

DEATH CERTIFICATION, INQUESTS AND CORONERS

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Coroners & Justice Act 2009

- Several Reports proposing reform of the coroner and death certification system were written in the 20th century (Luce and Smith reports)
- Following much debate and delay, the Coroners and Justice Act received royal assent in 2009
- The new law was implemented on July 25th 2013
- A **Medical Examiner (ME)** system will probably be implemented, but *when* remains undecided
- In future there may be a statutory duty on doctors to notify of some deaths to coroners

The disposal of the dead

“ The body of a deceased person may not be disposed of before a certificate of the Registrar (of Deaths) or an order of the coroner has been delivered to the person effecting the disposal”

Births and Deaths Registration Act 1926, s.1

An “Out of England” Order is needed from a coroner before the body of a deceased person may be removed out of England (ibid, s.3)

Duties on doctors

- There is a **statutory** duty on a medical practitioner to issue a Medical Certificate of Cause of Death (MCCD) if s/he attended a person in his last illness

(Births & Deaths Registration Act 1953, s.22(1))

- There is, as yet, **no statutory** duty to report a death to a coroner (but it is good practice and ONS guidance encourages it)
- There is a GMC duty
- There is an NHS contractual obligation
- There may be a duty in future to report to MEs

Statutory duties

Births & Deaths Registration Act 1953

- The registered medical practitioner who “attended [a person] during his last illness ... shall sign a certificate in the prescribed form [*the MCCD*] stating to the best of his knowledge and belief the cause of **death** and shall forthwith deliver that certificate to the registrar”

Coroners and Justice Act 2009

- s.18 Statutory notification by medical practitioner to coroners – **not yet in force**

Why bother?

- To make a statement that you know to be untrue may lead to a prosecution for Perjury

Perjury Act 1911, s.4

- To make a false declaration may lead to a prosecution

Births and Deaths Registration Act 1953, s.37

- **Inaccuracy causes delay and distress**

Consequences of error

- A death may not be registered by Registrar
- Funeral arrangements will be disrupted
- Forensic evidence may be lost
- Travel plans for overseas relatives will be disrupted
- You leave yourself open to complaints from relatives and to prosecution

The medical certificate of cause of death (MCCD)

- Too many are incorrectly completed
- Read the notes of guidance in the book
- Do not give a 'mode of dying'
- Diseases in part 2 should have contributed to the death – it is not a 'rag bag' of every pathology the patient happened to have
- **Beware accidents** (e.g. bone fractures) **and industrial diseases** (mesotheliomas)

Types of MCCD

- **Medical Certificate of Cause of Death** (Form 66) for any death after 28 days of life
- **Neonatal Death Certificate** (Form 65) for any death of a live-born infant occurring within the first 28 days of life
- **Certificate of Still-birth** (Form 34) for any death of an infant that has issued forth from its mother after the 24th week of pregnancy and which did not breathe or show any other signs of life at any time after being completely expelled from its mother

Is ignorance bliss?

- Little teaching of legal aspects of medical practice in the UK
- This has been so for decades
- Many doctors have trained abroad
- Whilst medicine might be universal, the law is not
- Need to improve standards

General Practice deaths

- More than one GP may have been involved in the patient' s care
- Out of hours; nights & weekends
- Deputising services
- Holidays and other absences
- Hospice care – nursing oversight
- May need referral to the coroner
- Try to brief a colleague
- **Avoiding the need for autopsy**

Purposes of death certification

- Enables the family to register the death
- Measures the relative contributions of different diseases to mortality
- MCCD data are used in research into the health effects of exposure to a wide range of risk factors in the environment, work, medical & surgical care, monitoring the health of the population, planning future health care requirements, etc., etc.

