Her Majesty's Coroner for the County of Cheshire

REPORTING DEATHS TO THE CORONER

The following notes, originally issued in December 1999, revised in 2009 and now revised again, are an aide-memoire, rather than a definitive exposition and include good practice, as well as statutory requirements.

Please refer to the guidance material issued by the Office for National Statistics (attached as slightly modified) and also the Medical Certificate of Cause of Death itself and the booklet that contains such certificates, both of which contain explanatory information.

My Office and Officers are at your disposal, to help with any enquiry and to take reports of any death reportable to the Coroner. If in doubt, please telephone; in no event will you be criticised for so doing and remember that a possibly unnecessary telephone call is far better than a family delayed in the registration of death due to an error or oversight.

The County is divided into four districts as follows:-

1. Chester 01 I&S
2. Crewe 01 I&S
3. Macclesfield 01 I&S
4. Warrington 01 I&S

To report deaths or to seek advice during the hours of 8.00am to 4.00pm, Monday to Friday, please telephone the number for your district, as above.

Alternatively, please telephone my Office in Warrington on 01 I&S. An answering machine is available for out of hours' messages. Please note that the office closes for thirty minutes at 12.30 each day.

To report deaths at all other times, please telephone Police Control on 01 I&S I&S.

In the event of an out of hours' emergency, my home telephone number is 01 PD PD and my mobile number is 07 PD. If you are unable to get through (I may be in an area of poor reception) please telephone Police Control (as above) who will be able to connect you to someone who can supply the telephone numbers of my deputies.

REPORTABLE DEATHS IN CHESHIRE

Deaths are to be reported in the following circumstances:-

(i) The cause of death is unknown. Remember, you must know the CAUSE of the death, rather than the mode of dying (heart failure, for instance, is not considered a cause of death but a mode of dying).

(ii) You did not attend (in the sense of treating or at the least monitoring treatment) the deceased in his or her last illness and to your knowledge, no other doctor so attended or if they did attend, they are not currently available.

(iii) The Registration Regulations cannot be satisfied for some other reason (e.g. the name of the deceased is not known).

(iv) The deceased has not been seen by you for treatment within the 14 days before death.

(v) The death was violent or unnatural or suspicious or unexpected.

(vi) The death may be linked to poison or drugs.

(vii) The death may be due in whole or in part to an accident, no matter when the accident occurred.

(viii) The death may be due to self-neglect or neglect by others, including poor care in a residential or nursing home.

(ix) The death may be due to an industrial disease or related to the deceased's employment or the deceased was in receipt of industrial injury or disablement pension or war pension, even if the death does not appear to be related to the condition for which the pension has been awarded.

(x) The death may be due to an abortion.

(xi) The death occurred during an operation or before recovering from the effects of an anaesthetic.

(xii) The death occurred within 24 hours of admission to hospital.

(xiii) The death may be linked to an operation or any other medical procedure or drug (medicinal or otherwise and whether or not prescribed). It is best practice to report a death when there has been any operative procedure in the preceding 12 months.

(xiv) The death may be linked to a fracture. It is best practice to report a death when the deceased has suffered a significant fracture within the last 12 months.

(xv) The death may be due to lack of medical care or allegations of medical mismanagement have been made.

(xvi) The death may be due to the actions of the deceased, including suspected suicide, drug or solvent abuse, etc.

(xvii) The death (whether natural or not) occurred during or shortly after detention in police or prison custody (even if the actual death occurs in hospital). Remember that although a prisoner may die in hospital, he is still in custody for these purposes.

(xviii) The death (whether natural or not) occurred during State Detention which includes detention under the Mental Health Acts or under a DOLS order (Deprivation of Liberty Safeguards).

(xix) The death (whether natural or not) occurred of a patient in a Mental Hospital whether detained or voluntary.

(xx) The death occurred within 30 days of SACT (Systemic Anti Cancer Therapy), i.e. chemo therapy or radio therapy.

