at the end of the report, not in order to pretend that I thought of them, but as an aide memoire for the future.
29.21 In that regard I would like to highlight one proposal in particular. As explained above,\textsuperscript{38} I regard the proposal to appoint a SIM as an admirable idea. As I understand it, he or she would be a Detective Superintendent or Detective Chief Superintendent and would have overall responsibility for the identification process. The SIM would provide the link with the SIO regarding the investigation process and would create a link between the coroner and his staff on the one hand and the police on the other and, together with the FLOs, would forge a crucial link between the police and the bereaved and survivors.\textsuperscript{39}

29.22 Particular concern has been expressed as to the position of relatives living abroad. I recommend that consideration should be given to inclusion within the Family Liaison chapter of the ACPO Manual of a section dealing with the treatment of relatives living abroad.

*Relationship between the Police and the Coroner*

29.23 DCS Webb and his working group\textsuperscript{40} recommend (and I fully endorse the recommendation) that consideration be given to the development of a formal protocol between the Home Office Department with responsibility for HM Coroners and ACPO regarding:

a. timescales for the release of information regarding identification of bodies to relatives;

b. the frequency with which the Identification Commission should sit;

c. police requirements at the mortuary;

d. publication of the identification criteria as part of the need to be open with families.

That suggestion relates to particular aspects of the problems which inevitably face both coroners and the police. I recommend that any such protocol cover all aspects of the relationship between the coroner and the police. I turn now to one such aspect in particular.

\begin{flushleft}
\textsuperscript{38} Paragraphs 16.30 to 16.34.
\textsuperscript{39} Paragraph 16.32.
\textsuperscript{40} Paragraph 14.9.
\end{flushleft}
Mortuary Responsibilities and Custody and Release of Bodies

29.24 I discussed in part two the importance of ensuring that it is clear who has responsibility for the custody of each body and for the release of each body and body part. The evidence which I have heard and read has persuaded me that this is of some importance because it has not always been clear who has custody of the body and who is responsible for the release of the body and body parts to the relatives. This case has shown how distressing it is if parts of a body which have been removed are not returned to the body before it is released to the relatives. It is therefore of the utmost importance that it should be known in advance whose responsibility it is to ensure that that does not happen. As I see it, different arrangements may be appropriate at a temporary mortuary from those which are appropriate at a permanent local authority mortuary. The key point is, however, that arrangements are made in advance of a casualty so that there is no doubt who is responsible for what.

29.25 In these circumstances I recommend that (to the extent that this has not already been done) a protocol or protocols be developed in each area between the coroner, the police, the local authority, the mortuary and the pathologists setting out clear procedures for the custody and release of the body and body parts in order to ensure that there is no confusion. I commend anyone charged with the responsibility for drawing up such a protocol to consider the Temporary Mortuary Plan for Surrey, which is referred to above and included in Annex H. I also recommend that those arrangements be reviewed in any particular case by the Identification Commission in order to ensure that they are being operated appropriately.

Relationship between Police and Pathologists

29.26 DCS Barry Webb and his working group recommend (and I fully endorse the recommendation) that consideration be given to the development of a formal protocol between pathologists and ACPO regarding all their respective mortuary responsibilities, including those to which I have just referred.

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41 Paragraphs 16.5, 16.8, 16.11, 17.8, 18.8 to 18.12 and 19.8.
42 Paragraphs 18.8 to 18.12 and 19.8.
43 Paragraphs 18.5 and 18.6.
44 Paragraph 14.9.
**Mortuary Staff**

29.27 This case has demonstrated the importance of following strict procedures and the distress which can be caused if errors are made. Those responsible for the management and running of mortuaries must ensure that strict procedures are followed and that all procedures are documented from the time a body or body parts arrive at the mortuary until the time a body is identified and released for burial. I commend Mr Butterfield’s submission to anyone devising systems in mortuaries.45

**Emergency Planning by Local Authorities and the Home Office**

29.28 Again this case has demonstrated the crucial importance of pre-planning.46 To this end I make the following particular recommendations, although I recognise that there is some overlap between these and others. All Home Office guidance to local authorities and others on emergency planning should include reference to the need to involve and consult the coroner in emergency planning and exercising.

29.29 Local authorities’ social services departments should identify individuals who can be jointly trained with FLOs to work with relatives following disasters.47

29.30 Local authorities’ social services departments should ensure that plans are drawn up in conjunction with the local police forces as to the treatment of relatives and other bereaved in the aftermath of a disaster.48

29.31 The Home Office should ensure that all agencies likely to be involved in the aftermath of major disasters are made aware of the need for contingency planning and are given the requisite training or guidance as to the management of a multiple fatality incident.

29.32 It is important that such contingency planning should cover the whole country. I am conscious of the fact that the evidence which has been available to the inquiry is by no means complete and there may be many excellent schemes around the country of which I am unaware. However, my impression is that the planning in some areas is more advanced and more sophisticated than in others. Although

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45 Paragraphs 19.2 to 19.7 and Annex I.
46 See eg. paragraphs 16.10 to 16.12, 18.6 and 23.6.
47 See generally the provision and co-ordination of counselling – paragraphs 26.14 to 26.16.
the risk of a major disaster may be greater in, say, London than elsewhere, a tragic accident involving large numbers of casualties can occur anywhere at any time. It is therefore of the utmost importance that there should be contingency plans throughout the country to ensure that local authorities, police, coroners, pathologists and others know what will happen in an emergency. I recommend that the Home Office take steps to this end.

**Identification Commission**

29.33 As indicated in part two, 49 there has been some debate as to who should chair the Identification Commission. For the reasons given there, it seems to me that in general the commission should be chaired by the coroner, but that there may be unusual cases in which that would not be appropriate. In such a case, as I see it, it must be for the coroner, no doubt in consultation with the overall incident commander, to decide who should take the chair. I recommend that this be stated as appropriate in the ACPO Manual and in any relevant protocol. 50

29.34 There was some debate as to whether the Identification Commission should be larger than it is at present. 51 However, it seems to me that it should not be too large and that it should be limited to the ‘core players’, but that further members should be co-opted as and when necessary. 52

**Viewing the Body**

29.35 In section 23 I expressed the opinion that the bereaved should in principle have the right to view the body. Consideration should I think be given to placing the ‘right’ to view the body on a statutory basis, especially since there may be some doubt as to the position under article 8 of the European Convention on Human Rights. 53

29.36 The importance of viewing the body for the grieving process should be emphasised to coroners and their staff by appropriate means. While the coroner or the coroner’s officers may have reservations about the wisdom of viewing the remains of the deceased where there has been disfigurement by trauma, dismemberment, decomposition or mutilation, coroners should be reminded that

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49 Paragraphs 16.23 to 16.25.
50 Paragraph 16.25.
51 Paragraphs 16.26 to 16.29.
52 Paragraphs 16.20 and 16.29.
53 Paragraph 24.5.
the members of the family should never be prevented from viewing the remains. Any such viewing is at the risk of the viewer but coroners and their staff should be reminded of the assistance to be gained from using counsellors, FLOs and religious leaders in this process. The evidence has shown that counselling is very important in cases where viewing the body may be very distressing. Thus the bereaved should, as I see it, be given the opportunity to receive full information, but, in order to decide whether to do so or not, should be provided with appropriate counselling.