How to complete the MCCD

- State the cause of death to the **best of your knowledge and belief**
- Not 'beyond reasonable doubt'
- No expectation of infallibility
- The degree of certainty will vary
- The listed sequence must be logical
- Do **NOT** use abbreviations on MCCD

Completing the MCCD 1

- Line 1a is for the **immediate**, direct cause of death
- Lines 1b & 1c are to record the sequence of events or conditions that led to the immediate cause of death – ***logically***
- The condition on the 'bottom line' should be the **underlying** cause

Completing the MCCD 2

- The stated causes should follow the ICD (International Classification of Diseases) coding rules
- Statisticians and epidemiologists use the underlying (not the immediate) cause for mortality statistics
- Record causes of death, not modes of dying

Completing the MCCD 3

- Part 2 is to record other diseases, injuries, conditions or events that **contributed to the death** but were not part of the direct sequence
- Part 2 is not a rag bag or dustbin to record every illness from which the individual suffered during life
- Include the time intervals

Completing the MCCD 4

- Get the name right
 - Family name & given name; spelling
- State the age and get it right
- Circle the appropriate options
 - Seen after death by me
 - Seen after death by another doctor
 - Not seen after death by a doctor

Completing the MCCD 5

- Sign – legibly, or print the name
- Give the doctors qualifications as registered with the GMC
- In hospital deaths, print the name of the consultant responsible
- Fill in the reverse side of the MCCD
 - A – reported to HMC
 - B – may be additional information later

Some “Modes of dying”

Asphyxia

Exhaustion

Brain failure

Heart failure

Cachexia

Hepatic failure

Cardiac arrest

Kidney failure

Cardiac failure

Renal failure

Coma

Liver failure

Debility

Respiratory arrest

“Old age” or “Senescence”

- Avoid using it as the **only** cause of death unless a more specific cause cannot be given
- Record contributory conditions in part 2 on the MCCD
- Not for those aged under 80 years
- Ageing populations & multiple pathologies present difficulties

Joint causes of death

- Sometimes there may be more than one cause of death
- If there is no way of choosing between them, they may be entered together, on one line
 - e.g. Ischaemic heart disease and chronic bronchitis (joint causes)

Accident

- Report any 'violent' or 'unnatural' death
- Some registrars of deaths may object to 'cerebro-vascular accident' until they understand it means a 'stroke'
- Any mention of 'accident' on an MCCD should warrant referral to HMC for consideration
- Each case then depends on its facts – perhaps not all require an inquest

Time between accident & death

Ia Cardiorespiratory failure

Ib Brain injury

- The story was of a boy aged 10 who suffered brain injury in a RTC but died in 2006, 24 years later. There was an unbroken chain of cause
- Horse riding – paraplegia – renal stones – renal failure is another example

BIRTHS AND DEATHS REGISTRATION ACT 1953
(Form prescribed by the Registration of Births and Deaths Regulations 1987)

MEDICAL CERTIFICATE OF CAUSE OF DEATH

For use only by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the deceased's last illness, and to be delivered by him forthwith to the Registrar of Births and Deaths.

Registrar to enter
No. of Death Entry

Name of deceased Joseph LIVETT ("Bob")
Date of death as stated to me 22/10/10 day of _____ Age as stated to me 81
Place of death St Cecilia's Nursing home
Last seen alive by me 18/10/10 day of _____

- 1 The certified cause of death takes account of information obtained from post-mortem.
 - 2 Information from post-mortem may be available later.
 - 3 Post-mortem not being held.
 - 4 I have reported this death to the Coroner for further action. *[See overleaf]*
- } Please ring appropriate digit(s) and letter
- a Seen after death by me.
 - b Seen after death by another medical practitioner but not by me.
 - c Not seen after death by a medical practitioner.

CAUSE OF DEATH
The condition thought to be the 'Underlying Cause of Death' should appear in the lowest completed line of Part I.