(xxi) Deaths involving children under the age of 18 from whatever cause MUST be reported.
(xxii) The death was that of a Mother and occurred following childbirth.
(xxiii) Falls with significant injuries in the last 12 months or falls proximate to the date of death

COMMON MISCONCEPTIONS AND DIFFICULTIES

- The year and a day rule no longer applies. If a death is related to an unlawful, accidental or intentional injury or non-natural cause, it is reportable, no matter how long ago the original event occurred.
- Industrial diseases and employment deaths often have their counterpart in natural disease processes. Always consider very carefully the possibility of an employment connection, particularly with a respiratory illness or cancer. Refer to the death certificate book for a list of many of the industrial diseases. **Do not deprive a family of a legitimate claim for compensation by failure to report.**
- I regard it as inappropriate to rely on viewing the body after death to overcome the fact that that the deceased was not seen within 14 days of death. At best this may help to rule out a violent death but will not assist in establishing the cause of death.
- Death due to alcoholism or smoking or sexually transmitted AIDS is not considered unnatural but please note that death due to the acute affects of alcohol is reportable.
- It is not a legal requirement for the certifying doctor to view the body before issuing a death certificate, but good practice nevertheless.
- Old age as the cause of death should be avoided unless entirely appropriate in all the circumstances and then only if the person is over 80.
- Some doctors confuse unnatural with unlawful; a death following a fall, choking on food or through the transfusion of infected blood is as unnatural as a death due to hanging, stabbing or gun shot wounds.
- Do not guess; you have a duty to report on the cause of death to the best of your knowledge, information and belief. Do not use the formula of Myocardial Infarction or Bronchopneumonia or Stroke, based on statistical likelihood rather than diagnosis.
- Families will be much assisted in avoiding unnecessary post mortems and delays if Doctors could plan strategically for their holidays and prolonged absences. If you have a patient who is expected to die while you are away, please ensure that a colleague attends the patient before your departure so that that doctor can issue a death certificate if your patient dies in your absence.
- If your patient has suffered a recent fracture or other significant injury then the death should be reported whether or not you believe that the cause of death was natural.
- **If before completion of the medical certificate as to cause of death you have cause to wonder whether the death should be reported, the answer is likely to be "yes", because otherwise you would not have had the thought process!**

July 2013

NICHOLAS L. RHEINBERG
H.M. CORONER CHESHIRE

ATTACHMENTS

GMC Good Medical Practice Guide 2013

1. You must be professional and compassionate when confirming and pronouncing death and must follow the law, and statutory codes of practice, governing completion of death and cremation certificates. If it is your responsibility to sign a death or cremation certificate, you should do so without unnecessary delay. If there is any information on the death certificate that those close to the patient may not know about, may not understand or may find distressing, you should explain it to them sensitively and answer their questions, taking account of the patient's wishes if they are known.

2. You must comply with the legal requirements where you work for reporting deaths to a coroner (England, Wales and Northern Ireland) or procurator fiscal (Scotland). You should be prepared to answer questions from those close to the patient about reporting procedures and post-mortems, or to suggest other sources of information and advice.

3. You must treat the patient's body with dignity and respect. You should make sure, wherever possible, that the body is handled in line with their personal religious or other beliefs.

OFFICE FOR NATIONAL STATISTICS GUIDANCE
(with amendments to paragraph 3)

Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales

From the Office for National Statistics' Death Certification Advisory Group, Revised July 2010

1 The purposes of death certification

Death certification serves a number of functions. A medical certificate of cause of death (MCCD) enables the deceased's family to register the death. This provides a permanent legal record of the fact of death and enables the family to arrange disposal of the body, and to settle the deceased's estate.