29.37 As stated above, it is important that there should be pre-planning so that arrangements are made before a major disaster occurs. It is of particular importance that all the agencies know what the policy is in the particular mortuary in order to ensure that families are not given mixed or confused messages. I recommend that a similar plan to the Temporary Mortuary Plan for Surrey be developed, subject to the two particular points mentioned above.

29.38 Further, where possible, viewing should be permitted as soon as the bereaved wish to see the body and facilities should be available at mortuaries for families to have access to the body rather than being restricted to viewing the body through a glass window.

29.39 The following have been noted by relatives as being helpful regarding attendance at the mortuary and viewing the bodies. I recommend that the following matters should be noted by FLOs, coroners and those involved in the viewing process:

a. before going to the mortuary, a detailed description of the layout of the mortuary should be given by the FLO;

b. a photograph of the body (if available) should be offered to explain any injuries and to prepare the relatives for the viewing;

c. prior to the viewing, information as to the state of the body should be given in a sensitive and compassionate manner – this information should include any odour, the colour and temperature of the body and a detailed description of the nature and extent of any injuries;

54 Paragraph 23.6.
55 Paragraphs 23.3 to 23.5.
56 cf paragraph 23.5.
d. the family should be asked if there is anything further that they wish to know.

**Information to Families**

**General Information**

29.40 I have tried to describe in section 25 the great strides that have been made over the years with regard to providing information and support for families and in section 26 I have tried to set out the way in which information is at present made available. It is in this area that the principles identified in section 27 above are of particular importance.

29.41 While, as Malcolm Williams pointed out, leaflets and pamphlets are no substitute for personal contact and personal explanation, they do have a part to play. It seems to me that there is a need for a comprehensive pamphlet in order to try to ensure that families are given as much information as possible. I therefore recommend that consideration should be given to the production by the Home Office of a pamphlet setting out the procedures which are followed and the entitlements of the families in the case of sudden death, for FLOs and counsellors to give out and to be available at police stations, hospitals and Coroner’s Courts. The pamphlet should contain, *inter alia*, the following information which should be set out in large clear writing:

- where a body will be taken once it has been found;
- what happens to a body at the mortuary;
- how the identification process will work and who will be involved in it;
- the role of the coroner and the police;
- what is a post mortem;
- when a post mortem takes place and why;
- what rights the families have regarding the body and the post mortem;

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57 Paragraph 26.10.
• the right to view the body;

• when the body will be released;

• what will happen to the body after it has been released;

• what an inquest is and the reasons for it;

• what will happen during the inquest.

29.42 The Royal College of Pathologists has prepared a document entitled ‘Examination of the body after death: information about post-mortem examination for relatives.’ The document deals both with post mortems by consent and with those required by the coroner in the case of sudden death. Relatives bereaved as a result of a major disaster find it difficult to assimilate even small pieces of information. It is therefore recommended that the document be split into two documents. Families could then be given the document relevant to the type of death with which they are dealing.

**Particular Information**

29.43 It is in this area that there have perhaps been the greatest strides since 1989. I merely stress again under this heading the importance of honest, accurate information being given to families as early and regularly as possible and at all times thereafter. If accurate information cannot be given, the families should be told why not. There are few things more frustrating than being told nothing and not being given any explanation for the fact that one is being kept in the dark. Thus, if FLOs do not already receive it, I recommend that they be given appropriate training in this regard.

**Information from Families**

29.44 The evidence strongly suggests that it is distressing to be asked the same question several times by different officials. Every effort should therefore be made to ensure that duplication of questioning of families is avoided. The assigned FLO (at least one per deceased) should remain the primary contact with the family throughout the identification process and the aftermath.
29.45 In cases where DNA profiling and the taking of samples are appropriate, the FLO should approach the mother of the victim in confidence and ask if there is anything she would like to advise regarding lineage, prior to obtaining blood samples for DNA purposes.\(^{58}\)

29.46 It has been submitted that relatives should be consulted as to the condition in which property found on the body should be returned. I see the force of that. It should be borne in mind that some relatives do not wish clothing to be cleaned and jewellery returned to its original state.
Part Four: Summary

30. Introduction

30.1 In this part I shall summarise some of the concerns of the families, which I take from paragraph 4.9. I shall then set out a summary of the main conclusions in part one. I shall not summarise the contents of part two, which is itself intended to be a summary of the present position, but I shall set out my recommendations in the form of a list because it is perhaps convenient to have them in one place. I should stress that the whole of this part is intended only as a summary and I therefore respectfully refer the reader to the body of the report.

31. Families’ Concerns

31.1 I summarised what seem to me to be the most important of the concerns of the families in paragraph 4.1. It is perhaps convenient to repeat them here as part of these conclusions:

- the removal of the hands for identification purposes at a time when identification by non-invasive means was likely in the near future;

- the failure of anyone in authority to inform the relatives that the hands had been removed;

- the refusal to allow the relatives to view the body;

- in some cases, the return of the body without the hands;

- the failure thereafter to return the hands to the body;

- in one case the disposal of hands which were discovered much later without informing the relatives and without their authority;

- the issue of inaccurate and insensitive interim death certificates;
• a lack of detailed information available to families; and

• a lack of overall co-ordination of the identification procedures.

That is not intended to be a complete list, but it gives a reasonable picture of some of the understandable concerns of the families.

31.2 I shall refer to some further concerns which have recently been expressed on behalf of the families by way of postscript in section 35 below.

32. The Past

Dr Knapman
Removal of Hands

32.1 It was evident from the outset that there had been considerable loss of life. In the event it was ascertained that 51, mostly young, people died as a result of the MARCHIONESS disaster. Of those, one body was recovered from the water on 20th August 1989, which was the day of the collision and 24 bodies were recovered from the wreck on the afternoon of the same day. Those bodies were all subsequently identified visually. Part one has been mainly concerned with the identification of the remaining 25 bodies, which were recovered from the river on and after 22nd August. The hands of all but one of those bodies were removed in order that fingerprints could be taken for the purposes of identification. Part one has focused on why that occurred and responsibility for it.

32.2 Dr Knapman, who was on holiday in Devon when the accident occurred, assumed jurisdiction for the bodies as the Westminster coroner on 20th August and travelled to London on the same day. The MPS opened a casualty bureau at New Scotland Yard and an incident room at Cannon Row police station. A number of what were known as relative liaison officers were appointed.

32.3 All the bodies were taken to Westminster mortuary and post mortems carried out. The means by which each body was identified and when are contained in

59 Paragraphs 5.2 and 5.17.
60 Paragraph 5.3.
61 Paragraphs 5.4 to 5.8.
three detailed schedules at Annexes B, C and D. Reference should also be made to the chronology at Annex E. Of the 24 bodies recovered from the water on and after 22nd August, 19 were identified by means of dental records and matching items of clothing or jewellery, four were identified by fingerprints and two were identified by distinctive clothing and/or jewellery alone.

