

When and how does one refer a death to the coroner?

Introduction

This article is aimed at junior doctors who may be required to write the Medical Certificate of Cause of Death. It highlights the importance of the coroner's role in investigation of death (Figure 1), when and how the coroner should be contacted, and what information needs to be presented to the coroner's officer if one feels unable to complete the Medical Certificate of Cause of Death.

Who is the coroner?

The coroner is primarily a quasi-judicial office rather than a medical one. The majority of coroners are legally qualified although some may be medically or even dual-qualified. Coroners are appointed by and funded through local authorities. Approval of the Lord Chancellor and

Chief Coroner is now required for appointments. They are independent judicial officers with close ties to the Home Office but without direct oversight. The system will certainly evolve over the coming years following the introduction of the office of Chief Coroner in late 2012. The coronial system operates within England and Wales. The Scottish system of Procurator Fiscal will not be discussed in this article.

What is the coroner's role?

The coroner's main role and duty is the investigation of unnatural, unexplained or suspicious deaths. Investigation may include questioning of witnesses, use of post-mortem examination and holding an inquest. This process can take a few days or a number of years depending on the

complexity of the case. Once investigation is complete, the coroner notifies the Registrar of Births and Deaths. This notification (form 100A/B) thus replaces the Medical Certificate of Cause of Death for the purposes of registering a death. In some cases after discussion with coroner's officers, the death can be certified by the reporting doctor.

Are all deaths reported to the coroner?

Approximately 46% of all deaths in England and Wales are referred to the coroner (Ministry of Justice, 2013). Of these 42% undergo post-mortem examination. The remainder are registered following initial investigation, if the coroner is satisfied, and if a natural cause of death is evident. If the death is deemed unnatural, unexplained or suspicious following post-mortem examination and/or other investigation, an inquest must be held. An inquest takes place in about 14% of cases referred to the coroner.

How do I know if I must refer a death to the coroner?

The first step is to decide whether you can complete the Medical Certificate of Cause of Death.

A Medical Certificate of Cause of Death should not be issued unless the doctor has:

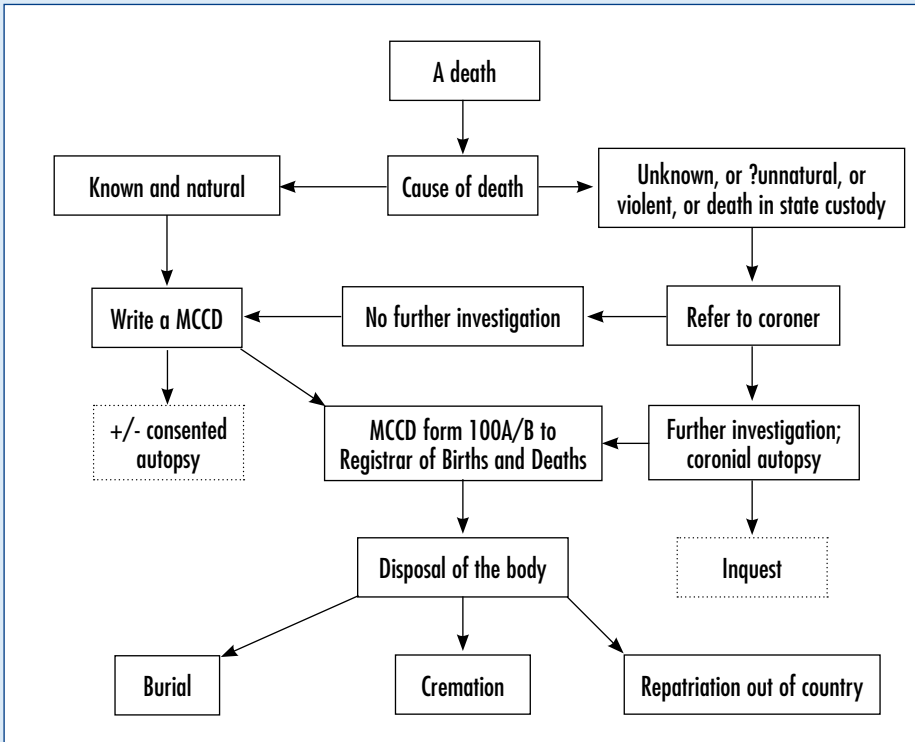
1. Attended the deceased during his/her last illness and
2. Seen the deceased within 14 days before death or
3. Seen the deceased after death.

Guidance on completing the Medical Certificate of Cause of Death was outlined earlier in this series (Porter and Winstanley, 2013).

When must a death be reported to the coroner?

If you think a death is unexplained, unnatural or suspicious you should certainly refer it to the coroner. The *Guide to Coroners and Inquests and Charter for coroner services* (Ministry of Justice, 2012) indicates the patterns of death which should be referred to the coroner, although many coronial jurisdictions have produced

Figure 1. What happens after a death. MCCD = Medical Certificate of Cause of Death. Dashed line box = may or may not take place.



