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

Coroners' perspective on death notification

Mr Zak Golombeck
Area Coroner for Manchester City

Miss Louise Pinder
Assistant Coroner for Derby and Derbyshire

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 Golombek

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).

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

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

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.