32.4 There was much debate as to the reason why the hands were authorised to be removed. My conclusion is that the police authorised their removal on and after 23rd August as a result of authority given to them by Dr Knapman as coroner on 20th and 22nd August at meetings in London before he resumed his holiday in Devon. He authorised the removal of hands where removal was considered necessary by the fingerprint officers. He first did so at a meeting or discussion on 20th August in the presence of Dr Shepherd, the lead pathologist, and a senior police officer, probably DCS Purchase. Dr Dolman, the deputy coroner, was not present.

32.5 Little, if any, mention of dental records was made at the meeting on 20th August. However they were mentioned at a meeting on 22nd August when Dr Knapman asked for dental records of all victims to be obtained. Dr Knapman indicated at one or both meetings that he wanted identification to be as sure as possible. He told the police that he required identification by both dental records and fingerprints because, as DI Raison is recorded as saying at a meeting on 24th August, ‘the Coroner wanted 100% identification before he would be satisfied. This means dental and fingerprint identification’. The reference to the coroner in that record was a reference to Dr Knapman and not to Dr Dolman and is evidence of what Dr Knapman had said to the police before he left London on 22nd August.

32.6 When Dr Knapman left London on 22nd August, only one body had been recovered from the water, namely the body which was recovered on 20th August. Possibly for that reason, Dr Knapman did not himself apply his mind to the question whether he would insist on fingerprints being taken from a body if, in order to do so, it was necessary to remove the hands in circumstances where dental records were in the course of being obtained. If he had thought about it or his
attention had been drawn to that question, it seems likely that he would have said that he did not expect the removal of hands to be carried out without waiting to see if a positive identification could be obtained by means of dental records.\(^{68}\)

32.7 However, the effect of his not considering the above question expressly was that he did not limit the authority which he gave to the police in any way. He correctly accepted during the course of his evidence at the inquiry that he ought to have made clear what limitations there were or ought to have been on the extent of the authority he was granting, that it would have been sensible to have done so and that the decision should have been reached on a body by body basis.\(^{69}\)

32.8 If he had done so, it is likely that DCS Purchase or DI Raison, when responding to the request to remove hands on 23\(^{rd}\) August, would have considered whether removal was appropriate in circumstances where dental records were in the course of being obtained. If Dr Knapman had made clear on 20\(^{th}\) August that he was giving only limited authority to remove hands and stressed the importance of obtaining dental records it is likely that the concerted efforts by the police which were made to obtain dental records on 23\(^{rd}\) August would have been made on 21\(^{st}\) August. In that event it is likely that many dental records would have been in the possession of the police on or before 23\(^{rd}\) August when the first request to remove hands was made.\(^{70}\)

32.9 Dr Knapman spoke to Dr Dolman before leaving London, but did not tell him that he had given authority to remove the hands. Indeed, Dr Dolman was not aware that any such authority had been given or that any hands had been removed until long after 1989.\(^{71}\) In my view, before leaving London Dr Knapman should have told Dr Dolman what authority he had given to the police as to the removal of hands. Dr Dolman was his deputy and was to act as coroner in his absence. It was thus of considerable importance that Dr Dolman should know what instructions and authority he had given the police. Some of the participants in the inquiry criticised Dr Knapman for returning to Devon. I do not, however, criticise him for that, but for doing so without advising Dr Dolman of the authority he had given.\(^{72}\)

\(^{68}\) Paragraph 6.12.
\(^{69}\) Paragraph 6.13.
\(^{70}\) Paragraph 6.13.
\(^{71}\) Paragraphs 6.6, 6.7 and 6.18.
\(^{72}\) Paragraph 6.14.
32.10 In short, my conclusion is that the authority to remove hands was in effect given by Dr Knapman on 20th August and confirmed by him on 22nd August before he returned to Devon. The police were left with the impression that Dr Knapman required fingerprints to be taken in every case and that, if it was necessary to remove the hands in order for fingerprints to be taken, that should be done. They in effect regarded themselves as instructed by the coroner to permit it because it was he who had to be satisfied as to the identity of each of the deceased.\(^{73}\)

32.11 During the afternoon of 22nd August a number of the bodies which had been recovered from the river arrived at Westminster mortuary. One of the fingerprint officers, Mr Viner, first inspected one or more of those bodies on 23rd August. More of the bodies were inspected on 24th August both by Mr Viner and his colleague Mr Strong. They formed the view that none of them was suitable for fingerprinting at the mortuary and that, in order to be fingerprinted, the hands would have to be removed and taken to the laboratory at Amelia Street.\(^{74}\)

32.12 The fingerprint officers accordingly asked a senior police officer, probably DI Raison, who was in charge of the mortuary police team for permission to remove the hands.\(^{75}\) The fingerprint officers were told by a senior police officer, probably DCS Purchase (or possibly DI Raison), that the coroner had authorised removal if they (as fingerprint experts) thought that it was necessary in order to obtain fingerprints.\(^{76}\)

32.13 In the light of the view of the fingerprint officers that removal was indeed necessary the police gave them authority to remove the hands. In doing so, they gave no consideration to the question whether it was necessary to do so having regard to other means of identification in any particular case. They simply acted on what they justifiably regarded as both the authority (and in effect) the instructions of the coroner, Dr Knapman. They therefore permitted the removal of the hands on a blanket basis and did not consider whether or not hands should be removed on a case by case basis.\(^{77}\)

32.14 No-one told the families of the deceased that hands had been removed. As a result they did not discover the true position until much later. I have summarised some of the evidence of the families in section 7 above, to which I refer the

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\(^{73}\) Paragraphs 6.20 and 6.27.

\(^{74}\) Paragraph 6.21.

\(^{75}\) Paragraphs 6.22 and 6.24.

\(^{76}\) Paragraph 6.25.

\(^{77}\) Paragraph 6.26.
reader. I also summarised what seem to me to be the most important of the concerns of the families in paragraph 4.1 and again in paragraph 30.2.