Information from death certificates is used to measure the relative contributions of different diseases to mortality. Statistical information on deaths by **underlying cause** is important for monitoring the health of the population, designing and evaluating public health interventions, recognising priorities for medical research and health services, planning health services, and assessing the effectiveness of those services. Death certificate data are extensively used in research into the health effects of exposure to a wide range of risk factors through the environment, work, medical and surgical care, and other sources.

After registering the death, the family gets a certified copy of the register entry ("death certificate"), which includes an exact copy of the cause of death information that you give. This provides them with an explanation of how and why their relative died. It also gives them a permanent record of information about their family medical history, which may be important for their own health and that of future generations. For all of these reasons it is extremely important that you provide clear, accurate and complete information about the diseases or conditions that caused your patient's death.

2 Planned changes to death certification *(N.B. I have amended the original text contained in this paragraph)*

The first major changes to death certification in England and Wales since 1953 are set out in the Coroner and Justice Act, which gained Royal Assent in November 2009 (http://www.justice.gov.uk/publications/coroners-justice-bill.htm). Part 1 (of nine) of the Act deals with the coroner service, investigation of deaths by coroners, death certification by doctors and the creation of a medical examiner service in England and Wales. **This new legislation has not been fully implemented yet. The most significant change so far as doctors are concerned will be the implementation of a Medical Examiner scheme. Current indications from Government suggest that the scheme will become operational in October 2014.**This guidance is to remind you of the continuing duties on medical practitioners **until the new legislation is implemented,** and to clarify best practice.

3 Who should certify the death?

When a patient dies it is the statutory duty of the doctor who has attended in the last illness to issue the MCCD. There is no clear legal definition of "attended", but it is generally accepted to mean a doctor who has cared for the patient during the illness that led to death and so is familiar with the patient's medical history, investigations and treatment. The certifying doctor should also have access to relevant medical records and the results of investigations. There is no provision under current legislation to delegate this statutory duty to any non-medical staff.

In hospital, there may be several doctors in a team caring for the patient. It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Any subsequent enquiries, such as for the results of post-mortem or ante-mortem investigations, will be addressed to the consultant.

In general practice, more than one GP may have been involved in the patient's care and so be able to certify the death. If no doctor who cared for the patient can be found, the death must be referred to the coroner to investigate and certify the cause.

If the attending doctor has not seen the patient within the 14 days preceding death, **and** has not seen the body after death either, the registrar is obliged to refer the death to the coroner before it can be registered. In these circumstances, the coroner may instruct the registrar to accept the attending doctor's MCCD for registration, despite the prolonged interval. In contrast, a doctor who has not been directly involved in the patient's care at any time during the illness from which they died cannot certify under current legislation, but he should provide the coroner with any information that may help to determine the cause of death. The coroner may then provide this information to the registrar of deaths. It will be used for mortality statistics, but the death will be legally "uncertified" if the coroner does not investigate through an autopsy, an inquest, or both.

4 Referring deaths to the coroner

Registrars of births and deaths are under a legal duty to report certain categories of deaths to the coroner before they can be registered. These include deaths which may be due to accident, suicide, violence, neglect (by self or others) or industrial disease and **deaths for which the cause is not known**. Deaths occurring during an operation, or before full recovery from an anaesthetic, as well as deaths occurring in, or shortly after release from, police or prison custody, should also be reported. In practice, doctors usually report such deaths themselves and seek the advice of the coroner. The Office for National Statistics (ONS) encourages doctors to do this and to explain to the family why the death is being referred, as well as how and when they will learn the outcome of the referral. The coroner should also be informed if there is no doctor who attended the deceased available to certify, or if the certifying doctor did attend the deceased, but has not seen them either within 14 days before death, or after death.

Strictly speaking, the law requires that the doctor should complete an MCCD even when a death has been referred to the coroner. In practice, if the coroner has decided to order a post-mortem and/or to hold an inquest, he may tell the doctor not to complete the MCCD. However, the coroner can only legally certify the cause of death if he has investigated it through autopsy, inquest or both. This means that, if the coroner decides not to investigate, the registrar will need to obtain an MCCD from a doctor who attended the deceased before the death can be registered. This may cause inconvenience to you and the family, if you have not already provided one.

