Shared Insights

Coroners' Question Time

Nicola Evans – Browne Jacobson

Professor Alan Fletcher – National Medical Examiner for England and Wales

Mr Zak Golombeck – Area Coroner for Manchester City

Miss Louise Pinder – Assistant Coroner for Derby and Derbyshire

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Browne Jacobson

Introduction

This session focussed on the role of the Medical Examiner when a death occurs and the initial stages of the Coroner's investigation.

We were delighted to welcome our panel:

- Professor Alan Fletcher – National Medical Examiner for England and Wales
- Mr Zak Golombeck – Area Coroner for Manchester City
- Miss Louise Pinder – Assistant Coroner for Derby and Derbyshire

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Statistics

Professor Fletcher began by setting out some statistics:

- In 2022, there were 577,000 deaths in England and Wales. This was a fall of 11,000 from 2021 but was 30,000 more than the average over the previous 5 years.
- The Office of National Statistics predicts an increase of 8,000 deaths in 2023.
- In 2022, 36% of deaths were notified to Coroners - this was a fall from 2016 when 46% were notified, but an increase from 33 % in 2021 The reasons for the increase are multifactorial and complex.
- 16% of registered deaths had post-mortem examinations.
- However, 6.2% of all registered deaths that resulted in an inquest did not have a post-mortem examination.

Medical Examiner perspective on notification of deaths to the Coroner

Professor Alan Fletcher – National Medical Examiner for England and Wales

Medical Examiner perspective on notification of deaths to the Coroner

- When someone dies, a doctor involved in their care has to complete a Medical Certificate of Cause of Death (MCCD), which is then forwarded to the register office to register the death.
- Doctors formulating a cause of death do so from a medically informed perspective.
- There are certain circumstances in which the death must be notified to the Coroner. These are set out in the Notification of Deaths Regulations 2019: the death MUST be notified to the Coroner where there is reasonable cause to suspect that the death was due to (that is, more than minimally, negligibly or trivially) caused or contributed to by specific circumstances, which are listed in the Regulations.
- There appears to be varying levels of knowledge and understanding of the Notification of Deaths Regulations 2019 by those required to report deaths. This can be further confused by local practices developed around the country.
- It is imperative that doctors understand their duty under the Notification of Deaths Regulations 2019.
- There is an incorrect assumption that notification to the Coroner automatically leads to an inquest. That is not the case but the doctor's role is not to second guess a Coroner's judicial decision. Where a death falls into one of the categories listed in the Notification of Deaths Regulations 2019 the Coroner should be notified, and it is the Coroner who makes a decision about how to proceed from there.
- If a doctor has questions about the cause of death, or about completing the Medical Certificate of Cause of Death, they should discuss these with a Medical Examiner.
- Medical examiner offices in England are based at acute trusts (and a small number of specialist trusts). They are staffed by a team of medical examiners, supported by medical examiner officers. The role of these offices is to examine deaths to:
  - Agree the proposed cause of death and the overall accuracy of the MCCD with the doctor completing it.
  - Assist the doctor to determine whether or not a death needs to be notified to the Coroner.
  - Discuss the cause of death with bereaved people and establish if they have questions or any concerns with care before death.
  - Act as a medical advice resource for the local coroner
  - identify cases for further review under local mortality arrangements and contribute to other clinical governance processes.
- The Medical Examiner will conduct a proportionate review of relevant medical records and will speak to medical practitioners and relatives of the deceased. Like the inquest process, the Medical Examiners' office will put the deceased and the bereaved at the centre of the process.
- Progress is being made towards implementing the statutory medical examiner system. In the coming months we expect the government to publish the draft regulations and to commence the relevant secondary legislation. It is anticipated that legislation will simplify and improve the death certification process, especially for bereaved people.
- Each year the National Medical Examiner publishes a report to show progress with implementing the medical examiner system, milestones achieved, examples of the impact medical examiners are having, and details of key activity during the period covered by each report. You can read these here.