32.15 No-one paused to consider the possibility of a deceased person being identified by dental records before the decision to remove the hands was taken.\(^78\) In paragraphs 8.3 to 8.5 I considered two particular cases, but my general conclusion is that hands were not being removed only as a last resort, but were being removed in all cases. As a result, hands were removed notwithstanding that dental records were being obtained or had been obtained or, possibly in one case, just after a dental match had been made. There was no system in place by which the progress being made to identify victims was reviewed when a request was made by the fingerprint officers to have hands removed, so that a judgment could be made as to whether or not removal was necessary as a last resort. As appears elsewhere in this report, it is my view that such a system should have been put in place. However, no such system was in place and as a result there was clearly no consideration on 24\(^{th}\) and 25\(^{th}\) August as to whether the removal of hands was necessary as a last resort.\(^79\)

32.16 Had there been such a system and consideration given to that question it is very likely that the judgment would have been formed that removal was not necessary. A decision would have been taken to wait and see whether the preliminary identification made by means of what had been found on the bodies could be confirmed by matching dental records. Dr Knapman said in his oral evidence to this inquiry that ‘if . . . a decision-maker knew that some dental records were on their way, manifestly, I think he should just have left it for 24 or 48 hours’. Having regard to the distress that removal of hands would be likely to cause to the next of kin, this would in my opinion clearly have been the correct approach. If that approach had been adopted in the case of the 11 bodies which were identified by dental records on 25\(^{th}\) August, their hands would not have been removed. It was probably for that reason that Dr Knapman agreed (in my view correctly) that in the case of many of the 25 bodies whose hands were removed pursuant to his authority those removals were unnecessary ‘given that dental records were very close to hand’.\(^80\)

32.17 Indeed, if what I regard as the correct question had been asked in each case, namely whether it was necessary to remove the hands as a last resort, it is more
probable than not that none of the hands would have been removed, especially since Dr Dolman was willing in appropriate cases to accept evidence which did not include either fingerprint or dental evidence.81

32.18 In short, my conclusion is that, even as at 1989, hands ought not to have been removed in order to take fingerprints for the purposes of identification unless, having regard to the absence of other sufficient means of identification, it was necessary to do so as a last resort. Moreover the question whether to remove hands should have been considered on a case by case basis and not on a blanket or wholesale basis. Thus for example, if at the time that question was asked, dental records were known to be on their way and/or were likely to be available in the near or comparatively near future, the hands should not have been removed. In order to ensure that decisions were taken on that basis, a proper system should have been set up requiring appropriate collation of the information so that a decision would never be made on the basis of anything other than all the information available at that time.82

32.19 The responsibility for the fact that such a system was not set up and for the removal of the hands in circumstances where they should not have been removed is that of Dr Knapman, although he acted throughout in good faith and with the best of intentions and he did not, in my opinion, act recklessly.83

32.20 Nevertheless he failed to give proper consideration to the question in what circumstances the hands of particular deceased should be removed. If he had, he should (and no doubt would) have limited the authority of the police to remove hands to cases of last resort.84 He authorised and in effect instructed the police to obtain fingerprints in every case and to remove the hands if it was necessary to do so in order to obtain fingerprints. In the event it was necessary to remove the hands to obtain fingerprints in 25 cases, but (for the reasons already given) it was not necessary to obtain fingerprints. It follows that the hands should not have been removed and Dr Knapman must bear the responsibility for the fact that they were.

81 Paragraphs 8.7 and 8.8.
82 Paragraphs 9.1 to 9.4.
83 Paragraphs 12.1, 12.2, 12.6, 12.7.
84 Paragraph 12.7.
32.21 In one case the wrong body was nearly released to the wrong person, although fortunately the mistake was discovered before that occurred and, in the event the correct body was released to the correct person in each case. However, in three cases, namely in the cases of Simon Senior, Julie Hunt and Elsa Garcia, the hands were not released with the body. The fact that bodies could be released without hands and, moreover, that in such cases hands were not subsequently returned to the appropriate funeral director shows that the system in place in Westminster mortuary at that time was far from satisfactory.

32.22 In the case of Simon Senior, the undertaker, Mr Wickenden, had to return to the mortuary to collect the hands and the police had to make arrangements for the return of Julie Hunt’s hands. In the case of Elsa Garcia, her mother Lucy Garcia was not told that her hands had been removed. Indeed, a veil of secrecy hid from Mrs Garcia, until this inquiry was well underway, that her daughter’s hands had not been reunited with the body but had lain in a freezer in the Westminster mortuary until their presence was reported in August 1993 to Dr Knapman who then authorised their destruction.

32.23 It is to my mind a shocking feature of the case that it was possible for a pair of hands to be left undiscovered in the mortuary, not just for months, but for years. The reason for the failure to return the hands with the bodies was that no record was kept at the mortuary of which bodies had had their hands removed and, it seems, a simple check was not made before bodies were delivered to the funeral director. The system has since been changed and this omission has been remedied.

32.24 The failure to return the hands in the above three cases was caused by a failure on the part of Westminster mortuary to have a proper system. It was not the responsibility of the coroner, Dr Knapman, to lay down such a system, and he cannot be criticised for failing to ensure that such a system was in place. However, where authority was given to remove hands it ought to have been made clear to the mortuary by the coroner that the hands were to be returned to
the body before the body was delivered to the undertaker. That was (as I understood it) accepted by Dr Knapman, although he correctly pointed out that he had no executive control over the mortuary personnel.\(^92\) If Dr Knapman had made it clear that hands which had been removed should be united with the body, it is more likely than not that the mortuary would have kept proper records (which it did not) and it may be that in those circumstances the hands of Simon Senior, Julie Hunt and Elsa Garcia would have been reunited with the bodies before being delivered to the undertaker.\(^93\)

**Failure to Provide Information**

32.25 Relatives were not told that post mortems were likely to be carried out or that there was a possibility that hands might be removed for fingerprinting purposes. Nor were they subsequently told that hands had in fact been removed. It was not the practice to give relatives information of that kind in 1989. In those circumstances I do not consider that it would be fair to criticise Dr Knapman for his failure to provide it.\(^94\)

32.26 I am, however, pleased to say that such a failure would be regarded as wrong in principle today. Dr Knapman’s practice and, indeed, the position generally are now very different. Relatives are informed as soon as possible that a post mortem is to be or has been carried out because an open and honest approach is now recognised to be right in principle. Where an Identification Commission chaired by a coroner reaches the conclusion that the removal of hands is necessary as a last resort, relatives should be (and no doubt are) informed of that decision in as humane and sensitive a manner as possible. The wishes of those who do not wish to know should of course be respected, but save in such cases the principles of openness and honesty require that the information be provided humanely and sensitively.\(^95\)

**Visual Identification and Viewing the Body**

32.27 Dr Knapman was criticised for giving instructions that relatives should not identify or view bodies which were recovered from the river. As to visual identification, Dr Knapman did give such instructions, but cannot fairly be criticised for doing so because the view of those attending the post mortems was

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\(^{92}\) Paragraph 12.8.  
\(^{93}\) Paragraph 12.9.  
\(^{95}\) Paragraphs 12.14 and 12.15.
that the bodies recovered from the river were in such a state that they were not suitable for visual identification. In my opinion Dr Knapman was entirely justified in deciding that in such circumstances visual identification would not be acceptable.96

32.28 As to viewing the body, I do not think that in any case Dr Knapman (or indeed Dr Dolman) gave instructions that relatives were not to view the body. Dr Knapman took the view that they could do so at the premises of funeral directors. It is likely, however, that the coroner’s officers or police liaison officers, acting from the best motives, namely to avoid distress to relatives sought to dissuade them from viewing the body. In these circumstances it is possible that some officers used language which suggested that viewing was prohibited rather than ill-advised. I am quite satisfied that the liaison officers (and indeed the coroner’s officers) acted throughout in what they perceived to be the best interests of the relatives and in such a way as to minimise the distress which they were bound to feel.97

32.29 In these circumstances, and having regard to the standards of 1989, I do not think that it would be fair to blame Dr Knapman in this respect. The position is quite different today. It is to be expected that, following an incident involving loss of life, some relatives will visit the mortuary in order to see the body of their loved one. As matters are perceived today, a coroner ought therefore to consider how requests to view the body should be dealt with and give appropriate directions since the body is in his possession. Good sense and regard for the feelings of the relatives require that this matter be addressed carefully and sensitively. There will inevitably be a need for appropriate counselling before viewing takes place and some may decide not to view when the condition of the body has been explained to them with due sensitivity. But in principle the request of a relative to view the body, if maintained after appropriate counselling, should be respected.

