



*a guide to*

*Working* *with the*

Torbay &  
South Devon  
Coroner



# *a guide to working with the Torbay & South Devon Coroner*

## **Introduction**

This Guide is produced for Medical Practitioners in Hospital and General Practice. It is likely to be of assistance to others dealing with the bereaved in understanding the Coroner's role in dealing with sudden and unexpected deaths. The Guide is in two parts. The first on pale blue paper provides ready reference guides to assist Practitioners in dealing with the Coroner, the Registrar of Births Deaths and Marriages and the Medical Referee/Crematorium at short notice.

The second part on white paper goes into greater detail of the Coroner's role and sets out what may be expected of Medical Practitioners. The Guide will be reviewed from time to time and written comments from Practitioners are welcome.

For more information on the the Torbay and South Devon Coroner, including a downloadable version of this document, please go to:

**[www.torbay.gov.uk/coroner](http://www.torbay.gov.uk/coroner)**



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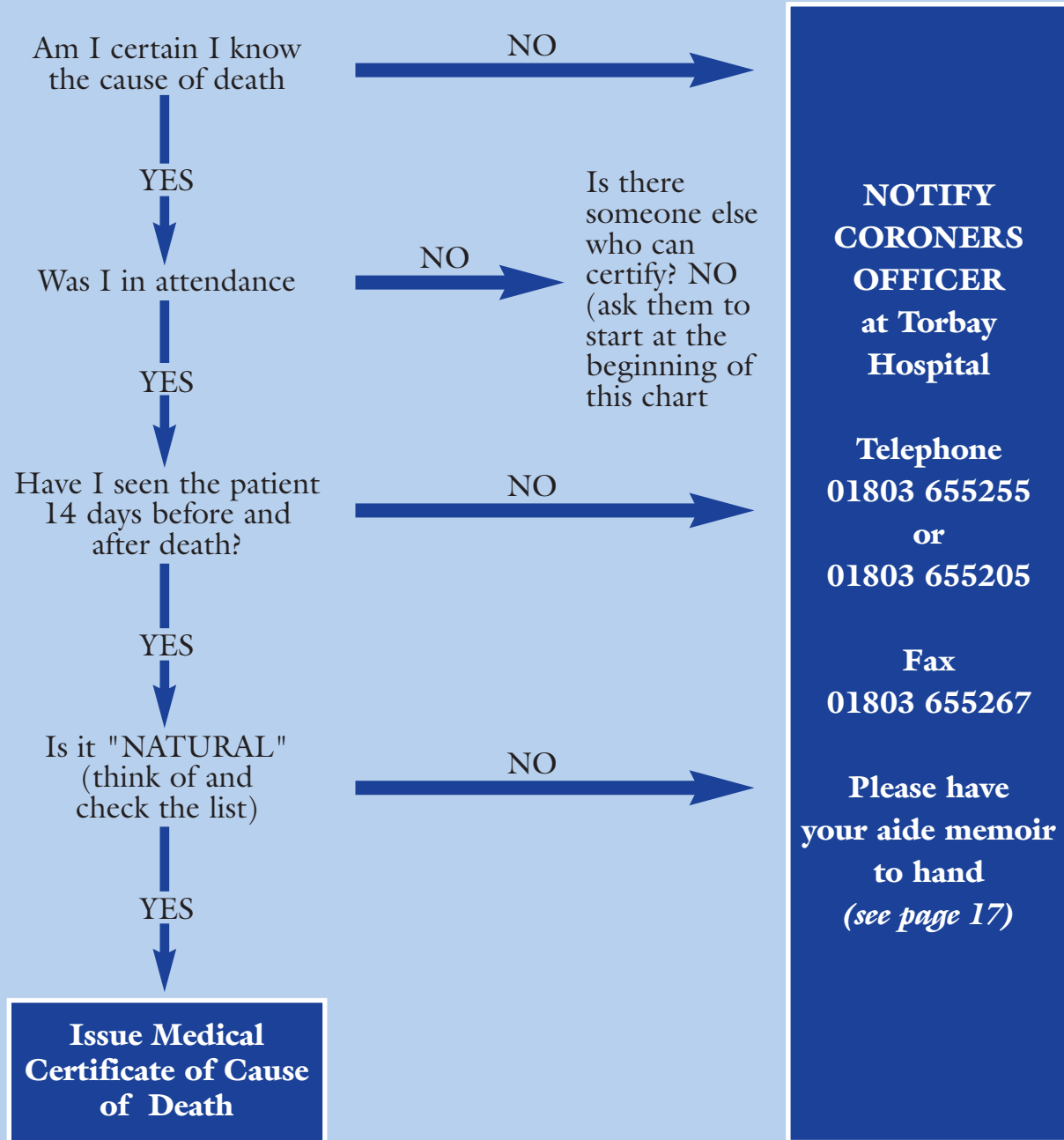
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## Section 1: Patient's death - Doctors flow chart