When a death is referred, it is up to the coroner to decide whether or not it should be investigated further. It is very important that the coroner is given all of the facts relevant to this decision. The doctor should discuss the case with the coroner before issuing an MCCD if at all uncertain whether he or she should certify the death. This allows the coroner to make enquiries and decide whether or not any further investigation is needed, before the family tries to register the death. The coroner may decide that the death can be registered from the doctor's MCCD. For example, 75% of deaths with fractured neck of femur mentioned on the certificate are registered from the original MCCD following referral to the coroner, while only about 15% go to inquest, and 10% are registered after a coroner's autopsy. Omitting to mention on the certificate conditions or events that contributed to the death in order to avoid referral to the coroner is **unacceptable**. If these come to light when the family registers the death, the registrar will be obliged to refer it to the coroner. If the fact emerges after the death is registered, an inquest may still be held.

In Scotland, deaths that may have been related to adverse effects of medical or surgical treatment, or to standards of care, or about which there has been any complaint, are

reportable to the procurator fiscal. While this is not a requirement in England and Wales, it is anyway advisable to refer such deaths to the coroner.

5 How to complete the cause of death section

Doctors are expected to state the cause of death to the best of their knowledge and belief; they are not expected to be infallible. Even before any changes to the law, it is likely that there will be increased scrutiny of death certification and patterns of mortality by local and national agencies as a result of the Shipman Inquiry. Suspicions may be raised if death certificates appear to give inadequate or vague causes of death. For example, if a patient dies under the care of an orthopaedic surgeon, it might be expected that some orthopaedic condition contributed to the death and so this condition would be mentioned in part I or part II of the certificate. Similarly, it would be surprising if a patient was being treated in an acute hospital, but no significant disease or injury at all was mentioned on their death certificate.

The level of certainty as to the cause of death varies. What to do, depending on the degree of certainty or uncertainty about the exact cause of death, is discussed below.

5.1 Sequence leading to death, underlying cause and contributory causes

The MCCD is set out in two parts, in accordance with World Health Organisation (WHO) recommendations in the International Statistical Classification of Diseases and Related Health Problems (ICD). You are asked to start with the immediate, direct cause of death on line Ia, then to go back through the sequence of events or conditions that led to death on subsequent lines, until you reach the one that started the fatal sequence. If the certificate has been completed properly, the condition on the lowest completed line of part I will have caused all of the conditions on the lines above it. This initiating condition, on the lowest line of part I will usually be selected as the **underlying cause of death,** following the ICD coding rules. WHO defines the ***underlying cause of death*** as **"a) the disease or injury which initiated the train of morbid events leading directly to death, or b) the circumstances of the accident or violence which produced the fatal injury". From a public health point of view, preventing this first disease or injury will result in the greatest health gain.** Most routine mortality statistics are based on the underlying cause. Underlying cause statistics are widely used to determine priorities for health service and public health programmes and for resource allocation. Remember that the underlying cause may be a longstanding, chronic disease or disorder that predisposed the patient to later fatal complications.

You should also enter any other diseases, injuries, conditions, or events that contributed to the death, but were not part of the direct sequence, in part two of the certificate.

Examples of cause of death section from MCCDs:
Cause of death ***the disease or condition thought to be the underlying cause should appear in the lowest completed line of part I***

I

(a) *Disease or condition leading directly to death*

Intraperitoneal haemorrhage

(b) *other disease or condition, if any, leading to* I(a)

Ruptured metastatic deposit in liver

(c) *other disease or condition, if any, leading to* I(b)

primary adenocarcinoma of ascending colon

II

Other significant conditions **Contributing to death** *but not related to the disease or condition causing it*

Non-insulin dependent diabetes mellitus