Coroners' perspective on death notification

Mr Zak Golombeck
Area Coroner for Manchester City

Miss Louise Pinder
Assistant Coroner for Derby and Derbyshire

Coroners' perspective on death notification

Mr Golombeck and Miss Pinder spoke about the role of the Medical Examiner and what happens next, once the Coroner has been notified of a death:

- For a properly functioning service you need collaboration with the Medical Examiner.
- There is a view that those reporting deaths are not utilising the resource of the Medical Examiners' office enough.
- The Medical Examiner can assist the reporting doctor to formulate the proposed cause of death and complete an accurate MCCD (if appropriate).
- The Medical Examiner can also help the doctor to determine whether or not a death needs to be notified to the Coroner.
- There are scenarios where the medical cause of death appears to be natural causes but family or clinicians have raised concerns about some aspect of the care and treatment. This is where the Medical Examiner's scrutiny can be so helpful. Following discussion with the Medical Examiner, consideration can then be given to how best to deal with any family concerns, for example by referral to PALS regarding concerns raised about food.
- It will be obvious that some concerns are not relevant to the death i.e. there is no reasonable cause to suspect that they have more than minimally contributed to the death.
- However, if there are concerns regarding clinical care which are relevant to the death (e.g. observations not being undertaken or medication not given), that would be sufficient from the Coroner's perspective to have reasonable cause to suspect that the death is unnatural and to require notification. The Medical Examiners' office can and does assist in respect of causes of death and medical causation. However, the Medical Examiner will be careful not to make decisions about causation which should be subject to a Coroner's judicial decision.
- Where the cause of death is not known, liaison with the Medical Examiner's office is important as this can sometimes assist with formulating the cause of death. If a cause of death cannot be ascertained following discussion with the Medical Examiners' office then the death must be notified to the Coroner and the notification should make it clear to the Coroner why the cause of death is unknown.

Coroners' perspective on death notification

Mr Zak Golombeck
Area Coroner for Manchester City

Miss Louise Pinder
Assistant Coroner for Derby and Derbyshire

Coroners' perspective on death notification

- Notification to the Coroner does not necessarily mean there will be an inquest. The majority of cases are dealt with by way of investigation and no inquest.
- The question for the Coroner is whether the statutory duty to investigate the death is triggered. This is set out in Section 1 of the Coroners and Justice Act 2009, which states that the Coroner has a statutory duty to investigate if he or she has reasonable cause to suspect that:
  - the deceased died a **violent** or **unnatural death,** or
  - the **cause of death is unknown**, or
  - the deceased died while **in custody or otherwise in state detention**.
- Once the Coroner has been notified of a death, a decision will be made by the Coroner as to what investigations (if any) are required. The Coroner will have a number of options:
  - Conduct **preliminary inquiries** to ascertain whether the Coroner's statutory duty to investigate the death is triggered. If the Coroner is satisfied that the deceased died a natural death, the cause of death is known and they did not die in custody or state detention then the death will be registered with no further investigation.
  - Conduct an **investigation**. This may include Post Mortem examination (either a full Post Mortem or by CT), toxicology analysis, and gathering some factual evidence). The Coroner will decide the type of investigations required but will take into account the deceased's views/beliefs as well as the family's. If at the conclusion of this investigation the Coroner is satisfied that the deceased died a natural death, the cause of death is known and they did not die in custody or state detention, the investigation will conclude without an inquest.
- Conduct an **inquest**. There will be some cases where it is clear from the outset that the statutory duty to hold an inquest is triggered and others where an investigation will be opened and then converted to an inquest when it becomes clear that the statutory duty is triggered i.e. the deceased died a violent or unnatural death, the cause of death is unknown or the deceased died in custody or state detention. If the statutory duty is triggered the Coroner has no discretion and must hold an inquest into the death.
- The purpose of the inquest as set out in Section 5 (1) of the Coroners and Justice Act 2009 is to ascertain:
  - **Who** the deceased was
  - **how**
  - **when** and
  - **where** the deceased came by his or her death.
- No matter whether the Coroner is sitting a 3-week Article 2 inquest, a half day inquest or a documentary inquest, the role of the Coroner is to determine who has died, when did they die, where did they die and how the individual came by their death.
- The first 3 questions (who, when and where) are almost always the most straightforward to answer. It is the question of "how" which often requires further analysis and becomes the focus of the inquest hearing. This includes but is not limited to the cause of death. For example, if a fall caused the death, there will also be consideration of the reason for the fall.
- Coroners must determine the medical cause of death and the particulars set out in the Births and Deaths Registration Act 1953.