Can I issue a Medical Certificate of the Cause of Death to the Registrar of Births Deaths and Marriages?



Tell the family they must go to the Registrar of Births Deaths and Marriage the next day. Make sure you send them to the correct office.

*NB None of the above relates to Cremation Certificates. See Iiv. Think about it at the same time you are considering issuing your Certificate. If you cannot complete the Cremation forms it is wise to report the death to the Coroners Officer anyway.*

## **Section 1(i) - Check list for referral to Coroner's officer**

- The cause of death is unknown
- It cannot readily be certified as being due to natural causes
- The deceased was not attended by the doctor during his last illness or was not seen within the last 14 days or viewed after death
- There are any suspicious circumstances or history of violence
- The death may be linked to an accident (whenever it occurred)
- There is any question of self-neglect or neglect by others
- The death has occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station)
- The deceased was detained under the Mental Health Act
- The death is linked with an abortion
- The death might have been contributed to by the actions of the deceased (such as a history of drug or solvent abuse, self-injury or overdose)
- The death could be due to industrial disease or related in any way to the deceased's employment See the long check list in the Medical Cause of Death Certificate book
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred)
- The death may be related to a medical procedure or treatment whether invasive or not
- The death may be due to lack of medical care
- There are any other unusual or disturbing features to the case
- The death occurs after admission to hospital within the period of any local rule (unless the admission was purely for terminal care).
- It may be wise to report any death where there is an allegation of medical mismanagement

*This note is for guidance only. If in any doubt contact the Coroner's Officers for further advice*

## Section 1(ii) - Notes on completion of the Medical Certificate of the Cause of Death approved by the Registrars of Births, Deaths and Marriages

### Should you complete the certificate?

You are required to complete a Medical certificate of cause of death, stating the cause of death *to the best of your knowledge and belief*, if you attended the deceased during his/her last illness. You must NOT complete the certificate if you did not attend the deceased during his/her last illness.

### Which is the correct certificate?

There are three types:

**Stillbirth Certificate** (after 24 weeks of pregnancy)

**Neonatal Death Certificate** (any death up to 28 days of age)

**Medical Certificate of Cause of Death** (any other death)

### Cause of Death Statement

#### Part One

State the disease or condition directly leading to the death on the first line (Part 1a)

Complete the sequence of disease(s) or condition(s) leading to the death on subsequent lines.

State the Underlying Cause of death on the last completed line of Part 1.

The disease or condition directly leading to the death and the Underlying Cause may be the same. In this case you only need to complete the first line of Part 1.

#### Part Two

If there is some significant condition or disease that contributed to the death but which is not part of the sequence leading directly to death, you should record it in Part II e.g. *diabetes mellitus* that is difficult to control in a patient with a widely disseminated malignancy.

**Do not** state a 'Mode of dying' unless you specify the disease or condition which preceded it otherwise it otherwise the Registrar will report the death to the Coroner as 'cause of death unknown'.

Modes of dying include organ failure (eg heart failure, renal failure, multi-organ failure) cardiac or respiratory arrest, coma, cachexia, debility, uraemia and shock.

The addition of 'acute' or 'chronic' to any of these terms does not make them acceptable as causes of death.

