

City of Wakefield Metropolitan District Council

Policy on Notification of Deaths to HM Coroner

1. Purpose and Background

The role of HM Coroner is to ensure that the circumstances of deaths are subject to scrutiny, and in particular that violent, unnatural or unexplained deaths are accorded a full medico-legal investigation and, if necessary, an Inquest. Since the starting point for investigation is the Coroner being alerted to the fact that a particular death may be untoward, all individuals have a common law duty to report to the Coroner any deaths where an Inquest may be required¹.

Furthermore, a recent Lords judgement² made clear that the Inquest into a death will ordinarily carry the function of an official public investigation into the duty³ to protect life with respect to the role of any 'agents of the state' who may be in some way implicated. Public authorities are therefore obliged in these circumstances to provide information to the Coroner that may assist in his/her decision as to whether to hold an Inquest, and not leave it to the next of kin to lodge a formal complaint.

The purpose of a Policy on Notification of Deaths to HM Coroner is to ensure that the Council and its employees carry out these duties effectively and consistently, and in a timely fashion, in support of the Coroner's own investigations into any untoward death.

2. Which cases need to be reported?

Although the Coroner's office is made administratively aware of all deaths that occur in Wakefield, not every death is "reported" to the Coroner in the sense of suggesting a need for further investigation, and nor is it necessary that they should be. A death can quite properly be registered and a body released for disposal by the Registrar for Births, Deaths and Marriages, provided that the death does not fall within the categories requiring further investigation. (This policy does not require any change in the way that Register Office staff carry out their duties.)

¹ *The law and practice on coroners*, Knapman & Powers, Chichester: Barry Rose 1985

² R. v. HM Coroner for the Western District of Somerset ex parte Middleton

³ Under Article 2 of the European Convention on Human Rights

However, there is limited awareness about which cases **do** need to be reported to the Coroner, not least because of the lack of clear statutory guidelines to support the common law duty to report.

The accepted legal position is that the Coroner needs to consider all cases where:

1. the death might have been due to or contributed to by a violent or unnatural cause (including an accident);
2. the cause of death cannot be identified;
3. the death might have been due to or contributed to by drugs, medicine, abortion or poison.

More detailed criteria are set out in Appendix 1.

The reporting responsibility is both an individual responsibility to report relevant information to the Coroner and a Corporate responsibility to ensure that Council employees comply with their individual duties. It is incumbent on the Council to support its employees in duties, which arise from their work, and it is clearly in the interests of the Council to ensure the efficient and effective transmission of relevant information to the Coroner.

There is an important time constraint in the very early stages after a death occurs, in that the decision about whether to hold a post mortem needs to be made before the body is released for burial or cremation. In effect, this means that an initial report to the Coroner must normally be made within **one working day** of the death.

3. Learning of a death

Information on deaths occurring in Wakefield is passed each month from the Coroner's Office to the Council and is used, for example, to trawl and update RAISE. This is a list of **all** deaths, and does not mean that any of these deaths have been "reported" to the Coroner in the sense of suggesting the need for a Coroner's investigation.

Knowledge of a death is also logged in the Council in a variety of other ways, formal and informal. However, in none of these processes is the information intended to be used to make judgements about the circumstances of the death, and in the vast majority of cases formal information will not arrive quickly enough to allow an initial report to the Coroner to be made within the required timescale.

Formal logging processes therefore cannot be relied upon to assist significantly with the responsibility to report sudden or unnatural deaths to the Coroner on a timescale of one working day from the death, and it will be necessary to make use of person-to-person communication between staff.

4. Clarifying the circumstances of the death and which deaths should lead to an initial report to the Coroner

The reporting duty is principally concerned with deaths of service users. These deaths fall into one of two categories:

- a) **Expected deaths:** these are deaths, which have been expected, where plans for the death are in place, the cause of death is known and there are no suspicious circumstances to suggest that anything untoward has occurred. This will usually be case for terminal illnesses, for instance.

There is no necessity to report the circumstances of these expected deaths, except as required under administrative systems which ensure cessation of services and charging and updating of RAISE and other Council databases.

- b) **Sudden or untoward deaths:** these are deaths which were not expected, **or** where the circumstances of death differ significantly from those anticipated, **or** where any professional, or relative, or anyone else with a legitimate interest has raised concerns about the death. It is these deaths which may need to be reported to the Coroner.

For people who are not current service users but with whom the Council has current contact (para. 5.1), it should be initially assumed that the death falls into category (b) unless there is clear evidence to the contrary. All deaths to which the Social Services Serious Incident Procedure applies should be included in this category.