Questions discussed by the Panel

Should all child/neonate deaths be notified and investigated by the Coroner?

The death of a child or neonate is not a special category of death for the Coroner's purposes and the usual notification requirements apply. The Notification of Death Regulations 2019 apply to all deaths and do not differentiate between children/neonates and adults.

When a patient dies in hospital and the police are investigating the circumstances which led to the admission, whose responsibility is it to notify the Coroner?

Multi-disciplinary liaison is very important in this kind of situation. As the death occurred in the hospital – it will be for the hospital to notify the Coroner of the death.

When asking the family to outline any concerns, is there an expectation on the Medical Examiner to filter out what may or may not have contributed to a death before notification to the Coroner?

Yes. It is important to listen to the family's concerns. It is also important to recognise that there are a range of concerns raised, some of which may relate to the clinical care, but also some that may relate to other aspects of the care which would not be causative of the death (cleanliness of rooms, food etc).

Family concerns are not automatically referred to the Coroner. The Medical Examiner may be able to resolve some or all of these concerns at an early stage. There were comments from delegates reporting their positive experience of the Medical Examiners helping to resolve family concerns and providing an early opportunity to explore these and provide explanations to families.

The panel agreed that if the family's concerns remain unresolved / or family are steadfast in their concerns about care – it would be advisable that those cases are notified to Coroners for an independent investigation to be undertaken.

Access to the Medical Examiner's review by Trusts and other parties

The Medical Examiner does not produce a formal report.

General unfettered access to the information held by Medical Examiner's office is not permitted and would give rise to data protection issues.

However, where the Medical Examiner has reviewed a death and identified concerns Professor Fletcher's view is that this information should be shared with the relevant parties as soon as possible so that the concerns can be addressed for safety and learning purposes.

A medicolegal expert commented that he often learns a lot from coroner's inquests and asked: what is the best way to disseminate this learning that improves wider clinical practice?

Learning should be fed back through the usual governance channels within the organisations involved. Contact the local Patient Safety Team to provide your reflections.

Where NHS Resolution is involved in an inquest (because there is also a compensation claim underway in relation to the death) then learning can also be fed back through NHS Resolution, either via the panel solicitor or claims handler or direct to the Safety and Learning team.

Coroners also have an important Patient Safety role under Regulation 28 of the Coroner's (Investigations) Regulations 2013. This creates a statutory duty for Coroners not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths (PFD Report). You can read more about this in our Guide to providing organisational learning evidence to Coroners.

Questions discussed by the Panel

Questions

The panel were asked for their insights into the use of CT post mortems

One challenge faced by Coroners is that there are not enough pathologists to undertake coronial post mortems. There are also a limited number of pathologists specialising in areas such as maternal deaths. This should not influence the Coroner's decision where a Post Mortem is required, but it does mean that it may take longer for the body to be released while waiting for a Post Mortem and also that Coroners cannot simply ask for a Post Mortem in every case. Careful thought needs to be given to whether this will assist the Coroner's investigation.

In some cases, the cause of death offered at the time of the death notification may be accepted by the Coroner. Therefore, no further investigation may be required. However, if further investigation is required then it is for the Coroner to decide what these further investigations should be and whether for example to arrange an invasive post mortem or a CT post mortem. CT post mortem can assist in establishing a cause of death without interfering with the deceased's body, and can be undertaken more quickly than an invasive autopsy. There may also be scenarios where it would not be appropriate for an invasive autopsy to be undertaken as the cause of death can be established without one (for example with a death due to hanging). However, it is important to remember that there are other investigations, such as toxicology that may need to be undertaken to assist the Coroner.

As part of this decision making process, there needs to be care taken to recognise and respect the faith and beliefs of the deceased and their family. However, the risk that the advent of CT Post Mortem may exacerbate health inequalities was put to the panel. There was some discussion about the importance of not making assumptions about the deceased's cultural beliefs. The panel discussed the importance of clear communication to the family, with thought given to the language barriers and support to ensure that the family are able to express their views clearly at a time when they are bereaved and grieving and may struggle to understand the significance of the information they are being asked to process.

The Chief Coroner has published guidance on the use of Post Mortem Imaging.