Death Certificates

32.30 As Eileen Dallaglio said in evidence, the entry in the register of Births, Marriages and Deaths relating to her daughter Francesca gave the date and place of death as 23rd August 1989 and the River Thames, Poplar, whereas she correctly observed that her daughter had died on 20th August 1989 and not at Poplar. It

96 Paragraphs 12.15 and 12.17.
97 Paragraphs 12.15 to 12.17.
appears that it was not uncommon at the time to enter on the form, not the date and place of death, but the date and place of life being pronounced extinct. For my part, I cannot understand how it can be right to enter any information other than that required by the form, namely the actual place and date of death, once it has been established.\textsuperscript{98}

32.31 In my view the place and time of death should have been stated correctly on the certificate. It was accepted by Dr Knapman that they did not have to be recorded by reference to the date upon which a doctor pronounces life extinct. As I understand it, the register can in appropriate circumstances be amended and, for my part, I can see no reason why it should not be amended in the case of Miss Dallaglio.

\textit{The Police Officers}

32.32 Some participants in the inquiry sought to criticise the police in a number of ways. I have, however, reached the conclusion that it would not be just to criticise them on the available evidence. Thus I do not consider that they can fairly be criticised for not seeking to obtain dental records until after Dr Knapman had referred to them on 22\textsuperscript{nd} August before returning to Devon. Of course they could have started to obtain dental records before then but, since it was the coroner’s decision as to what identification evidence was to be accepted, it seems to me that it was reasonable for them to follow his lead.\textsuperscript{99}

32.33 Equally I do not think that the police can fairly be criticised for failing to co-ordinate the identification process and the information which was being obtained, in order to ensure that hands were only removed as a last resort. DCS Purchase cannot fairly be criticised for not adding his own limitation to the authority granted by the coroner. There is no basis for criticising the system adopted by the police. The problem was not a failure by the police to put an appropriate system in place, but a failure to consider the question whether hands should be removed on a case by case basis having regard to all the circumstances. That was the fault of the coroner and not the police, who reasonably thought that what the coroner wanted was both dental and fingerprint identification. Since it was the coroner who had to be satisfied, I do not think that the removal of the hands can be fairly blamed on the police, once it was accepted (as proved

\textsuperscript{98} Paragraph 7.6.
\textsuperscript{99} Paragraph 12.20.
to be the case) that, if it was necessary to take fingerprints, the hands had to be removed.\(^{100}\)

**The Fingerprint Officers**

32.34 Neither of the fingerprint officers can be blamed for failing to consider whether the removal of the hands was appropriate in circumstances where identification by dental evidence was imminent because their sole function related to the taking of fingerprints.\(^{101}\)

32.35 The fingerprint officers concluded that, if fingerprints were to be taken, it would be necessary to remove the hands and take them to the laboratory at Amelia Street. That conclusion was justified by the condition of the hands caused by the length of time they had been immersed in water. It follows that the officers cannot fairly be criticised in any respect.\(^{102}\)

**The Coroner’s Officers**

32.36 The coroner’s officers were criticised by some for not themselves collating the identification evidence and for not considering whether in all the circumstances it was appropriate to remove the hands. Their responsibilities did not, however, include collation of the evidence in circumstances in which the police were doing just that at Cannon Row. I do not therefore think that those criticisms of them are justified. It is true that both Mr Rumbold and Mr Foster-Smith learned during the week commencing 21\(^{st}\) August that hands had been removed, but, since it was no part of their duty to monitor the steps being taken to identify the bodies, again I do not think that they are fairly to be criticised on that, or indeed any other, score.\(^{103}\) It is simply an unfortunate fact that neither of them mentioned it to Dr Dolman.

**Dr Dolman**

32.37 Dr Dolman did not know that any hands had been removed until long after 1989. It was suggested that he should have taken more steps than he did to check what the police were doing and that, if he had, he might have learned that which Dr Knapman failed to tell him. It is true that some coroners might have asked

\(^{100}\) Paragraphs 12.21 to 12.25 and 12.27.
\(^{101}\) Paragraphs 12.26.
\(^{102}\) Paragraphs 12.27 to 12.33.
\(^{103}\) Paragraphs 12.34 to 12.39.
more questions than he did, but he considered the evidence in each case which came before him and made a decision on the basis of it. It is, in my opinion to be wise after the event to blame Dr Dolman for the removal of any of the hands and I do not do so.\textsuperscript{104}

\textbf{The Pathologists}

32.38 All criticisms of the pathologists were withdrawn, in my opinion correctly. I agree that no criticism can fairly be advanced of them.\textsuperscript{105}

\textbf{Westminster Mortuary}

32.39 The mortuary is properly to be criticised in three respects. First, it should have had in place a proper system for ensuring that hands removed from a body were replaced with the body before it was released to a funeral director on behalf of the relatives. Secondly, it should have had a better system for ensuring that the correct body was released to the correct undertaker, although this did not in the event lead to a body being released to the wrong person. Thirdly, it should have had a proper system for ensuring that body parts did not remain in the mortuary for excessive periods of time.

33. \textbf{The Present}

33.1 In part two I have tried to set out the present position under a number of heads. I have done so largely in summary form so that nothing is to be gained by summarising the contents of part two again here, save to indicate the heads under which I described the position. In section 15 I tried to describe the role of the coroner under these heads: the office of coroner,\textsuperscript{106} the duty to identify and possession of the body\textsuperscript{107} and the coroner and identification procedures.\textsuperscript{108} In section 16 I described the role of the police. I first set out the basic position\textsuperscript{109} and then briefly discussed a number of particular topics as follows: the relationship between the police and the coroner,\textsuperscript{110} collation and matching of

\textsuperscript{104} Paragraph 12.40.
\textsuperscript{105} Paragraph 12.41.
\textsuperscript{106} Paragraphs 15.1 to 15.5.
\textsuperscript{107} Paragraphs 15.6 to 15.10.
\textsuperscript{108} Paragraphs 15.11 to 15.16.
\textsuperscript{109} Paragraphs 16.1 to 16.9.
\textsuperscript{110} Paragraphs 16.10 to 16.12.
ante mortem and post mortem information, the Identification Commission and the Senior Identification Manager or SIM.