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their own guidance documents which are slightly more expansive and functional (Meadows, 2003; HM Coroner for the city of Sunderland, 2010). A list of commonly reported deaths is given in *Table 1* for guidance only.

If you find that in the course of completing a Medical Certificate of Cause of Death one or more of the situations listed in *Table 1* might apply, you should refer the death to the coroner. There is considerable variability in coroners' practices, for example some require mandatory referral of all health-care-acquired infection and others do not. It is imperative you make sure you are aware of local reporting guidelines. Your coroner's officers and bereavement services department will be able to advise you.

Remember, not every referral to the coroner results in a post mortem or an inquest (over half result in neither). There is nothing to be lost in asking the coroner's service for an opinion if you think a death is reportable.

Table 1. Deaths which should be referred to the coroner

Unknown cause of death
The identity of the deceased is unknown
Suspicious, violent or accidental death
The deceased was not attended by the doctor during the last illness or was not seen within the last 14 days or viewed after death
Self-neglect or neglect by others (public authority, organizations and individuals)
Death in police or prison custody or under Mental Health Act 1983
Death linked to abortion or childbirth
Death might have been caused by actions of the deceased (history of drug abuse, self-injury or overdose)
Death could be the result of industrial disease
Death occurring during an operation or before full recovery from the effects of an anaesthetic
Death may be related to a medical procedure or treatment whether invasive or not (e.g. hospital-acquired infection, adverse drug reaction, thrombosis)
Death may be the result of lack of medical care or medical mismanagement
Death occurs within 24 hours of admission to hospital (except terminal care)

How do you make a referral?

It is standard practice to telephone the local coroner's office as soon as possible following the patient's death. Remember, a family cannot proceed with funeral arrangements until this process is completed. Bereavement services will usually have the telephone number of the local coroner. You will almost certainly be directed to one of the coroner's officers who will manage the case on behalf of the coroner.

The coroner's officer will want to ask you questions about the case. These will allow correct administration of the referral and will inform the decision as to how to proceed. If you are asked for information to which you do not know the answer, do not obfuscate. Offer to find the information and report back at a later time. *Table 2* indicates the information you should have to hand when making a referral to the coroner's office.

Table 2. Information you should have to hand when making a referral to the coroner

Name, address, date of birth
Date of death, place of death
Last seen alive by which doctor
Death confirmed by which person at what time
Any concerns raised by anyone at any time
Consultant, hospital number, date and nature of admission
Next of kin details
Whether the family has been notified of the referral
Proposed medical cause of death (if available)
Relevant medical history
Brief employment history

What happens after the referral is made?

Under instruction from the coroner, coroner's officers conduct interviews with relatives and health-care workers, examine relevant documents and form a report. After considering the information available, the coroner may decide that no further investigation is necessary or he/she may order a post mortem or open an inquest.

The coroner's officer might be able to offer advice as to what could be stated on the Medical Certificate of Cause of Death. Remember that it is your legal responsibility to complete a Medical Certificate of Cause of Death accurately and to the best of your knowledge. Do not allow yourself to be pressurized into issuing a Medical Certificate of Cause of Death if you are not absolutely content to do so. Always ask a senior member of your clinical team if you are unsure about how to proceed. **BJHM**

Conflict of interest: none.

- HM Coroner for the city of Sunderland (2010) Guide to reportable Deaths. www.sunderland.gov.uk/index.aspx?articleid=3940 (accessed 16 December 2012)
- Meadows NS (2003) A guide to reporting deaths to H.M. Coroner and death certification. www.plymouth.gov.uk/a_guide_to_reporting_deaths_to_h.pdf (accessed 16 December 2012)
- Ministry of Justice (2012) Guide to Coroners and Inquests and Charter for coroner services. www.justice.gov.uk/downloads/burials-and-coroners/guide-charter-coroner.pdf (accessed 16 December 2012)
- Ministry of Justice (2013) Coroners Statistics 2012. Statistics Bulletin. www.gov.uk/government/uploads/system/uploads/attachment_data/file/199793/coroners-statistics-bulletin-2012.pdf (accessed 11 June 2013)
- Porter S, Winstanley A (2013) Death certification: a practical guide. *Br J Hosp Med* 74(6): M82-5

Further reading

- Coroners and Justice Act 2009 (www.legislation.gov.uk/ukpga/2009/25/contents/enacted)
- Dorries C (2004) *Coroner's Courts: A guide to law and practice*. 2nd edn. Oxford University Press, New York

KEY POINTS

- The coroner is responsible for the investigation of unnatural, unexplained or suspicious deaths.
- Deaths should be referred to the coroner if the Medical Certificate of Cause of Death cannot be completed or if it falls within the category of 'reportable deaths'.
- Do not complete the Medical Certificate of Cause of Death if you have any doubts or concerns about the nature of the death and whether it should be referred. Ask for help (senior doctor, coroner's officer or a member of bereavement services) and do not delay.
- When contacting the coroner's office, ensure you have all the required information to hand.
- Try to attend the inquest of any of your patients even if you are not summoned by the coroner, to broaden your understanding of this area.