West Yorkshire (Western) Coroner Area

A GUIDE TO REPORTING DEATHS TO H M CORONER AND DEATH CERTIFICATION
Dated 15 April 2019

This guidance note replaces the previously issued guidance.

A death is reportable to the **CORONER** under S.1 Coroners and Justice Act 2009 if the cause of death is violent, unnatural, unknown or occurred whilst in custody or state detention.

You should also report a death in the following circumstances:

1. You are in **ANY DOUBT** at all as to **THE CAUSE OF DEATH**

2. A death can be caused or contributed to or accelerated by an omission or any event, process, intervention or act and such does not have to be the main or predominant cause and the test for the Coroner (not you) is whether it contributes to the death more than minimally, trivially or negligibly. A death should be referred if:

    a. Any unnatural event, process, intervention or act or omission has or may have contributed to the death more than minimally, trivially or negligibly and/or

    b. If there has been a loss of opportunity to give timely treatment to a potentially effective cause of the death

3. Deaths, which are **SUDDEN**, **UNEXPLAINED** or **SUSPICIOUS**

4. Deaths not due or not entirely due, to natural causes, e.g. all **ACCIDENTS** including late deaths from consequences of **MEDICAL MISHAPS,** deaths occurring **DURING AN OPERATION** or as a later **CONSEQUENCE OF THE OPERATION or BEFORE RECOVERY** from the effect of an **ANAESTHETIC**

5. Hospitals deaths after any procedure, operation, treatment or anaesthetic, or discharge from Hospital

6. **ALL** hospital deaths of persons under **18 YEARS OF AGE**.

7. Deaths due or contributed to by all **FRACTURES OR FALLS**

8. Deaths due or contributed to by **a DEFECT OR A FAILURE IN A SYSTEM OR PROCEDURE**

9. **ALL ALLEGED MEDICAL OR NURSING MISHAPS** (nb deaths after appropriate procedures, even if properly executed, might be natural deaths but they are still reportable) or **INAPPROPRIATE TREATMENT** or where **a CRITICAL INCIDENT PROCEDURE** has, is or will be recorded.

10. Any case of possible **LATE DIAGNOSIS** (e.g. meningitis) or **TREATMENT**

11. Deaths **DUE** or **CONTRIBUTED TO** by **DRUGS** (including therapeutic) where overdose, idiosyncrasy, poisoning or addiction is involved.

12. Acute alcohol poisoning (but not chronic alcoholism).

13. Where there is any doubt as to a **STILLBIRTH** e.g. any evidence that the foetus breathed or showed any other signs of life.

14. Any deaths caused or contributed to by **NEGLECT** or **SELF-NEGLECT**

15. All deaths due to **SUICIDE, MALNUTRITION, HYPOTHERMIA**

16. Any death caused or contributed to by **UNUSUAL DISEASES** (e.g. old or new variant Creutzfeldt-Jakob disease)

17. Deaths due to or contributed to by **OCCUPATIONAL INJURY or DISEASE** from whatsoever cause or suspected cause e.g. pneumoconiosis, mesothelioma, farmer's lung, Weil's disease, bladder cancer etc. This means any death which you suspect could possibly be caused or contributed to by the deceased's occupation must be reported. .

18. Any deaths where there is a history of recent contact with the **POLICE** or **PRISON** or **ABUSED DEPENDENCY** situations where the individual's vulnerable dependence has been abused, i.e. the mentally ill or the elderly, and any death where the individual dies whilst an inpatient on a mental health unit, whether this is as a voluntary (informal) patient or a patient detained under the Mental Health Act 1983.

19. Deaths due to **TETANUS, SEPTICAEMIA** or **GANGRENE** without the known underlying cause being identified; deaths due to HEPATITIS **IN A DOCTOR, DENTIST OR SIMILAR**.