5. Procedure for determining which deaths should be notified to the Coroner

Whenever any member of staff becomes aware of a sudden or untoward death (as described in para.4.1 (b)) they must immediately notify their manager, who will complete the Format for Report to HM Coroner and fax it to the Coroner's office. If a manager is not available then the worker should do it. The manager should liase with and brief their Head of Service

This requirement applies to deaths of:

- current (or recent) service users, including in-house services or services that the Council contracts for or has otherwise arranged);
- anyone not currently receiving services but who is an open or pending case to a social worker or social work team.

The lead manager, must consider whether the death satisfies the criteria set out in Appendix 1 and/or whether further information or advice is required in order to make that judgement.

If there is any doubt about whether the criteria for reporting are satisfied, the lead designated manager should seek advice from a senior manager and/or from Legal services (see contacts list).

If this is not possible within one working day, the manager should discuss the case directly with one of the Coroner's Officers (see contacts list) and agree whether a report is required, and on what timescale. The response may of course be that the Coroner has already been made aware of the death.

6. Procedure for Reporting Deaths to the Coroner

The Initial Report should be made by fax to the Coroner's office (see contacts list) as soon as possible, and in any case **within one working day** of the death, giving the details required on the form (Appendix 3).

A report must then be made to the responsible Senior Manager within the relevant directorate, repeating the details already reported to the Coroner but giving full details of the circumstances so far as they are known. This further report must also give details of the role of the Council both at the time of death **and** during any preceding period that appears to be relevant. Full details of any issues that raise concern should be included in the report (using the outline format of the Initial Report).

If an independent sector service provider or an Arms Length Provider is linked to the death in any way, discussion should take place with the contracts support officer in the relevant directorate with a view to ensuring that the service provider also makes a prompt report to the Coroner.

7. Other Matters

If the manager making the initial report to the Coroner considers that the circumstances of the death may indicate a risk to others, they must immediately report this to a senior manager, who must decide on the basis of relevant directorate policy what further immediate action should be taken.

Fatalities to staff, service users or members of the public arising out of our work activities must also be reported to the Health and Safety Executive under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations). The manager made aware of the death must, as soon as possible, telephone Human Resources who will complete the necessary report form with the manager's assistance. If the manager is unsure about whether or not a death should be reported, they should contact the Health and Safety

Adviser for the relevant directorate. Guidance on RIDDOR can be found on the intra net.

In cases where immediate and serious risk to service users is perceived the relevant Senior Manager must be informed without delay and an assessment of risk carried out and appropriate action taken.

A death which satisfies the criteria for reporting to the Coroner potentially may well also satisfy the criteria for a other reporting systems within the relevant directorate e.g. Social Services Serious Incident Policy. Similarly, a serious incident which involves a death will almost certainly be reportable to the Coroner. Senior Managers should therefore operate the reporting procedure in parallel with other relevant reporting procedures.

Deaths in registered social care services must always be reported to the Commission for Social Care Inspection as Regulation 37 Notifiable Incidents.

8. Who needs to be made aware of the information that has been given to the Coroner?

- Information sent to the Coroner should always be copied to:
The relevant Head of Service and Executive Director
- The Principal Solicitor
- The Organisational Development Manager (Occupational Health and Safety)
- The senior manager in the Corporate Media Relations Team)

Directorates may wish to designate a list of other officers within their own Directorate who must be also be copied in.

9. Further Liaison with the Coroner

Once the report has been sent, further liaison with the Coroner's office or with any investigating officer acting on behalf of the Coroner, and any preparation for involvement in an Inquest, should be governed by the each Directorate's Policy for handing Serious Incidents.

10. Links to other policies and procedures

There are clear and obvious links to the following policies and this policy should be read and operated alongside them.

- Serious Incident Policy (for Directorates where these are in place)

- Policy Statement and Procedure Guideline, Notifiable Incidents: Death, Illness and other Events
- Adult Protection Policy & Procedures
- Child Protection Policy & Procedures
- RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)

11. Impact

The benefits of an effective reporting system will include:

- early identification of the need for staff to act as witnesses at an Inquest
- opportunities for gleaning information by which services can be improved, enabling risks to service users and the Council to be better managed, and
- enhanced confidence in Council-run and Council-commissioned services.

Appendix 1

Criteria for Reporting of Deaths to HM Coroner

A1.1 In general, the coroner will want to consider further investigation where there are:

- a) suspicious circumstances
- b) any history of violence
- c) the possibility of self neglect or neglect by others
- d) the deceased might have contributed to the death.