I (a) Disease or condition directly leading to death Bronchopneumonia
 (b) Other disease or condition, if any, leading to I(a) Acquired brain injury
 (c) Other disease or condition, if any, leading to I(b) _____

II Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition causing it. Dislocated shoulder

These particulars not to be entered in death register

Approximate interval between onset and death

2 weeks

7 years

6 weeks

The death might have been due to or contributed to by the employment followed at some time by the deceased. Please tick where applicable

†This does not mean the mode of dying, such as heart failure, asphyxia, assthenia, etc: it means the disease, injury, or complication which caused death.

I hereby certify that I was in medical attendance during the above named _____ Signature [Signature] Qualifications as registered by General Medical Council } MB BS

Fractures – tell the coroner

- Not all fractures warrant an investigation
 - e.g. pathological fractures and osteoporotic fractures
- But a simple fracture may lead to immobility which, in turn, leads to a fatal chest infection
- Beware the MCCD that gives just 'bronchopneumonia' as the sole cause – what caused the bronchopneumonia?

Occupation and death 1

- A detailed list of conditions thought to be associated with occupation is set out on the back of every MCCD
- Always consider whether a stated cause of death might have an occupational origin
- Not all doctors will think of the link

Occupation and death 2

- Exposure to ionising radiation and death from malignant diseases
- Work in aniline dye industries
- Lung tumours and asbestos
- Lead poisoning and paints
- Anthrax and contact with animals
- Lung diseases and mining – etc.

Inquests and Coroners

The **present system** in **England & Wales**

[Scotland is different! -

Fiscals, Sheriffs & FAls, etc.]

The duty of Coroners

To conduct, as soon as practicable, an **investigation** when informed that

- there is the **body** of a deceased person **lying** within their area **and**
- the coroner has reason to suspect that the deceased
 - has died a **violent or unnatural** death
 - the **cause of death is unknown**
 - has died while in custody or otherwise in state detention

Get to know your coroner!

- The coroner service is local, not national, funded by the local authority
- A Chief Coroner supplies oversight and guidance
- Coroners vary from area to area in what they require
- c. 90 coroner areas in England and Wales
- Populations and patterns of death vary
- What is ***violent***? What is ***unnatural***?

General Medical Council 1

“ You must co-operate fully with any formal inquiry into the treatment of a patient...”

“You must assist the coroner... in an inquest or inquiry into a patient’s death by responding to their inquiries and by offering all relevant information ...”

(+ rule 22 exception)

From Good Medical Practice, [2006] GMC, paragraphs 68, 69

General Medical Council 2

- You must be honest and trustworthy when giving evidence to courts or tribunals.
- You must make sure that any evidence you give or documents you write or sign are not false or misleading.
- You must take reasonable steps to check the information. You must not deliberately leave out relevant information.
- You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in [Confidentiality](#).
- You must make clear the limits of your competence and knowledge when giving evidence or acting as a witness

Good Medical Practice 2013 edition; paragraphs 72-75

NHS Guidance

“ All those who have information which could help coroners inquiries should disclose it voluntarily and not only when requested ”

CMO's Update, 20/98

Going off duty?

- You owe a duty to deal promptly with death certification
- If you 'disappear' before completing the MCCD, and no-one else can complete it, you will create problems
- If you cannot issue an MCCD for any reason, ***tell the Coroner's Office***

Statutory provisions

- Coroners and Justice Act 2009
- The Coroners (Inquests) Rules 2013
- The Coroners (Investigations) Regulations 2013
- The Coroners Allowances, Fees and Expenses Regulations 2013

- The Treasure Act 1996
 - Department of National Heritage; Code of Practice

Other provisions

2. Case law

i.e. Law made by judges following judicial reviews and appeals, which set binding precedents

- Court of Record
- Recording of evidence
- Evidence given on oath/affirmation

Annual statistics

- c. 501,000 deaths are registered in England and Wales (E&W)
 - c.70% led to cremations (11% in Northern Ireland) and 30% to burials (89% N.I.)
- 230,595 (c.47%) were referred to coroners
- Of the deaths referred to coroners, 101,940 (c.46%) underwent autopsy
- 30,800 inquests were opened

