Family Doctor Association Conference

“How to avoid the Coroner?”

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A GP Observation test

• A new feature of revalidation from the Royal College of GP’s
• You will need a pen and paper
• You will have to concentrate
• You will need to hand in your answer
Observation task

• Video of people playing with basketballs
• Three in white shirts, three in black shirts
• Your task is to count the number of times the team in white pass or bounce the ball.

• Count the score as follows:
  – Score 1 for a bounce
  – Score 1 for a pass
  – Score 2 for a bouncing pass

• At the end I'll ask you for your total score
• Please keep quiet while the movie is in progress
THE STATUTORY FRAMEWORK

- The Coroners (Investigations) Regulations 2013 – C Inv Regs
- The Coroners (Inquest) Rules 2013 – C Inq Rules
- The Coroners Allowances, Fees and Expenses Regulations 2013 - CFRegs
- The Coroners and Justice Act 2009 - CJA
- The Coroners Charter
What does society want or need from a death certification and investigation process?

• To ensure that suspicious deaths are identified and investigated?
• To establish whether or not the death was from natural or unnatural causes?
• To establish what “the” pathological cause of death was?
• To record pathological causes of death for the public record?
• To record pathological causes of death to inform public health information and identify trends or issues to allow the development of health policies and allocation of public funds?
• To allow claims for compensation for negligent treatment?
• Do we need reliable statistical information?
Current death certification system

- Births and Death Registration Act 1953
- 1a. 1b. 1c. 11. 111. ?
- Are Doctors good at death certification?
- Do Doctors know why people have died?
- What standard of proof applies?
- NCEPOD Study 2006
- 2008 Article about rates of PM Histology
- What is unnatural? Touche
- Has Society changed? Harold Shipman?
- Is there variability in the quality of PMs?
- Is the PM the “GOLD” standard
- RC Path 2014 Standards
Lies, damned lies and Coroner statistics

- 2013 MoJ published statistics
- 227,984 deaths reported to Coroners
- This represents 45 % of all registered deaths
- In last 10 years of deaths reported to Coroners 28 % natural causes, 26 % Accident/Misadventure and 12 % Suicide
- 94,455 Post Mortems = 41 % of all deaths reported
- 89,732 standard @ £96.80 = £8,686,057 – true cost ?
- 4273 special @ £276.90 = £1,183,193 – true cost ?
- Over last 10 years proportion of PM’s to deaths reported has dropped from 53 % to 41 % - WHY ?
- 281 deaths in state custody – of which 155 in prison and 97 in mental health detention units
Lies, damned lies and Coroner statistics

- 29,942 Inquests opened = 13% of all deaths reported
- 31,579 inquests concluded
- Over last 10 years the % of inquests to deaths reported has remained about the same.
- 84% of Inquest cases had a PM
- 128,702 where there was no PM or inquest
- 81% of cases reported resulted in no inquest
- In 34% of non inquest cases a PM was conducted
- In 20% of all PMs done histology was done
- In 14% of all PMs done was toxicology done
Lies, damned lies and Coroner statistics

- Conclusions at Inquests in 2013
- 28% natural causes
- 26% accident/misadventure
- 17% unclassified (includes Narrative, Drug/Alcohol related and Road Traffic Collision)
- 12% suicide (80% of which were male)
- 6% open (71% of which were male)
- 2% drug related
- 1% all other causes
- 67% of inquests related to males
- 19% of all inquests related to persons over 65
- 8% of all inquests related to persons under 25
Lies, damned lies and Coroner statistics

- Number and proportion of deaths reported to Coroners?
- 20% of all registered deaths were reported to the Coroner in South Northumberland and 3 others with < 30%
- 99% of all registered deaths were reported to the Coroner in Blackburn, Hyndburn and Ribble Valley!
- 3 Coroner areas had between 80-90% reported!
- Total of 8 in the Isles of Scilly
- Total of 6252 in Nottinghamshire area
- Total of 3468 in South Yorkshire Eastern area
- In Manchester less than 10% of all inquests were suicides
- This was greater than 20% in Somerset, Wiltshire, Dorset, Cambridgeshire, Shropshire and Birmingham!
The new law introduces three distinct parts to the Coroner’s investigation and enquiries:

- Pre-investigation preliminary enquiries
- Investigation and no inquest
- Investigation and inquest
- Inquest not completed by implementation date – see Reg 3 C Inv Regs and Rule 3 C Inq Rules
Pre-investigation preliminary enquiries

After the death is reported, a Coroner can:

- Order a post mortem examination and any consequent tests, analysis or examinations under S.14(1) CJA
- Post mortem can be conducted anywhere
- Obtain records or documents
- Speak to the family or the doctors to obtain further information but must keep records of what he does/finds
- Make any other enquiries (S.1(7) CJA) to determine whether to duty to investigate under S.1(1) CJA is engaged
- If no duty to investigate then can issue Form 100A (no PM) or Form 100B (if PM)
- Reg 10, 11 and 12 C Inv Regs re notifying PR/next of kin, etc - ? retention/preservation of material
Investigation and no inquest

• Duty to investigate arises under S.1(1) CJA if Coroner made aware that the body of a deceased person is within his area; AND

• There is reason to suspect that:
  ~ The deceased died a violent or unnatural death
  ~ The cause of death is unknown
  ~ The deceased died in custody or otherwise in state detention (as defined in S.48(2)) ? Voluntary patients/DOLS

• The Coroner must do so as soon as practicable and MUST attempt to identify and notify PR’s or next of kin of the decision to begin an investigation – Reg 6 C Inv Regs

• Coroner MUST discontinue an investigation if PM reveals cause of death before began to hold an inquest and he thinks it is not necessary to continue – S.4(4) – explain if requested to give reasons
Post Mortem examinations

- S.14 of the C & J Act
- Coroner “may request a suitable practitioner” to conduct…
- “Suitable practitioner” = a Dr or as designated by the CC
- “Post Mortem examination” not defined by the Act
- Coroners “request” may specify kind of examination made
- S.14 (4) Dr’s whose treatment may have been improper or negligent cannot conduct the PM BUT………..
- Do you examine all parts of a body and take toxicology ?
- S.14(5) Person conducting the PM must report the findings as soon as practicable in what ever form the Coroner requires ! RCPath best practice scenarios
- Are we doing too many and unnecessary PMs ?
Investigation and an inquest

- S.6 CJA – Coroner who conducts an investigation MUST (as part of the investigation) hold an inquest
- Rule 8 C Inq Rules – MUST complete inquest within 6 months of being made aware of the death, or as soon as reasonably practicable
- **BUT**
- S.4 CJA – Coroner MUST discontinue an investigation if:
  - ~ PM reveals cause of death before Coroner began holding an inquest, and;
  - ~ Coroner MUST give an explanation (in writing if requested) to an interested person as to why the investigation has been discontinued
- ~ BUT this does not apply where there is reason to suspect a violent or unnatural death or while in custody or state detention
Matters to be ascertained

• S.5(1)
  ~ Who the deceased was
  ~ How, when and where the deceased came by his or her death
  ~ Death registration particulars

• S.5(2) – Where necessary to avoid a breach of any convention rights, it includes in what circumstances the deceased came by their death

• S.5(3) – Neither the Coroner nor the jury may express an opinion on any other matter, but this is subject to the Coroner making a report of concern to prevent future deaths. (para 7 of Schedule 5 CJA)
Inquest to be held in public and recorded

- Rule 5 – 11, 25 – C Inq Rules
- Coroner MUST open inquest in public and as soon as reasonably practicable
- At the opening, Coroner MUST where possible set dates on which subsequent hearings are scheduled to take place
- All hearings to be recorded
- Coroner MAY hold a PIRH during an investigation and before an inquest (this may be held in chambers or in public but must still be recorded)
- DoLs
Coroners’ Powers

• Common law powers retained?