### **Please write legibly**

**Do not** use abbreviations

**Do not** use medical symbols

**Do not state** 'old age' or 'senility' unless a more specific causes of death cannot be given, it is an acceptable cause of death in patients over 80 and above (age subject to change should the Coroner deem it necessary).

### **Remember**

There is a statutory time limit of 5 days during which the family have to register the death. Swift and accurate completion of the Medical Cause of Death Certificate enables grieving families to commence the practicalities of dealing with funerals, the estate and in the case of widows/widowers getting on with their own lives. If a patient is dying and you are about to go on holiday, try to get a colleague to drop in to the patient thereby enabling them to complete the MC on your behalf and in your absence. This saves having to ask the Coroner to become involved in what should be a straight forward case.

## **Section 1(iii) - Notes on completion of the Cremation Acts Forms**

### **Certificate of Medical attendant - Form B**

- (a) Confirm full name - occupation - age
- (b) You must have attended the deceased prior to death
- (c) See and identify the body after death
- (d) Speak to the second certifying Doctor who will complete part C to make sure they can assist. You should do this before signing the form.
- (e) Complete the form in full and legibly. Do not use abbreviations
- (f) Make sure you answer question 8. Do not pre-complete this as you are likely to come unstuck.
- (g) Answer question 18 in full. If you are not providing both the Medical Cause of Death Certificate and the Certificate for Cremation, ask yourself why not.
- (h) If you have referred the death to the Coroner's Office clearly state so, ideally give the time and date you are referring.

### **Confirmatory Medical Certificate Form C**

- (a) Make sure you see the body
- (b) Note question C 5 - 8 must be in the affirmative or the Certificate will be referred back to you.
- (c) You are confirming all is in order before cremation. Ask yourself should you refer this to the Coroner

### **Generally**

Sign and print your name - consider investing in a rubber stamp.

Remember you are providing a service for the deceased and the bereaved.

Errors could result in a funeral being postponed.

## **Section 2 - Information on the Coroner's role**

A Civilised Society deals with its living and dead in a dignified way. Births and Deaths are recorded. This information aids Society. In this country births and deaths are recorded by the Registrar of Births Deaths and Marriages under authority derived from the Registration Act 1953. The record is made after information is gathered by that Registrar. This permanent written record is made in a ledger. For a fee a certified copy can be obtained. This is an individuals Birth Certificate or Death Certificate as the case may be. A death may involve many Agencies (see Annex A for example)

### **1. Who are Coroners?**

Coroners are independent judicial officers in England and Wales who must follow laws which apply to Coroners and Inquests. Each Coroner has a deputy and one of them must be available at all times to deal with deaths that need to be reported to them. Coroners are usually lawyers but may be doctors. They are appointed and paid by the Local Authority.

### **2. What do Coroners do?**

Coroners inquire into deaths reported to them which appear to be violent, unnatural, or of sudden and unknown cause. The Coroner will seek to establish the medical cause of death; if the cause remains in doubt after a post mortem, or if the cause is violent or unnatural, an Inquest will be held.

The proceedings and evidence at an Inquest shall be directed solely to determine:-

- Who the deceased was;
- How, when and where the deceased person came by his death;
- The details of the death which the Registration Acts require to be registered.

### **3. Are all deaths reported to the Coroner?**

No. In many cases a GP or hospital doctor can certify the medical cause of death and the death can be registered by the Registrar of Births and Deaths in the usual way. There are lengthy guidance notes in the Medical Cause of Death Certificate book which advises on the completion of parts 1 and 2 of the Certificate by a practitioner who was in attendance during the last illness. This may be somebody who was involved in monitoring/treating the final illness. If in any doubt the matter should be reported to the Coroner's Officer.

A medical cause of death certificate should not be issued unless the doctor has:-

- (a) attended the deceased during their last illness
- (b) seen the deceased within 14 days before death or;
- (c) seen the deceased after death

However, Registrars of Births Deaths and Marriages must report deaths to the Coroner in certain circumstances. For example; if a doctor cannot give a proper certificate of a cause of death; if the death occurred during or following an operation; if the death was due to industrial disease; or if the death was unnatural or due to violence, or in other suspicious circumstances.

