The Coroners Service

In Northern Ireland, coroners are independent judicial officers appointed by the Lord Chancellor, but hold office under the Crown. They must be a qualified and experienced barrister or solicitor. The Coroners Service is headed by a High Court Judge.

Coroners are supported by a dedicated staff based in Belfast. Police officers normally assist the coroners, for example, by obtaining medical notes and reports and making enquiries on behalf of the coroner.

Reporting deaths to the coroner

Section 7 of the Coroners Act (Northern Ireland) 1959 states: “Every medical practitioner…who has reason to believe that the deceased died…as a result of negligence or misconduct or malpractice on the part of others, or from any cause other than natural illness or disease for which he has been seen and treated by a registered medical practitioner within 28 days prior to his death, or in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic), shall immediately notify the coroner.”

Therefore deaths should be referred to the Coroners Service if there is reason to suspect that the death has been as a result of one of the following:

- A result of violence or misadventure or by unfair means
- A result of negligence, misconduct or malpractice of others
- From any cause other than natural illness or disease
- From natural illness or disease for which he had not been seen and treated by a registered medical practitioner within 28 days prior to his death
- In such circumstances as may require investigation
- In prison or in police custody (this list is not exhaustive).
- A death in hospital should be reported if:
  - You suspect that the deceased may have died as a result of medical negligence or misadventure, or in any of the circumstances listed above
  - The death occurred before a provisional diagnosis was made, and the GP is not willing to certify the cause
  - The cause of death is unknown
  - The patient died as the result of the administration of anaesthetic
  - The death was due to an industrial disease (e.g., asbestos related diseases).

You should not delay notifying the coroner of a death as this may delay the registration of the death and the release of the body for either cremation or burial, adding to the distress of the bereaved.

The Registrar General has an extra-statutory list of causes of death that are refeerable to the coroner, which includes industrial diseases and poisoning.

If you are unsure about whether or not to report a death, discussion with a senior colleague may help to clarify the issues. You can also contact the Coroners Service, who will be able to advise you whether a formal report is appropriate. Any such discussions should be documented carefully in the clinical records.

The coroner’s decision

Following the report of a death the coroner may adopt one of three courses:

1. Direct that the doctor should issue a Medical Certificate of Cause of Death (MCCD).

After discussion the coroner and doctor may agree that the cause of death does not need to be investigated and the MCCD can be completed. You should record the discussion in the patient’s notes. In order to complete the MCCD, the doctor must have seen and treated the patient within the 28 days leading up to the death.
Doctors should ensure that they follow the ‘rules for good practice’ for completing a MCCD, as set out in the Department of Health, Social Services and Social Security’s Guidance on death, stillbirth and cremation certification.

2. Allow the death to be processed under the “pro-forma” system.

The Coroners’ Pro-forma is a special form for stating the cause of death and providing brief particulars of the background circumstances. Normally, the coroner will agree to use the “pro-forma” system where:

- It is a natural death and the only reason a death certificate cannot be issued is that the doctor has not seen and treated the deceased for the condition from which they died within 28 days of death
- The cause of death is not a natural one but there are no suspicious circumstances
- The cause of death is not a natural one but a postmortem examination is unnecessary as a definite diagnosis had already been made.

A doctor should not proceed to use the “pro-forma” system for a death without having first agreed that course with the coroner.

The pro-forma should be sent immediately by fax and followed by hard copy to the Coroners Service. It should not be given to the family as they may confuse it with an MCCD and try to take it to the Registrar.

If the death was due to natural causes which a doctor is able to confirm, the coroner will advise the Registrar by issuing a Coroner’s Notification and the death can be registered.

3. Direct a postmortem examination.

A coroner will usually request a postmortem examination if there is uncertainty over the cause of death, or the death was sudden and the cause unknown.

If a postmortem is ordered then the death cannot be registered until the coroner’s investigation has been completed. However, the coroner’s liaison officer will provide the family with a “Coroner’s Certificate of Evidence of Death” which can be helpful in the administration of the Estate.

Once the investigation is complete, the coroner will decide whether to hold an inquest or, if this is not necessary, the coroner will issue a Coroner’s Notification to the Registrar of Deaths.

If an inquest is to be held, witnesses may be called to give evidence in person or required to submit written evidence to be presented at the inquest.

The GMC’s Good Medical Practice states: “You must co-operate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality.”

In relation to hospital deaths, the police officer will normally require a member of staff to formally identify the body.

If the coroner directs a postmortem examination, the doctor who reported the death should prepare a clinical summary for the pathologist.

Stillbirths

A judgment handed down by the Court of Appeal in Northern Ireland concluded that in relation to the Coroners Act 1959, the definition of a deceased person includes “a foetus in utero then capable of being born alive”. When dealing with cases of stillbirth, practitioners should consider their obligations to notify the coroner in accordance with Section 7 of the Act.

In December 2014, the Chief Medical Officer and Chief Nursing Officer issued a letter to assist medical practitioners in deciding the circumstances in which cases should be reported to the coroner. The letter explains that if the demise of a fetus occurs early in pregnancy, at a point when independent life is not possible, then it will not be a fetus capable of being born alive and therefore should not be reported to the Coroner. Although the legal age limit for viability is 24 + 0 weeks, the letter advises doctors to give consideration to the emerging evidence of the increased survival of babies born from 23 weeks onwards.

Equally, if the demise of a fetus in utero occurs as a result of some defect which would mean it would not survive birth, the Chief Medical Officer explains that it would not be capable of being born alive and should not be reported to the coroner. It is emphasised that if there are doubts about the demise of the fetus or the mother has concerns, the circumstances should be reported to the coroner.

Registration of a death

Before a death can be registered, there must be either a properly issued MCCD issued by a registered medical practitioner (the death certificate is issued by the Registrar of Births and Deaths) or a certificate from a coroner issued after appropriate investigations.
If you are the attending medical practitioner in a patient’s last illness, you are required by law to sign a certificate stating the cause of death to the best of your knowledge and belief. This must be submitted by the informant to the Registrar of Births and Deaths. However, if the death has been or will be referred to the coroner, you should not complete the MCCD until the matter has been discussed with the coroner. The certificate is a legal statement and medical practitioners are obliged to take reasonable steps to check the information. Relevant information must not be deliberately left out.

Other functions of the coroners

A coroner must also be notified in every case when a body is to be taken out of Northern Ireland. Coroners also currently have responsibility for investigating when treasure is found in their district.

Further information

- Coroners Service for Northern Ireland – www.coronersni.gov.uk/
- General Register Office – www.groni.gov.uk/