• Schedule 5 includes:
  ~ Notice to attend the hearing to give evidence or produce a document or any other item
  ~ Notice to provide during an investigation a written statements or produce documents or any other item
Action to prevent other deaths

• Para 7 Schedule 5 – now statutory force

• Where a Coroner has been conducting an investigation and anything is revealed that gives rise to a ‘concern’ that circumstances creating a risk of other deaths will occur or will continue to exists in the future, and in the Coroner’s opinion action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk, the Coroner MUST report the matter to any person who has power to take such action.

• Response required from recipient

• Now called Regulation 28 PFD reports
Action to prevent other deaths (2)

- Reg 28 and 29 C Inv Regs
- Report may not be made until the Coroner has considered all the documents, evidence and information that in the opinion of the Coroner is relevant to the investigation
- Standard national template to be followed
- Can report during an investigation where no inquest is held, or before an inquest if one is held, or after an inquest
- Copies to Chief Coroner, IP’s and anyone else who Coroner thinks may find it useful
- Not Coroner’s responsibility to identify actual solutions or make specific recommendations but point out matters of concern
Conclusion, findings and determinations

• S.10 – Coroner/jury to make a ‘determination’ of the who, where, when and how (and in what circumstances if Article 2 is engaged) and make ‘findings’ about the death registration particulars.

• Cannot appear to determine criminal liability on part of a named person or civil liability but …….

• Rule 33 C Inq Rules require recording of determination and findings on Prescribed Form in Schedule 2 – similar to old law.
What is not enacted?

- Medical Examiner scheme – S.18 – 21
- Treasure provisions – S.25 – 31 plus Schedule 4 para 3-5
- Medical Advisor to the CC – S.38
- Power of entry, search and seizure – Schedule 5 – para 3-5
- Appeals to the CC – S.40
PM (A)CT/MRI(V)

- Started in this country in Manchester
- Are we actually offering this service?
- How much and who pays?
- 2012 The Lancet – Manchester/Oxford study reported
- 2012 RC Path and RC R published standards for cross sectional post mortem imaging
- Chief Coroner’s Guidance on PM Imaging 2013
- Forensic Pathologists views? Professor Guy Rutty
- Is it strictly speaking an alternative to a PM?
- CT or MRI? PM Coronary Angiography and Pulmonary Ventilation
- Radiologists are vital to interpret the scans but is there a nationally accredited training course?
- I-Gene?
Paediatric MIA

- MIA = minimally invasive autopsy
- Professor Sebire – Great Ormand Street
- Not for all cases
- 2 cm incision
- Still requires full clinical history and records, histology, microbiology, toxicology, metabolic studies and any other necessary tests
- Vital element is PM imaging interpreted by Paediatric Radiologists with understanding of post mortem changes
Regular issues and pit falls

- The quality of NHS - SUI/RCA/II reports
- The quality of GP records and history taking
- Do you ask about adverse drug reactions or APR’s?
- To be open and transparent – “Yellow Carding”?
- To follow specific requirements when things go wrong with care and treatment
- The 12 fundamental standards
- Paragraph 75 GMC Good Practice 2013
Some conclusions and outstanding questions

- “Liza Minelli” in Cabaret
- Introduction of the Medical Examiner and dual death certification in every death?
- Introduction of medical adviser to the Chief Coroner?
- Do we have enough CT/MRI scanners? Are they being used as much an efficiently as they could be?
- Do we have enough GP’s, Radiologists Pathologists?
- Post code lottery? Who pays?
- Do we ask the right questions?
- CT/MRI provides permanent record
- Adjunct not a replacement or direct alternative
- Need for joined up thinking and working
- Need for quick efficient toxicology
And finally………

• Make sure you take a proper history which is clearly and accurately recorded
• Ensure that routine correspondence/reports are properly read and actioned
• Ensure that follow up is timely and appropriate
• Ensure that you see your elderly and terminally ill patients regularly
• Understand the basics of MCCD completion
• Assist the Coroner when asked for records or print outs
• Never be shy in contacting the Coroner for advice or to report a death