Before making out a death certificate the following questions should be asked:

1. Was I in attendance on the last illness? If not, pass it to someone who was and if there is no one, ring the Coroner's officer.
2. Can I satisfy the registration regulations. If not the matter should be reported.
3. Is the cause of death reportable to the Coroner anyway?

Please remember the following when making out the Medical Cause of Death Certificate:

1. To write your name in block letters below your signature and to add your pager/bleep number - this can save relatives being delayed at the Registrar's Office.
2. No question marks, alterations or queries should appear on the certificate.
3. No abbreviation should appear on the certificate
4. Always initial any alterations.

**If the cause of death is not known then a hospital post mortem should never be requested. It should be reported to the Coroner's Officer who may organise a Coroner's post mortem.** This is also in line with advice contained in the Alder Hey report. (In cases where a Medical Cause of Death Certificate has been issued by the hospital doctor, without consultation with the Coroner, then the doctor should issue the cremation certificate). In a Coroner's case where information of death is provided after the post mortem, then the cremation certificate will be issued by the Coroner.

#### **4. What deaths should be referred to the Coroner?**

**The Alder Hey report advises that failure to carry out a Coroner's post mortem examination in cases where such examinations should be performed results in a lack of proper scrutiny of medical practice and the benefits of openness and transparency are lost.**

A death should be referred to H.M. Coroner if:-

There are any suspicious circumstances - violence, accident or neglect. This should also include sudden or unexpected deaths of which the cause is unknown and specifically, deaths due to:-

- **Abortions** - whether spontaneous or not
- **Accidents** - of any kind and however long before death they occurred (even many years). If you are satisfied that, for example, a fracture is due to a medical condition, you can so certify e.g.
  - 1 (a) Bronchopneumonia
  - 1 (b) Non-accidental fracture neck of right femur
  - 1 (c) Osteoporosis

N.B. 1(c) is essential to show precisely why it was non-accidental

Remember that any incident, however small, that might possibly be related to the death, could, in law, be an accident. It is important to always try to establish the full history from the family, rather than simply relying on third party information.

- **Acute Alcoholic Poisoning**
- **Anaesthetic deaths**
- **Drugs** - even when used therapeutically
- **Industrial Disease** - a long list appears in the certificate book - a short-list on the certificate. Apart from pneumoconiosis asbestosis and asbestos, mesothelioma, remember to consider recognised industrial origins for carcinoma, particularly of the bladder, renal pelvis or ureter. Consider the deceased's working life and if you can, exclude an industrial origin. Care must be taken not to deny the deceased's estate of a post mortem and thus a possible compensation claim. Enquiry should be made of the family to establish whether or not the deceased was in receipt of an industrial pension or whether a claim had been lodged. In these circumstances a post mortem should always be held if there is any doubt.
- **Medical Mishaps/Errors** - death caused by an operative error/ mishap must always be reported. The death of a seriously ill person after a properly performed operation which was part of the treatment must also be reported. Complaints by the bereaved should also be reported - in these circumstances it is wise to request a post mortem through the Coroner's office.
- **Pensioners** - the death of a person in receipt of a War Pension or an Industrial Disability Pension should always be reported.
- **Poisoning** of any kind should be reported
- **Deaths of Prisoners** and all persons in custody of any kind, even if transferred to hospital for treatment and even if from natural causes.
- **Stillbirths** - if there is any doubt whether the child was born alive
- The death has occurred during or shortly after **Detention** in police or prison custody (including voluntary attendance at a Police Station).
- The deceased was **Detained** under the Mental Health Act
- Any local **Hospital Admission/Discharge Rule**

It may be that the Coroner may be happy to issue a certificate after consultation

It should be remembered that it is always preferable to refer a death direct to the Coroner than to issue a certificate that will cause the Registrar of Deaths to refer to him. The latter, inevitably, causes some delay and is likely to cause distress to the relatives who are unable to register the death when they first go to the Registrar of Deaths.

If there is the slightest doubt as to whether you should issue a certificate, telephone the Coroner's Officers who will always be willing to advise.

