CHIEF CORONER

GUIDANCE No.23

REPORT OF DEATH TO THE CORONER

1. The Chief Coroner has drafted a template form for a doctor reporting a death to the coroner by electronic means. The form is attached.

2. Many senior coroners have their own forms. Some do not. The Chief Coroner's form does not have to be used to replace other forms. It is simply intended as a guide for coroners and local authorities where no form is used.

3. The form may be used as a Word document and sent to the coroner's office by email or it may be used as the basis for a web-based solution on the local authority website. Some coroners use the latter as part of a 'paperless' office approach. Some have persuaded hospitals to use software that populates some information automatically from hospital records on to a referral form.

4. In any event, the Chief Coroner now expects death referrals to be completed electronically. He requests senior coroners and their local authorities to take all necessary steps to achieve this. A referral form provides a permanent written and early record in the words of the doctor (not in the words of a coroner's officer interpreting a doctor's words on the phone). It concentrates the doctor's mind on the important details in advance of communication with the coroner. It reduces the number of telephone calls to the coroner's office and saves the time of coroners' officers.

5. It may sometimes be necessary for a phone call to follow, but the call, following receipt of the completed form, will be more focused and therefore more useful.

6. There are notes for the reporting doctor on the back of the form. They include the main reasons for referral.

7. There are, at present, no statutory criteria for medical practitioners reporting deaths to coroners. This has sometimes created uncertainty and inconsistency. When should a doctor report a death to the coroner? The answer to this question is not definite.

8. The notes for doctors attached to the Medical Certificate of Cause of Death state, under the heading *When to Refer to the Coroner:* 'There is no statutory duty to report any death to a coroner.' The notes to the MCCD, therefore, do no more than encourage doctors to report voluntarily any death which the registrar of births and deaths would need to refer to the coroner, as listed in paragraph 5.3 of

those notes. The list set out in the notes attached to the Chief Coroner's form broadly follows that same list.

9. It will be a matter for Parliament in regulations to decide what types of death should be referred to the coroner. Some other countries provide detailed criteria for reporting, for example in the New Zealand Coroners Act 2006 and the State of Victoria Coroners Act 2008 in Australia. In England and Wales Parliament has envisaged that the Lord Chancellor could make regulations 'requiring a registered medical practitioner, in prescribed cases or circumstances, to notify a senior coroner of a death of which the practitioner is aware': section 18, Coroners and Justice Act 2009 (not yet in force). Draft regulations are available, were the Medical Examiner scheme to be implemented.

10. In the meantime, coroners are advised to follow the list in the notes (attached to the Chief Coroner's form). The adoption by coroners of practices requiring reporting beyond the scope of the list is not helpful. It tends to provide inconsistency from one coroner area to another and to be confusing for doctors who work in different parts of the country. If coroners wish doctors to report using wider criteria than at present, they should lobby for change when draft regulations are being discussed before being brought into force.

HH JUDGE PETER THORNTON QC
CHIEF CORONER

27 July 2016