33.2 I next tried to answer the question what happens to the body in section 17. In sections 18 and 19 respectively I discussed the temporary mortuary and the mortuary and mortuary staff. In section 20 I set out the role of the coroner’s officers and included a number of paragraphs on the role of the coroner’s officers after a major disaster. In section 21 I referred briefly to the role of the pathologist and in section 22 I set out the various methods of identification, namely visual identification, dental charting, fingerprints and DNA.

33.3 Section 23 contains a discussion on viewing the body, while section 24 discusses articles 8 and 9 of the European Convention on Human Rights. Section 25 discusses family liaison, first generally and then with regard to families living abroad. Finally part three concludes with section 26 on information and counselling, which (after a short introduction) is divided into general information, specific information and the provision and co-ordination of counselling.

34. The Future

General Principles

34.1 In part three I have included a short discussion of some of the topics which were omitted from part two and have paid tribute to the Bristol and Alder Hey reports. I have also summarised the general principles which in my view

111 Paragraphs 16.13 to 16.19.
112 Paragraphs 16.20 to 16.29.
113 Paragraphs 16.30 to 16.34.
114 Paragraphs 20.3 to 20.7.
115 Paragraphs 22.5 to 22.16.
116 Paragraphs 22.17 to 22.20.
117 Paragraphs 22.21 to 22.33.
118 Paragraphs 22.34 to 22.41.
119 Paragraphs 25.1 to 25.11.
121 Paragraphs 26.4 to 26.10.
123 Paragraphs 26.14 to 26.16.
124 Section 28.
should be kept in mind throughout the identification process after a major disaster. They are:

(1) provision of honest and, as far as possible, accurate information at all times and at every stage;

(2) respect for the deceased and the bereaved;

(3) a sympathetic and caring approach throughout; and

(4) the avoidance of mistaken identification.

Those principles seem to me to be consistent with those set out by the Chief Medical Officer in the Advice which he wrote in the light of the Bristol and Alder Hey reports and the evidence given in those inquiries. 125

Recommendations

34.2 The recommendations set out in section 29 may be summarised as follows:

Recommendation 1.
I recommend that a detailed review be undertaken as to the role of the coroner by, say, the Law Commission, and that a statutory scheme be devised which codifies the powers, duties and responsibilities of the coroner. 126

Recommendation 2.
Any review of the law relating to coroners should include a consideration of the following questions, no doubt among many others: 127

a. Should there be a general principle that there is no property in a body or a body part? If so, what, if any, exceptions should there be? If not, who should have property in a body or body part, from when and for what purpose?

125 Paragraphs 27.5 to 27.8.  
126 Paragraph 29.10.  
127 Paragraph 29.13.
b. Who should have a right to possession of a body and when?

c. Should personal representatives of the deceased (or others, and if so who) have a right to call for possession of body parts for the purpose of burial or disposal?

d. Who should have possession or custody of a body at a mortuary or temporary mortuary?

e. Who should be responsible for identification of a body? What powers should such a person or entity have?

f. In each case should the powers and duties concerned be laid down by statute or in some other way and, if so, what?

g. What criteria should be adopted or tests applied before human material (including limbs and other body parts) is removed for the purposes of identification?

Recommendation 3.
Apart from the wide review contemplated above, consideration should now be given to regulating the removal from deceased persons of any human material, whether it be body parts, tissue or organs, for any purpose, including identification. ¹²⁸

Recommendation 4.
Any consideration of the recommendations made in the Bristol and Alder Hey inquiries should take account of the possibility of the removal of body parts or other human material for identification purposes. ¹²⁹

Recommendation 5.
It should be made clear that the methods used for establishing the identity of the deceased should, wherever possible, avoid any unnecessary invasive procedures or disfigurement or mutilation and that body parts should not be removed for

¹²⁸ Paragraph 29.15.
¹²⁹ Paragraph 29.15.
the purposes of identification except where it is necessary to do so as a last resort. The position is somewhat different in the case of samples taken for DNA purposes.\textsuperscript{130}

**Recommendation 6.**
Consideration should be given to requiring coroners to undergo extensive training, both before appointment and from time to time thereafter. Such training should be uniform across the country and should include:

a. the identification of unknown bodies in multiple fatality incidents;

b. dealing with bereaved relatives in major disasters;

c. the management of and contingency planning for multiple death disasters; and

d. the likely ethnic, cultural and religious interests of minority and religious groups in case of death.\textsuperscript{131}

**Recommendation 7.**
I endorse the recommendations made by Michael Burgess, secretary to the Coroners’ Society that:

a. while the actual methods for establishing the identity of the deceased person should in any particular case be left to the coroner, the Home Office should issue guidance on the criteria and suitable methods which might be used;

b. such guidance should be kept under regular review and there should be consultation with such persons or organisations as the Home Office may from time to time determine; and

c. the guidance should take account of advances in scientific knowledge and available techniques.\textsuperscript{132}

\textsuperscript{130} Paragraph 29.16.
\textsuperscript{131} Paragraph 29.17.
\textsuperscript{132} Paragraph 29.18.
Recommendation 8.
Coroners and coroners’ staff should meet with families or family groups to explain the identification and other procedures to be followed. They should also keep relatives informed of the progress of the identification process.  

Recommendation 9.
I endorse the recommendations made by DCS Barry Webb and his working group, following their review of casualty bureau procedures, family liaison arrangements and identification procedures in the aftermath of the Ladbroke Grove train crash, that consideration should be given to the following matters:

a. incorporation into the ACPO Manual of a Pro-Active Unit as an integral part of the Casualty Bureau;

b. inclusion in the ACPO Manual of the Ladbroke Grove Casualty Bureau MISP ER grading system as a specific example of good practice;

c. incorporation into the ACPO Manual of a proposal that two FLOs be assigned to the Casualty Bureau;

d. highlighting within the ACPO Manual the need for timely quality control to be introduced within Casualty Bureau;

e. reviewing the format of MISP ER reports to ensure they highlight key aspects in completing individual reports and are compatible with the HOLMES II screen;

f. commissioning research by ACPO to maximise the IT opportunities presented by the introduction of HOLMES II;

g. the creation of a Senior Identification Manager post to have overall responsibility for the identification process;

h. inclusion in the ACPO Manual of the removal of body parts as a component of the identification process;