It is extremely helpful if the information you have on the deceased is collated before you contact the Coroners Officer. A pro forma aide memoir for your use is attached. In complex cases you may be asked to fax this information to the Officer so that you are both in possession of the same information.

## **5. Notification of Death**

The Registrar of Births and Deaths is under a statutory duty to inform the Coroner of the fact of a death in certain circumstances, some of which relate to medical treatment or lack of it.

## **6. Investigation**

Coroner's Officers who may be police officers, or under the direction of Coroners, liaise with bereaved families, police, doctors and funeral directors. After considering the results of interviews with relatives, doctors and healthcare workers, the Coroner may decide that no further investigation is necessary or he may order a post mortem.

The Coroner selects the pathologist and there may be circumstances where a pathologist with particular forensic experience is chosen. Where there is potential for any criticism of medical or nursing care provided by a particular hospital, it is usual for a pathologist from a different site to carry out the post mortem.

## **7. Statement for the Coroner**

Doctors and healthcare workers making a statement for the Coroner can assist his investigations by providing a detailed, chronological account of their role in the clinical sequence. The report should be factual, based on the practitioner's part in the treatment. It is helpful to include dates and times, where relevant, the time the patient was seen.

Details should be given about the history, the findings on examination, diagnoses, investigations and the treatment ordered. Other doctors or healthcare workers involved in the clinical sequence should be identified as the Coroner may also wish to seek their comments.

The Coroner may require the deceased patient's clinical notes to be submitted to him. The deceased patient's relatives may apply for disclosure of such records in advance of an Inquest.

## **8. What is an Inquest?**

An Inquest is an inquiry to establish the facts stated in paragraph 2. An Inquest is not a trial; the Coroner will not blame anyone for the death.

An Inquest is usually opened primarily to record that a death has occurred and to identify the dead person. It will then be adjourned until any police enquiries and the Coroner's investigations are complete. The full Inquest can then be resumed.

## **9. Attendance at an Inquest**

When the Coroner's investigations are complete, a date for the resumed Inquest is set and the people entitled to be notified will be told, if their details are known to the Coroner. Inquests are open to the public and journalists are often present.

The Coroner will decide which witnesses to summon to the Inquest. He arranges for the attendance of a witness either by voluntary agreement after 'due notification' by a formal

summons, or by a Crown Office subpoena. If a witness fails to comply with a Coroner's summons or to answer questions this may lead to a fine or imprisonment for contempt of Court.

## **10. Questioning of witnesses**

Witnesses will first be questioned by the Coroner and there may be further questions by "properly interested persons" or their legal representatives. Questions must be relevant to the purpose of the Inquest.

Persons with a "proper interest" include:

- Parent, child, spouse or legal personal representative of the deceased
- Person who may have a responsibility for the death;
- A beneficiary from an insurance policy issued on the life of the deceased
- The Insurers who issued such a policy of Insurance
- A representative from a relevant Trade Union (if the death arose in connection with the person's employment or is due to industrial disease)
- Certain inspectors or representatives of enforcing authorities or persons appointed by a Government department;
- The Police;
- Any other person the Coroner considers to have a legitimate interest for the purpose of the Inquest.

## **11. Inquests with a Jury**

The Inquest will be held with a jury if the death occurs in prison, in custody whilst detained under the Mental Health Act, at work or if further deaths may occur in similar circumstances. In these cases, the Coroner decides matters of law and the jury decides matters of fact.

## **12. Verdicts**

Inquests do not determine blame and the verdict must not identify someone as having criminal or civil liability. Possible verdicts include natural causes, misadventure, accident, suicide, unlawful killing, industrial disease and open verdicts (where there is insufficient evidence for any other verdict).

The Coroner may also report the death to any appropriate person or authority if he considers that action is needed to prevent more deaths in similar circumstances.

## **13. Civil Proceedings**

Civil proceedings (for example, for compensation) are not dependent on the outcome of an Inquest or Criminal proceeding. Most Civil Court proceedings must be started within three years of death.

Evidence given at an Inquest, or during criminal proceedings, may help families understand what has happened. It may also assist in considering whether to proceed with claims for compensation.