A1.2 More specifically, deaths should be reported if any of the following circumstances apply:

- a) where a certificate of natural cause of death cannot be readily provided by a doctor;
- b) where the death appears to have been unnatural, unexpected or to have been caused by violence or neglect;
- c) where there is an allegation of medical or nursing mishap;
- d) where there has been a fracture or a fall;
- e) death from drugs taken for any reason;
- f) death due to alcoholic poisoning;
- g) death that may be linked to an accident even if a long interval has passed in between accident and death;
- h) suspicious circumstances or history of violence;
- i) self neglect or neglect by others;
- j) where the deceased may have contributed to his or her own death.

This is not an exhaustive list, and if in any doubt about whether to report, further advice should be sought in line with paras. 5.4 and 5.5 of the policy

Appendix 2: Contact numbers

Coroner's Officers for Leeds:

H M Coroner's Office
Symons House
Belgrave Street
Leeds
LS2 8DD

Tel: 0113 2432963

Fax: 0113 2448585

E-mail: leedscoroner@wakefield.gov.uk

Coroner's Officers for Wakefield and Pontefract:

71 Northgate
Wakefield
WF1 3BS

Tel: 01924 302180

Fax: 01924 302184

E-mail: hmcoroner@wakefield.gov.uk

Appendix 3

Report to HM Coroner

Report to HM Coroner of a death with which has come to the attention of Wakefield MD Council

This form is to completed as best you can and faxed to HM Coroner 01924 302184

Please ensure the report contains facts not opinions

Name of Deceased	
Date of birth if known	
Home address if known	
Date of death	
Place of death if known	
If you are able, give the names and addresses of those present at the death or discovery of the body	<ol style="list-style-type: none"> 1. 2. 3.

Name, work address and phone number of person making notification	
Briefly explain your involvement with the deceased and reason for making notification. Indicate if the council has knowledge of the deceased which other agencies reporting might not have.	
Details of a manager whom the Coroner can contact if he requires more information	
Name, number and station of any police officers involved if known	1. 2. 3.

Signed

Dated

Print name

Also copy this form by fax to:

Designation	Fax No.
Your Head of Service	
Your Executive Director	
Principal Solicitor (Litigation)	
Organisational Development Manager (Occupational Health & Safety) For logging.	
Senior manager for corporate media relations	

Appendix 4: Illustrative Case Scenarios

Case 1: A woman in her 70s is suffering from cancer and has been receiving a palliative care package for several weeks. A family member rings to let you know the woman has passed away peacefully.

Based on this information, you would not be expected to notify the Coroner of this death.

Case 2: A very disabled but otherwise healthy woman in her 80s is receiving home help three times a day. A family member rings to let you know that the woman fell at home yesterday and has been taken to hospital, and so does not require further services at present. Three weeks later you learn that the woman has died in hospital, but you do not know whether this is in any way connected with her fall.

Based on this information, you should notify the Coroner of this death. Whilst the Coroner might know of the death, he might not know of the fall.

Case 3: After a very cold night a middle-aged man is found dead at the rear of a Council building where he was known to shelter regularly on rainy nights. The police have attended and indicated that there are no signs of violence or injury, but the cause of death is not yet known.

Based on this information, you should notify the Coroner of this death.

Case 4: A Wakefield Homes manager reports that a mentally ill man in his 30s has been found dead in his flat, leaving a suicide note. The police have attended. **Based on this information, you should notify the Coroner of this death.**

Case 5: A female resident of your care home takes ill with pneumonia and dies the day after her 97th birthday. The doctor has attended and issued a death certificate.

Based on this information, you would not be expected to notify the Coroner of this death unless there were concerns or complaints about the care the woman had received.

Appendix 5: Frequently Asked Questions

Q1. Will I be criticised if I make a report to the Coroner and another Council officer has also made a report?

A. No you will not. If it is practicable to agree who will make the report to the Coroner then that is a sensible way to proceed, but should not delay making a report whilst you check out what everyone else is doing.

Q2: Will I be opening up the Council to liability by reporting a death to the Coroner?

A. No; so long as you are truthful and accurate to the best of your knowledge at the time this will not make the Council liable for anything.

Q3: If I only know part of the story should I wait until I have all other information before sending a report to the Coroner?

A. It is reasonable to gather together what you know into one report, but you should not delay reporting whilst you check into everything.

Q4: Can I take further advice before deciding whether to make a report to the Coroner?

A. Yes, if at all possible you should take advice from a more senior manager, or if this is not possible then from Legal Section. However, if you are unable to get advice within the required timescale (one working day), you will need to go ahead and make the report.

Remember: The Coroner may have already heard about the death but will be anxious to know whether anyone can add information he doesn't already know.