133 Paragraph 29.19.
i. inclusion in the ACPO Manual of the need for careful documentation of all procedures undertaken at the mortuary;

j. arranging a meeting between representatives of the ACPO Homicide Working Group, Emergency Procedures Sub-Committee and Race and Diversity Portfolio with a view to discussing Family Liaison in incidents of major disaster;

k. including in the ACPO Emergency Procedures Manual and draft Family Liaison Guidelines a paragraph that highlights the crucial role the FLO has in assisting the identification process;

l. the ACPO Manual highlighting Family Liaison team leaders as good practice;

m. the ACPO Manual highlighting the long term benefits of the family viewing the body if at all possible;

n. developing the concept of partnership between police and bereaved families within the ACPO Emergency Procedures Manual;

o. incorporation into the ACPO Manual of a section which covers good practice regarding to the involvement of independent advisers;

p. inclusion in the ACPO Manual of advice concerning the need for enhanced bereaved family information packs to be prepared as part of the advance planning process;

q. inclusion in the ACPO Manual of a paragraph highlighting that good practice has shown that hotel accommodation provides the most suitable environment for family liaison;

r. inclusion within the ACPO Manual of a section on the benefits of FLOs viewing a photograph of the body with which they are dealing;

s. inclusion in the Family Liaison Chapter of the ACPO Manual of a section on Family Liaison Logs;
t. inclusion in the ACPO Manual and Draft Family Liaison Guidelines document of a reference to the equipment needs of FLOs;

u. inclusion in any nationally designed FLO course of media training and an awareness of Casualty Bureau functions.\footnote{134}

\textbf{Recommendation 10.}

In particular I support the proposal to appoint a Senior Identification Manager (‘SIM’), namely a senior police officer to have overall responsibility for the identification process.\footnote{135}

\textbf{Recommendation 11.}

Consideration should be given to inclusion within the family liaison chapter of the ACPO Manual of a section dealing with the treatment of relatives living abroad.\footnote{136}

\textbf{Recommendation 12.}

I endorse the recommendation of DCS Webb and his working group that consideration be given to the development of a formal protocol between the Home Office Department with responsibility for HM Coroners and ACPO regarding:

\begin{itemize}
  \item a. timescales for the release of information regarding identification of bodies to relatives;
  \item b. the frequency with which the Identification Commission should sit;
  \item c. police requirements at the mortuary;
  \item d. publication of the identification criteria as part of the need to be open with families.\footnote{137}
\end{itemize}
Recommendation 13.
I recommend that any such protocol cover all aspects of the relationship between the coroner and the police, to the extent that they are not already covered.138

Recommendation 14.
I recommend that (to the extent that this has not already been done) a protocol or protocols be developed throughout the country between the coroner, the police, the local authority, the mortuary and the pathologists setting out clear procedures for the custody and release of body and body parts in order to ensure that there is no confusion. I commend anyone charged with the responsibility of drawing up such a protocol to consider the Temporary Mortuary Plan for Surrey.139

Recommendation 15.
The arrangements set out in the protocol or protocols referred to in recommendation 14 be reviewed in any particular case by the Identification Commission in order to ensure that they are being operated appropriately.140

Recommendation 16.
I endorse the recommendation of DCS Barry Webb and his working group that consideration be given to the development of a formal protocol between pathologists and ACPO regarding all their respective mortuary responsibilities, including those to which I have just referred.141

Recommendation 17.
Those responsible for the management and running of mortuaries must ensure that strict procedures are followed and that all procedures are documented from the time a body or body parts arrive at the mortuary until the time a body is identified and released for burial. I commend Mr Butterfield’s submission to anyone devising systems in mortuaries.142

138 Ibid.
139 Paragraph 29.25.
140 Ibid.
142 Paragraph 29.27.
Recommendation 18.
All Home Office guidance to local authorities and others on emergency planning should include reference to the need to involve and consult the coroner in emergency planning and exercising.143

Recommendation 19.
Local authorities’ social services departments should identify individuals who can be jointly trained with FLOs to work with relatives following disasters.144

Recommendation 20.
Local authorities’ social services departments should ensure that plans are drawn up in conjunction with the local police forces as to the treatment of relatives and other bereaved in the aftermath of a disaster.145

Recommendation 21.
The Home Office should ensure that all agencies likely to be involved in the aftermath of major disasters are made aware of the need for contingency planning and are given the requisite training or guidance as to the management of a multiple fatality incident.146

Recommendation 22.
The Home Office should ensure that there are appropriate contingency plans and protocols in place throughout the country to ensure that local authorities, police, coroners, pathologists and others know what will happen in an emergency.147

Recommendation 23.
The Identification Commission should in general be chaired by the coroner, although there may be unusual cases in which that would not be appropriate. In such a case, it should be for the coroner, in consultation with the overall incident commander, to decide who should take the chair. I recommend that this be stated as appropriate in the ACPO Manual and in any relevant protocol.148
**Recommendation 24.**
The Identification Commission should not be larger than it is at present, except for the addition of the SIM. It should be limited to the ‘core players’, but further members should be co-opted as and when necessary.149

**Recommendation 25.**
Consideration should I think be given to placing the ‘right’ to view the body on a statutory basis.150

**Recommendation 26.**
In each area there should be pre-planning of policy with regard to viewing of the body, so that the bereaved are not given mixed messages as to whether they can view the body at the mortuary or not. I recommend that a similar plan to the Temporary Mortuary Plan for Surrey be developed, subject to the two particular points mentioned above.151

**Recommendation 27.**
The following should be among the matters emphasised to coroners and their staff in the course of any training, information or advice which they may be given:

a. the importance of viewing the body for the grieving process;

b. the bereaved should never be prevented from viewing the remains of the deceased, even in circumstances where the coroner or the coroner’s officers may have reservations about the wisdom of viewing the remains because there has been disfigurement by trauma, dismemberment, decomposition or mutilation;

c. any such viewing is at the risk of the viewer but coroners and their staff should be reminded of the assistance to be gained from using counsellors, FLOs and religious leaders in this process in order that they may decide what information to receive and whether to view the body or not.152

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149 Paragraph 29.34.
150 Paragraph 29.35.
151 Paragraph 29.37.
152 Paragraph 29.36.
Recommendation 28.
Where possible, viewing should be permitted as soon as the bereaved wish to see the body. 153

Recommendation 29.
Where possible, facilities should be available at mortuaries for families to have access to the body rather than being restricted to viewing the body through a glass window. 154

Recommendation 30.
The following particular matters should be noted by FLOs, coroners and those involved in the viewing process:

a. before going to the mortuary, a detailed description of the layout of the mortuary should be given by the FLO;

b. a photograph of the body (if available) should be offered to explain any injuries and to prepare the relatives for the viewing; 155

c. prior to the viewing, information as to the state of the body should be given in a sensitive and compassionate manner – this information should include any odour, the colour and temperature of the body and a detailed description of the nature and extent of any injuries;

d. the family should be asked if there is anything further that they wish to know. 156

Recommendation 31.
Consideration should be given to the production by the Home Office of a pamphlet setting out the procedures which are followed and the entitlements of the families in the case of sudden death, for FLOs and counsellors to give out and to be available at police stations, hospitals and Coroners’ Courts. The

153 Paragraph 29.38.
154 Ibid.
155 Paragraph 23.5.
156 Paragraph 29.39.
pamphlet should contain, _inter alia_, the following information which should be set out in large clear writing:

- where a body will be taken once it has been found;
- what happens to a body at the mortuary;
- how the identification process will work and who will be involved in it;
- the role of the coroner and the police;
- what is a post mortem;
- when a post mortem takes place and why;
- what rights the families have regarding the body and the post mortem;
- the right to view the body;
- when the body will be released;
- what will happen to the body after it has been released;
- what an inquest is and the reasons for it;
- what will happen during the inquest.\(^{157}\)

**Recommendation 32.**

I recommend that the document prepared by The Royal College of Pathologists entitled ‘Examination of the body after death: information about post-mortem examination for relatives’ be split into two documents, in order that families can be given the document relevant to the type of death with which they are dealing.\(^{158}\)

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\(^{157}\) Paragraph 29.41.