Further Questions

There were a number of further questions raised in the chat which the panel did not have time to address. We have set these out below with some insights and thoughts from the panel in response:

In the current NHS climate, harm from delays to treatment due to operational /resource pressures is becoming a concern - I would be interested to hear the views about referring deaths to the Coroner's service when the death has occurred whilst a patient is on a waiting list for an operation, for example. These are cases where there may not be any culpable human failing but the delays are symptoms of operational pressures - are these unnatural?

Professor Fletcher intends to prepare a Good Practice Series guide to Medical Examiners on this matter. Keep an eye out for this and other useful guidance on the National Medical Examiner webpage.

Is there also clear guidance for Medical Examiners/ Coroners around feedback and liaison with Children or Adults' services who are often running Serious Case investigations concurrently? It can at time be challenging to get updates regarding Cause of death/ Coroners investigations/ inquests updates even though both are following processes seeking an understanding that led to the death of someone. Do you feel this communication could be improved?

We are not aware of any specific guidance, but we would support consistent, helpful communication where investigations are being conducted.

In the context of the Chief Coroner's Guidance no.45 if there are 'signs of life' in the context of termination of pregnancy must this be reported to the coroner?

As per the guidance; "a child who is born showing signs of life, whether that is prior to the 24th week of pregnancy or after it, has had an independent life and that child's death must be investigated if section 1 Coroners and Justice Act 2009 is engaged. This is so even where the mother's pregnancy was intentionally terminated. If there is doubt over whether a child was born alive, that is a matter for the coroner to determine."

Once the Medical Examiner service is on a statutory footing what will the consequences be to primary care if they do not refer a natural death to the ME service or refuse to provide access to the deceased's records?

A death will not be registrable if a medical certificate of cause of death (MCCD) is written but not confirmed by a Medical Examiner after scrutiny. It will be a statutory requirement for a certifying doctor to notify a Medical Examiner and provide access to records. Compliance with statutory requirements is set out by the GMC.

What will be the mechanism in the statutory system to help with second guessing registrar decisions/ having referrals made to hmc for cases we are sure are not unnatural but registrars will not accept it?

A summary of the new processes is to be published alongside the new draft regulations, and so further explanation on this point should follow shortly.

Top Tips,

Resources

&

How we can help

Top Tips from the panel

- Collaboration between all the parties when notifying a death is key. This includes; Hospitals, Coroners, Medical Examiners and registrars registering the death.
- The Medical Examiner's Office can help formulate an accurate cause of death and help ensure you comply with your statutory duties under the Notification of Deaths Regulations.
- If you are notifying a death, make use of the Medical Examiners office as a resource and the local Coroner's Office for practical advice.

Resources

Browne Jacobson have produced a range of resources to help organisations and witnesses involved in the inquest process, which are available all free of charge on our website:

- Inquest Guide for Clinical Witnesses
- Writing Statements for an Inquest
- Checklist when preparing for remote participation in an inquest hearing
- Mitigating the risk of a report for the prevention of Future deaths
- Mock inquest training video and other inquest resources

NHS Resolution have also produced some free resources which you can access here.

Please join us for our next Shared Insights Sessions:

- On 23 January 2004 we are jointly hosting a Shared Insights session with Irwin Mitchell and NHS Resolution when we will be joined by the **Chief Coroner His Honour Judge Edward Thomas Teague KC** to discuss **Improving communication with families through the inquest process**. You can book your spot **here**.

Call for Evidence!

You may be aware that the Justice Committee has launched a new inquiry into the Coroner Service and has invited written submissions by 15 January 2024 addressing a list of specific questions. Browne Jacobson is compiling a response and we held a Shared Insights session on 12 December to collate feedback from health and care professionals across the system. If you would like to feed your comments into our response, please do get in touch with Nicola (Nicola.evans@brownejacobson.com).

Other ways we can help

Our specialist team can support you and your staff through the inquest and litigation process. Including;

- Deep dives of claims/inquests to assist with identifying your risk profile, trends and themes to drive learning from claims and inquests and turn this into measurable patient safety improvements.
- Support and training in relation to Inquests. There are still spaces available on our next Mock Inquest which starts in February 2024. If you have a number of people who would like to attend, please contact Nicola.Evans@brownejacobson.com to discuss block booking rates

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