20. Deaths **where there is, or may be, a complaint concerning the care** of the deceased whilst in the care of the **hospital, residential home, nursing home, general practitioner or other person or persons.**

21. Provided that none of the other circumstances as detailed in this guidance note apply deaths within **24 hours** of admission to Hospital or a Hospice do not need to be reported with respect to a death of a person over 18 years of age in the following circumstances:

    - A qualified medical practitioner certifies death is due to natural causes and
    - The family or other party do not raise any concerns

22. **Re DoLS**

- Mandatory inquests are now no longer required.
- Natural deaths need not be reported to the coroner.
- Where there is concern that the death is unnatural, violent or unknown, the circumstances should be reported to the coroner's officer who will refer it to the coroner.
- Where there is concern about care or treatment before death or the medical cause of death is uncertain it should be reported to the coroner's officer to enable the coroner to investigate in the usual way.
- Where concerns have been raised by the family with respect to the care or treatment before death or the medical cause of death is uncertain, it should be reported to the coroner's officer to enable the coroner to investigate in the usual way.
- Where the deceased has been referred for DoLS authorisation, albeit no formal authorisation is in place at the time of death, the matter should be referred to the coroner via the coroner's officer.
- Bear in mind that there does not need to be a 'formal' DoLS authorisation in place for a person in hospital or social care to be deprived of their liberty and in state detention. Where a person dies under such circumstances it should be referred to the coroner's officer.

Death Certification by Doctors

A licensed qualified Medical Practitioner should not sign a Medical Certificate as to the cause of Death (MCCD) in respect of a Death from wholly natural causes unless:

1. He or she has attended (this means treated and/or assessed and not just saw the deceased) the patient and for the patient's last illness **and**

2. Within 14 days before death or have seen the body after death **and**

3. Is satisfied as to the cause of death **and**

4. Is satisfied that the death is wholly from natural causes **and**

5. Is satisfied that the death is not otherwise reportable to the Coroner

Please remember that a doctor's legal requirements differ between burial and cremation. The best practice is always to assume it will be a cremation and fill in the Cremation Certificate in full because 70% of funerals are cremations but you will have to have seen the body after death in order to complete part one of the cremation certificate. Doctors should ensure that they provide their General Medical Council number.

Important Reminders:

1. Not to confuse modes of dying (e.g. cardiac arrest, renal failure, shock, uraemia, multi organ failure, etc. with the pathological cause of death)

2. **Never use "possible" or "probable". The explanatory notes in the MCCD provide additional guidance**.

3. **Never guess or surmise a cause of death. Do not use abbreviations. Always complete it in legible handwriting and print your name, qualifications and GMC number. If you do not do this it may not be possible for the Registrar to register the death and this may cause unnecessary delay and distress for the relatives.**

4. Do not promise relatives a Certificate unless you know that you can deliver

5. You are very often the only person who can decide if a death is reportable or not so it is wise for you to attend after every death (even if a burial is intended)

6. **It is an offence to move or otherwise interfere with, a body or the surrounding evidence, without leave of the Coroner where death has occurred in circumstances, which may lead him to hold an Inquest. The MCCD is a legal document and you should only complete it if you are genuinely in a position to do so. Under no circumstances should you be influenced or pressured into issuing a certificate as a result of religious, ethnic or cultural considerations or a desire to avoid a possible post mortem or out of sympathy with the deceased's relatives objections to a possible post mortem examination or where it is intended to apply to remove the body out of England and Wales for Burial or Cremation. Referral to the Coroner does not automatically mean that a Post Mortem examination will be ordered. In some circumstances it may be possible to have an M.R.I. scan.**

7. The Registrar of Deaths is required by law to refuse registration, and to report a death to the Coroner if the Certificate of death does not comply with the legal requirements. Such refusal by the Registrar causes distress and inconvenience to relatives, and, possibly, the postponement of the funeral with all its attendant consequences.

8. **These notes are provided for guidance only. They are not conclusive. If you have any doubts or are in need of help or advice as to whether or not a particular death should be reported, please contact either myself or one of my Officers. Never be afraid to seek advice. I and my Officers are always willing to discuss a case. We always try to help, (even if only by confirming what you already think) and agree the procedure over the telephone.**

9. Please have the notes with you when you contact us. The Coroner and Superintendent Registrar have agreed procedures at weekends or in cases of urgency especially to deal with individual cultural or religious considerations.

HOW TO CONTACT THE CORONER'S OFFICE

During office hours (Monday to Friday 8.00 to 4.00):

Coroner's Officers

Tel: 01274 373721

Email: coronerswest@westyorkshire.pnn.police.uk for general enquiries

coronersoffice@bradford.gov.uk for all referrals

Outside the usual office hours, sudden deaths should be reported through any police officer using the 101 non-emergency telephone number, except for cases where immediate police involvement is required when the normal emergency number should be used.

The police will contact the Coroner on your behalf.

M D FLEMING
H M SENIOR CORONER
West Yorkshire (Western) Coroner Area

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