\(^{158}\) Paragraph 29.42.
Recommendation 33.
I stress again the importance first, of honest, accurate information being given to families as early and regularly as possible and at all times thereafter and, secondly, if accurate information cannot be given, of the families being told why not. If FLOs do not already receive it, I recommend that they be given appropriate training in this regard.\textsuperscript{159}

Recommendation 34.
Every effort should be made to ensure that duplication of questioning of families is avoided. The assigned FLO (at least one per deceased) should remain the primary contact with the family throughout the identification process and the aftermath.\textsuperscript{160}

Recommendation 35.
In cases where DNA profiling and the taking of samples are appropriate, the FLO should approach the mother of the victim in confidence and ask if there is anything she would like to advise regarding lineage, prior to obtaining blood samples for DNA purposes.\textsuperscript{161}

Recommendation 36.
Relatives should be consulted as to the condition in which property found on the body should be returned. It should be borne in mind that some relatives do not wish clothing to be cleaned and jewellery returned to its original state.\textsuperscript{162}

35. Postscript – the Samples found at Westminster Mortuary

35.1 On 19th January 2001 the director of Legal Services at the City of Westminster wrote to me in order to bring to my attention what he called a matter of some sensitivity. In mid December 2000 Dr Knapman asked for a written schedule of all specimens at the Westminster mortuary. When the mortuary survey was

\textsuperscript{159} Paragraph 29.43.  
\textsuperscript{160} Paragraph 29.44.  
\textsuperscript{161} Paragraph 29.45.  
\textsuperscript{162} Paragraph 29.46.
completed on 18th January, it was discovered that among the specimens found were four sample pots with numbers likely to correspond to four of those who died as a result of the loss of the MARCHIONESS.

35.2 The pots contained very small samples of tissue from the major organs of each of the four deceased. The samples were apparently taken as standard practice, but there is no suggestion that any of the organs were retained or that the samples were retained for the purpose of research or indeed for any other purpose. It appears that they simply remained at the mortuary rather than being disposed of after a matter of months, as would normally be the case.

35.3 Dr Knapman and the City of Westminster thought it right to bring the matter to my attention. Bill Sandal wrote to the City of Westminster and to Dr Shepherd asking for further information and replies were sent on behalf of both on 23rd January. On 24th January Mr Sandal sent copies of the correspondence to all participants. No substantive replies were received until 5th February, when I received a letter from Roger Eastman, counsel for Dr Knapman, asking for guidance. Before a reply was sent on my behalf, I received a letter dated 6th February on behalf of the MAG setting out a number of concerns.

35.4 The letter sets out their concern that it has taken 11 years to emerge that samples were taken from at least four individuals and submits that the discovery of these pots gives rise to the need to carry out a full investigation into the manner in which the bodies were treated in the aftermath of the disaster. In particular they seek a further investigation as to why specimens were taken in the first place, why the removal of tissue (without consent) is standard practice at post mortems, why samples were taken from these particular bodies, what records were kept by Westminster mortuary relating to the samples and where the samples were kept over the past 11 years.

35.5 The letter from the MAG was received at a time when I had almost completed this report, but I thought it appropriate to ask others for comments. I asked them to respond by 1300 on 8th February. As a result I received responses from solicitors on behalf of the MPS, Dr Shepherd, the Westminster mortuary and Dr Knapman. Some of the replies, notably that of Dr Shepherd, contain a detailed response to a number of points made on behalf of the MAG.
35.6 I have considered, both before and after receipt of the letter written on behalf of the MAG, whether I should take any action arising out of the discovery of the four pots and, if so, what. I can see that this discovery has given rise to concern and have considered whether I should postpone concluding my report while further inquiries are made. However, it seems to me that these discoveries are not directly relevant to the issues of identification which are the subject of my terms of reference, and that, in these circumstances, I would not be justified in investigating these further matters, which would involve substantial further time and public expense.

35.7 The concerns are in some ways not dissimilar from those considered in the Bristol and Alder Hey inquiries, as indeed is recognised in the letter. I have reached the conclusion that the concerns raised are outside my terms of reference and that, if they are to be considered further, they should be considered in the context of the problems identified there rather than in the context of the problems identified here. As indicated above, the Bristol and Alder Hey reports and the Advice from the Chief Medical Officer make wide-ranging recommendations for reform (of both law and practice) regarding the removal and retention of human material, whether following hospital or coroners’ post mortems.

35.8 In all these circumstances I do not think that the public interest requires an extension of this inquiry along the lines suggested. However, I have asked Bill Sandal to forward to the Secretary of State for Health and the Chief Medical Officer the correspondence which I have received regarding the discovery of the sample pots at Westminster mortuary. I have done so because it seems to me that it should be brought to the attention of the person or organisation charged with the task of considering and/or implementing the recommendations made in the two reports and the Advice. Thus, if appropriate, the specific concerns expressed on behalf of the MAG can be considered along with those which have been considered in the other inquiries.

36. Final Thoughts

36.1 Now that I have come to the end of the fourth report which I have written arising out of the MARCHIONESS disaster, I feel that I have spent a significant
proportion of my life over the last 17 months considering a number of issues which have engendered emotion and strong feelings. On occasion they became evident during the hearings and, as stated in the last paragraph of our report in the Formal Investigation, I continue to have great sympathy for the families of those who lost their lives in a casualty which should never have happened.

36.2 In addition, the evidence has demonstrated the distress that was caused when the families discovered that the hands of 25 of the deceased had been removed and, then, in three cases not returned with the body. Moreover, I doubt whether anyone present will forget the moving statement made by Mrs Garcia when she returned to the inquiry having learned that her daughter’s hands had been left in a freezer at the mortuary for three years and that they had then been disposed of without her knowledge or consent. I hope that this inquiry and the publicity which has attended it will help to ensure that nothing like that ever happens again.

36.3 I would like to repeat the hope expressed at the end of the report in the Formal Investigation that it will be possible for all those whose lives have been affected by this tragedy and its aftermath to put the issues raised in the inquiries behind them and look to the future.

36.4 Finally, the families who have played a part in this inquiry have to my mind made an important contribution to the learning of lessons for the future. The principal lesson which can be learned from this and other major disasters is the importance of respecting the dead and their relatives, of acting with sensitivity throughout and of ensuring that (save where a compelling public interest requires otherwise) full, honest and accurate information is given to relatives at every stage. I recognise that many of these lessons have already been learned over the past 11 years since 1989, but thanks in large part to the families, the evidence in this inquiry has underlined them and I hope that they will never be forgotten.

\[\textit{The Rt Hon Lord Justice Clarke}\]

February 2001