## 14. The Verdict

At the conclusion of an Inquest held with a jury, the Coroner will sum up the evidence which has been given and will direct the jury on any points of law that arise. The jury's findings will cover the matters which are the concern of the Inquest. The question of how the deceased person died will be answered by a brief summary of the circumstances, leading to the death, as determined by the jury, in view of the evidence given.

When the Coroner sits alone, as is normally the case, he will summarise and record his own findings and conclusions on the inquisition form the formal record of the Inquest.

The verdict comprises:

- The deceased person's name
- The injury or disease causing the death
- The time, place and circumstances in which the injury was sustained
- The conclusion as to death
- The registration particulars

There is a comprehensive list of suggested (though not compulsory) verdicts given below. When directed by the Coroner the following words, where appropriate, may be added "and the cause of death was aggravated by neglect/ self neglect".

List of suggested verdicts;

1. Natural causes
2. Industrial disease
3. Dependence on drugs/non-dependent abuse of drugs
4. Want of attention at birth
5. Suicide
6. Attempted/self-induced abortion
7. Accident
8. Lawful killing
9. Open Verdict
10. Unlawful killing
11. Still-birth
12. Narrative - setting out in succinct terms the circumstances of the death

The Coroner's Rules provide that no verdict is framed in a way as to appear to determine criminal or civil liability. When the inquisition form has been completed it will be signed by the Coroner.

When the Inquest is finished it must be closed formally. The Coroner's Officer will ask everyone present in the court to stand as the Coroner leaves the bench.

## 15. Publicity

The Coroner knows that every death is a personal tragedy and tries to treat each case sympathetically. The Inquest tries to get at the truth and can often help to stop the spread of untrue stories about the death.

Inquests are held in public unless they involve national security. The press can attend and will report any Inquest that is newsworthy, for example, because of the manner of death or if the deceased is a famous person. If the press contact a practitioner, he/she is advised not to comment as he/she has a duty of confidentiality to the deceased patient.

## **16. Coroner's Courts**

The Coroner's Courts are held in Torquay for Torbay deaths and in the nearest convenient Court if the death is in South Hams or Teignbridge.

## **17. Registrars**

The Registrar for Torbay is at Oldway, Paignton (Tel: 01803 207130)

The Registrar for South Hams is at Follaton House, Old Plymouth Road, Totnes (Tel: 01803 861234)

The Registrar for Teignbridge is at 15 Devon Square, Newton Abbot (Tel: 01626 206341)