Coroners' "Pink Forms"

- Most deaths reported to coroners do **not** proceed to inquest
- Nationally, about 12% of cases proceed to inquest (the percentage varies in different areas)
- Most coroners have a list of deaths that should be reported to them (varies from coroner to coroner; *handout*)

Peach Form A procedure

- Doctor discusses case with HM Coroner or (more usually) with Coroner's Officers
- Discussion with relatives
- No PM and no inquest if coroner satisfied death was "not unnatural"
- "**Peach Form A**" is issued to enable death to be registered

Pink Form B procedure

- Where the cause of death is uncertain or unknown the coroner may order a pm examination
- If the cause of death after PM is a natural cause, and the coroner has no reason to think the death was 'unnatural', s/he may issue "**Pink Form B**" (no inquest)

Inquest formalities

- Must be held 'as soon as practicable'
- Must be opened, adjourned and closed in a formal manner
- Must be held in public
- Must not be held on Christmas day, Good Friday, a Sunday or a bank holiday
- Certain people are entitled to notice
- Proceedings must be voice-recorded
- Some inquests require a **jury**

Scope of inquests

To answer four questions:

- **Who** the deceased was and
- **How, when** and **where** the deceased came by his/her death **and**
- to ascertain the particulars required by the Registration Acts to register the death (date & place of birth, address, occupation, martial status, &c)
- **No expression of any opinion on any other matter** (*section 5, C&JA 2009*)

“How” the individual died

- “**How**” means ‘by what means’ the deceased came by his/her death – i.e. how, not why, they died
- The Human Rights Act and Article 2 ECHR has widened the scope of some inquests
- Deaths “in the care of the state” include deaths in NHS hospitals and in custody
- The inquest must then investigate “**by what means and in what circumstances**” the deceased came by his/her death

Scope of inquiry

A coroner (or jury where there is one) must not frame a verdict in such a way as to appear to decide any question of

- *Criminal liability on the part of a named person, or*
- *Civil liability (e.g. negligence)*

[section 10(2)]

Thorough investigation

However, case law has made clear that the coroner must conduct a full, fearless and thorough inquiry into all relevant facts that might bear upon liability

Therefore searching questions may be asked, even if no adverse civil or criminal finding can form part of the verdict

Prevention of future deaths

A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter to the person or authority who may have power to take such action.

(Section 32; Schedule 5, paragraph 7)

Coroners procedure - 1

- The procedure is inquisitorial
- It is not adversarial
- It is *not* a trial
- It *is* a fact-finding inquiry conducted on behalf of the sovereign (hence "H.M." Coroners)
- The hearsay rules do not apply
- The coroner will select the witnesses

Coroners procedure - 2

- There are no 'parties'
- There are 'interested persons' (s. 47)
- Counsel may represent interested persons, but no-one may address the coroner or the jury on the facts
- Evidence may be documentary (*rule 23*)
- Rule against self-incrimination (*rule 22*)
- Power to call for statements, notes, etc.
(*schedule 5*)

Evidence - 1

- **Written evidence – statements/reports**
 - Statements – facts, not opinion
 - Not a paper for a scientific journal
 - Times and dates
 - Who did what, why and when
 - First person singular, active tense
 - Avoid jargon and abbreviations
 - May obviate need to attend in person

Evidence - 2

- **Oral evidence – appearing in court**
 - Best to come voluntarily and willingly
 - Can be summoned (schedule 5)
 - Contempt of court
 - An opportunity to explain what happened
 - Look the part
 - Stand up, speak up, shut up
 - Prepare to be “cross-examined” by ‘interested persons’

Coroners Officers

- Most of the daily work of HM Coroners is performed by coroners officers
- Some but not all are retired police officers
- In London they are civilian employees of the Metropolitan Police Service
- In some (but not all) areas there is a duty rota for nights and weekends
- They have a demanding role
- They are not well paid and resourced and have little training and support

The end

Any questions?

