THE CORONER

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WHAT IS A CORONER?

- A Coroner is an independent judicial office holder, appointed by the local authority.
- Coroners are usually lawyers who work within a framework of law passed by Parliament.
- The Chief Coroner heads the Coroner service and gives guidance on standards and practice.

WHAT DO CORONERS DO?

- Coroners investigate deaths if they have reason to suspect that:
  - The death was violent or unnatural; or
  - The cause of death is unknown; or
  - The deceased died while in state detention.
- When a death is reported to a Coroner they:
  - Make preliminary inquiries to decide if an investigation is required;
  - If so investigate to establish the identity of the person who has died; how, when, and where they died; and any information required to register the death; and
  - May use information discovered during the investigation to assist in the prevention of other deaths.
- The Coroner may decide to hold an Inquest as part of the investigation.

WHAT CAN THE CORONER DECIDE?

- the identity of the person who has died;
- How they died
- When they died
- Where they died

- And possibly make recommendations about prevention of future deaths

WHICH DEATHS ARE REFERRED TO THE CORONER?

- the cause of death is unknown
- the deceased was not seen by the certifying doctor either after death or within 14 days before death
- the death was violent or suspicious
- the death was unnatural
- the death may be due to an accident (whenever it occurred)
- the death may be due to self-neglect or neglect by others
- the death may be due to an industrial disease or related to the deceased’s employment
- the death may be due to an abortion
- the death occurred during an operation or before recovery from the effects of an anaesthetic
- the death may be a suicide
- the death occurred during or shortly after detention in police or prison custody
- the death occurred while the deceased was subject to compulsory detention under the Mental Health Act
- for any other concerning feature

HOW DO YOU REPORT A DEATH TO THE CORONER?

- A hospital death should always be reported by a senior doctor.
- The coroner (by a coroner's officer) may wish to contact you about the written referral.
- Once a death is referred to the coroner, the reporting doctor may not issue an MCCD to a family until agreed by or on behalf of the coroner.
- Where the medical cause of death is agreed by the coroner, the doctor signing the MCCD must indicate that the coroner has been informed and must record the exact words as agreed with the coroner (with no abbreviations).

WHEN SHOULD THE DEATH BE REPORTED TO THE CORONER?

Before the end of the next working day

WHAT WILL THE CORONER DO ONCE A DEATH HAS BEEN REFERRED?

- **When a death is reported to the Coroner's Office the Coroner will usually consider the information on the same or the next working day.**
- **In some cases the Coroner will review the available reports and be satisfied that the person died of natural causes. There is therefore no need to inquire any further and permission will be given to the GP or hospital doctor to issue the Medical Certificate of Cause of Death (MCCD). Relatives can then register the death at the Register Office just as they would have had the MCCD been issued without referral to the Coroner. Once this has been done the funeral can take place.**
- **Coroners generally complete enquiries very quickly and usually within the same or next working day but sometimes it can take longer if, for example further information is required or a doctor has to be located who can issue the MCCD**

WILL THERE BE A POST MORTEM?

A post-mortem examination will be necessary if;

- The cause of death is not known. Even if the cause is likely to be natural it may be necessary to find out which disease or condition was involved.
- The cause of death may be unnatural.
- The deceased died in some circumstances of state detention.

The Coroner never requests a post-mortem examination without careful consideration. Where it seems likely that death was due to natural causes, every effort is made to trace a doctor who may be able to certify the cause of death.

CORONER'S INQUEST

The law says that the Coroner must open an Inquest into a death if there is reasonable cause to suspect that the death was due to anything other than natural causes (a natural disease process running its natural course where nothing else is implicated) or occurred in state detention.

- An Inquest is a public, fact-finding inquiry to establish who the deceased was, when and where they died and how they came about their death. The Coroner will confirm the particulars required to register the death, the medical cause of death and record a conclusion appropriate to the evidence.

- Inquests cannot deal with issues of blame or criminal/civil liability. These can be addressed in other courts if necessary.

- Any complaints about care should be addressed to the organisation concerned

GIVING EVIDENCE IN CORONER'S COURT

- The Coroner may require you to give evidence during the Inquest if you have factual information that could assist with the Coroner's inquiry.
- When the time comes to give your evidence, the Coroner will call you to the witness stand.
- You will need to take an oath or affirmation that you will give truthful evidence. You can do this on the Holy book of your choice or make a non-religious solemn promise.
- The Coroner will then guide you through your evidence. If the Coroner has questions following a witness's evidence the Coroner will ask them first and then the Interested Persons will have the opportunity to ask further relevant question

REGULATION 28

- The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths
- Example - “there should be a comprehensive, cohesive, frictionless system for the timely collation (including from the family and/or other carers) and timely communication / transfer of sufficient, accessible information ((not, simply, risk assessments) pertaining to suicide risk in patients / service users / residents, by and between each of the service providers concerned”

SHOULD WE REFER THESE CASES TO THE CORONER?

Some examples

CASE 1

- 89 year old man
- Admitted after a fall at home with a fractured neck of femur
- Pre-op assessment decided that the patient not fit for surgery
- Hospital acquired pneumonia
- End of life care initiated
- Died in hospital

CASE 2

- 45 year old housebound patient with multiple co-morbidities
- Carers 4 times a day
- Admitted with infected pressure sores
- Treated with antibiotics
- Despite treatment died from sepsis due to pressure sores

CASE 3

75 year old man with pulmonary fibrosis due to asbestos exposure

Smoker

Admitted with an obstructed, infected kidney

Despite antibiotics, patient died from sepsis

THANK YOU

ANY QUESTIONS?