## **18. Help and Advice**

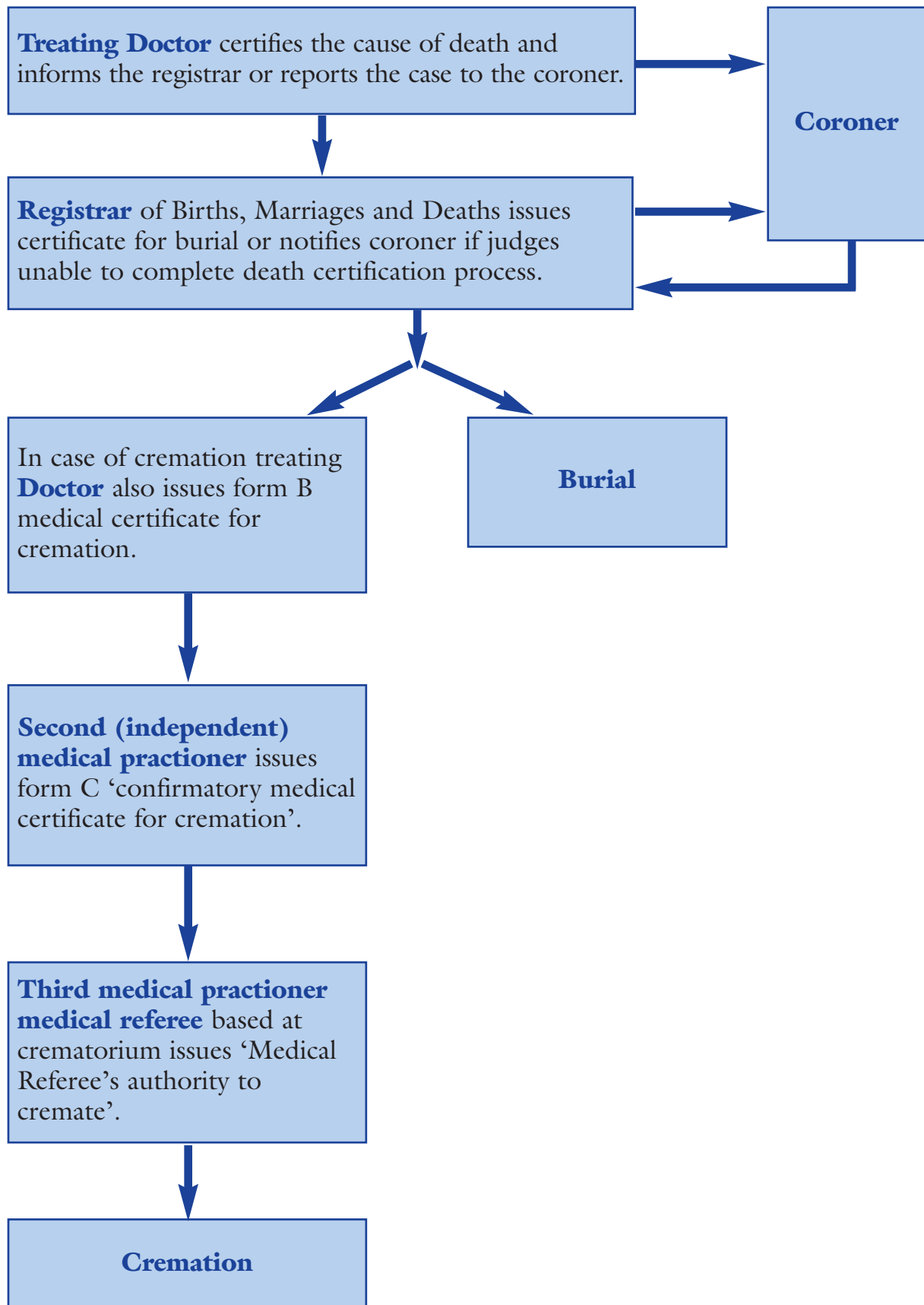
Doctors are advised that any problems which they may have should always be discussed with the Coroner's Officers in the first instance. A quick telephone call may enable the issue of a Medical Certificate of Cause of death where appropriate and avoid the unnecessary upset caused to relatives who are turned away by the Registrar of Births and Deaths, due to incorrectly completed Certificates.

## **19. The Future**

The Government's positional statement issued in March 2004 setting out the future plans for the Coroners' service, provided that all deaths would be reported to the Coroner. A certified cause of death will be provided by a first certifying Doctor and that will be scrutinised by a second Doctor being a Medical Examiner within the Coroner's service.

It is apparent that there will be a need for further training to assist the Medical Practitioners in what will be expected of them.

### Section 3 - Annex 'A'



## Section 4 - Aide Memoir

**Doctor's discussion with Coroner's Officer (Office use File No. )**

Reported by Dr. ....Time: .....Date:.....

Contact Telephone No: .....Beeper No:.....

I wish to issue/I cannot issue a Medical Cause of death Certificate/I wish to discuss

Name of deceased: Mr./Mrs./Miss /Ms. ....

Address: .....

Date of Birth:.....Age: .....Married/divorced/widowed/single/separated

If known: Place of birth .....Maiden name:.....

Previous/current occupation: .....

Date of death: .....Time:.....

Place of death:.....

Last seen by Dr. ....on.....

Certified dead by Dr.....at .....

Any concerns raised by any party yes/no detail

Consultant: ..... Hospital No: ..... Date admission:.....

Next of kin: ..... Relationship:.....

Address/telephone: .....

Have family been notified of report to Coroner's Officer yes/no

Funeral Director .....Burial/Cremation

Proposed medical cause of death for certificate:

1a .....

1b .....

1c .....

2 .....

Circumstances and previous medical history

