The Association of Greater Manchester LMCs

Reporting deaths to HM Coroners in Greater Manchester

(February 2019)

Background:

The HM Senior Coroners issued new and revised guidance in May 2018 on which deaths are reportable. The Association of Greater Manchester LMCs convened a meeting with the Coroners to clarify the full detail. This document has been produced as a result of this meeting and provides the GM Coroners' guidance and explanatory notes and examples where this was felt to be useful for GPs.

Coroners' contact details:

Mr Nigel Meadows, Senior Coroner

Manchester City - Central Manchester

coroners.office@manchester.gov.uk Tel: 0161 219 2222

Ms Joanne Kearsley, Senior Coroner

Manchester North - Oldham, Rochdale & Bury

coroners.office@rochdale.gov.uk Tel: 01706 924 815

Ms Alison Mutch, Senior Coroner

Manchester South - Stockport, Tameside & Trafford

coroners.office@stockport.gov.uk Tel: 0161 474 3993

Mr Alan Walsh, Acting Senior Coroner

Greater Manchester West - Bolton, Salford & Wigan

coroners@bolton.gov.uk Tel: 01204 338 799

Coroners' guidance (May 2018):

A death should be reported to the Coroner when a Doctor knows or has reasonable cause to suspect that the death:

- Occurred as a result of poisoning, the use of a controlled drug, medicinal product or toxic chemical
- Occurred as a result of trauma, violence or physical injury, whether accidental, inflicted intentionally or otherwise;
- All deaths which occur within 24 hours of an admission to hospital. This does not apply to hospices unless there is another criterion, which means the death must be referred to the coroner
- Is related to any treatment or procedure of a medical or similar nature this includes *but is not limited* to the following:
    - Operations
    - Complications of any procedures
    - Medical Equipment Failure
    - Antibiotics
    - Immunotherapy
    - Chemotherapy
    - Anti-Coagulation
- Occurred as a result of self-harm (including failure by the deceased person to preserve their own life) whether intentional or otherwise
- Occurred as a result of an injury or disease received during, or attributable to, the course of the deceased person's work;
- Occurred as a result of a notifiable accident, poisoning or disease;
- Occurred as a result of neglect or failure of care by another person;
- Was otherwise unnatural for example following submersion or found in water

- Is reportable as detailed in the General Register Office Cause of Death List
- All cases where the deceased is aged 18 or under
- The death occurred in custody or otherwise in State detention -of whatever cause
- No medical practitioner attended the deceased at any time during the course of their last illness or where no attending medical practitioner is available by the close of business the next working day to prepare a Medical Certificate of Cause of Death (MCCD)
  (please see explanatory notes below)
- The identity of the deceased is unknown

Practitioners should ensure they are familiar with the General Register Office Cause of Death List. There is a scanned copy of this list enclosed with the communication (it is difficult to get an electronic copy of this information)

Explanatory Notes

Reporting can only take place where death has been verified, and not before.

It is a common misconception that any death where the doctor has not seen the patient within 14 days prior to death is reportable. This is incorrect. A doctor may issue an MCCD where they have *treated* the deceased person during and with regards to their final illness AND where they have EITHER seen the person alive within 14 days prior to death OR after death and where the death is not otherwise reportable to the coroner for any other reason.

Treatment in this context must be in relation to the condition that led to the person's death. As a general rule, *treatment* implies a face-to-face contact. In some instances, other modes of contact e.g. a video consultation may suffice. The MCCD requires

that the “date last *seen*” is stated. For this reason, treatment without *seeing* the patient e.g. issue of a prescription or a telephone consultation will not be sufficient. If in any doubt, err on the side of reporting the death.

The requirement to prepare an MCCD on the next working applies *only* where there is no Statement of Intent (SoI) or equivalent Special Patient Note (SPN) in place. Where a Statement of Intent or similar is in place, the death was, by definition, not Coroner reportable. In these instances, the GM Coroners have no specific expectation as to how soon after death the MCCD is completed, provided it is issued as soon as possible. If there are any unforeseen delays then the surgery should liaise with the family of the deceased and the nominated funeral director.

Please note that the definition of (reportable) *unnatural* death includes circumstances where an illness was induced by the illicit use of drugs, e.g. liver conditions secondary to hepatitis C where the person was an IV drug user. In contrast, death caused by liver disease triggered by legal substances (alcohol) is not reportable. Another example of an unnatural death is a death secondary to a haemorrhage, where such bleed may be due to their use of anticoagulants.

Doctors should be aware that it is not necessary to be 100% certain as to the cause of death. The cause of death is established on the balance of probabilities. It must be more likely than not based on all the information you are aware of i.e. the circumstances of the death and the patient’s medical history.

Do not put “unknown cause of death”. This is not acceptable and will be rejected by the Registrars.

Please note, in cases which are reportable some Coroners require a copy of the MCCD faxing or sending to them with a death report. This is to ensure the MCCD you are willing to provide has the same cause of death reproduced on any Coronial

paperwork (the A form), if the cause of death is accepted by the Coroner. In these cases, you will provide the paperwork, MCCD, to the family once Coroner approval is received. It is therefore important you do not alter the cause of death after this. The Coroner will forward the registrars the A form.

Authors:

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