The Newcastle upon Tyne Hospitals NHS Foundation Trust

Reporting Deaths to the Coroner
The Regulations on Cremation, with notes on the completion of Cremation Forms

Version No.: 3.3
Effective From: 22 November 2016
Expiry Date: 22 November 2019
Date Ratified: 26 July 2016
Ratified By: Clinical Policy Group

1 Introduction

The death of a loved one is an extremely distressing event for family members and friends. Many of them struggle with the formalities surrounding death certification, registration of the death and arrangements for cremation.

Failure to complete, in a timely fashion, the relevant paperwork causes enormous distress to families and seriously adverse publicity for the Trust.

Inadvertent breaches of the regulations surrounding reporting of deaths to the Coroner and failure accurately to complete the various forms required for cremation causes delay and huge distress. It can at worst lead to delay in funeral arrangements.

A detailed understanding of the regulations is necessary to avoid this. Junior doctors unfamiliar with their obligations and the relevant statutes should take advice from the responsible Consultant or their designated deputy at an early stage.

The Senior Coroner for the City of Newcastle upon Tyne or the Coroner’s Officers are happy to provide advice and to discuss individual cases with clinical staff.

They can be contacted on 0191 277 7280/07795238758. Both the Senior Coroner and the Coroner’s Officers are available on call continuously should an urgent situation requiring advice arise.

When contacting the Coroner’s Office or reporting a death it is essential that you are fully familiar with all aspects of the patient’s history. You must have all necessary information to hand and be prepared to respond to the questions which will be asked.

If you do not feel sufficiently well informed about any aspect of the case you should ensure that a more senior member of the team with all the relevant information contacts the Coroner’s Office.

2 Scope

This document is designed to provide some of the relevant background information and to assist in completing the relevant forms in an accurate and timely fashion.
3 Aims

This policy aims to ensure that all appropriate staff are aware of the requirements for reporting deaths to the coroner and to ensure required documentation is processed in a timely manner to prevent avoidable delays.

4 Duties (Roles and responsibilities)

4.1 Trust Board

The Trust Board is responsible for ensuring that a robust system exists within the Trust for reporting deaths to the Coroner.

4.2 Medical Director

The Medical Director is the Executive Lead for reporting deaths to the Coroner and hence has ultimate responsibility for the policy.

5 Definitions

There are no specific definition requirements in the policy.

6 Deaths which should be reported to the Coroner

6.1 Deaths occurring as a result of poisoning, the use of a controlled drug, medicinal product, or toxic chemical

This has wide application and applies to drugs of abuse and medicines (prescribed and otherwise) in addition to conventional poisons. The essential question is whether the use of the substance (however well intended) may have made a contribution to the death.

The substance does not need to be wholly responsible for the death. The fact that it has contributed is sufficient to require a report.

A death arising from a recognised side effect of a medicinal drug is an unnatural even though the situation is known to occur from time to time.

Toxic chemicals includes substances used as legal highs and any other such products not yet banned.

6.2 Deaths occurring as a result of trauma, violence or physical injury, whether inflicted intentionally or otherwise

A death is reportable where any trauma has contributed to the death no matter how innocent or accidental. The immediate cause of death is not the determinative issue. For example bronchopneumonia is a natural cause but if it has arisen through immobility following trauma then the death must be reported.
There is no time limit between trauma and death. Even if the incident leading to the trauma occurred many years prior to death, the death remains reportable.

6.3 Deaths related to any treatment or procedure of a medical or similar nature

This is a wide ranging category. It involves surgery, diagnostic or therapeutic procedures/investigations or anaesthetic. Anything done to a patient that is related to the death - it does not matter that the reaction or effect is a known complication of the procedure. The death is still unnatural and thus reportable.

This is not an issue of fault. It does not matter that the treatment was necessary to prolong life. The death is unnatural and must be reported.

There are no time limits. If there is reason to suspect that the death may have been contributed to by the treatment or procedure, even if it were years before, the death is reportable. In addition, if the patient is to be cremated and has undergone any operation in the year prior to death the coroner should be informed.

If there are actual or potential expressions of concern regarding a patient’s care/treatment/management the death should be reported.

6.4 The death occurred as a result of self-harm (including a failure by the deceased person to preserve their own life) whether intentional or otherwise

This includes suicidal acts or attempts at self-harm that may have caused death, even unintentionally.

This category includes issues of self-neglect i.e. failing to take adequate nourishment or liquid, obtain basic medical attention or adequate shelter or warmth.

This does not affect a patient’s entitlement to refuse medical treatment. It is a matter of common sense for a doctor to decide whether the issue is sufficient to report.

Please note that a “lifestyle choices” such as chronic alcohol abuse and smoking continue to be regarded as legitimate natural causes of death.

6.5 The death occurred as a result of an injury or disease received during or contributable to, the course of the deceased persons work

This includes industrial accidents, coal mining or asbestos related diseases. Chronic bronchitis or emphysema (however expressed) in a person who has worked as an underground miner may now constitute an industrial disease (The Social Security) (Industry Injury's) (Prescribed Diseases) (Amendment) (Number 2) Regulations 1993.
There is no requirement that death occurred during the course of their employment. It is sufficient that the originating cause of the death has arisen during that time.

This includes those indirectly affected e.g. a spouse who dies of mesothelioma as a consequence of washing their partner’s asbestos covered overalls.

6.6 **The death occurred as a result of a notifiable accident, poisoning or disease**

Deaths which occur in situations where notice must be given to the Health and Safety Executive.

6.7 **The death occurred as a result of neglect or failure of care by another person**

Any death that may have risen from neglect by another (e.g. hospital, nursing home or relatives) whether or not they had a duty to care for the deceased must be reported.

6.8 **When death was otherwise unnatural**

This is a “catch all” to ensure that any form of unnatural death that is considered not encompassed by the other categories is reported e.g. deaths occurring whether there are unusual or disturbing features.

6.9 **The death occurred in custody or otherwise in state detention of whatever cause**

Any death (this includes natural deaths) occurring in any form of custody or state detention must be referred to the Coroner. State detention includes:

a. Persons under arrest but not yet in a police station
b. Persons in secure accommodation for young offenders
c. Immigration detention centres
d. Persons detained under the Mental Health Act legislation
e. Persons subject to Deprivation of Liberty safeguards at the time of their death.

6.10 **No attending practitioner attended the deceased at any time in the 14 days prior to death or no attending practitioner is available within a reasonable period to prepare an MCCD**

See Regulation 41 of the Births, Deaths and Marriages Regulations 1987.
6.11 The identity of the deceased is unknown

If the identity of the deceased is unknown or in doubt then even if the patient died of a natural cause an Inquest is necessary to ascertain identity and thus the death must be reported.

6.12 Reporting the death of a child up to the age of 18

The death of a child must be reported if it falls within any of the criteria detailed above.

In addition the death should be reported of the following:-

a. A child who is the subject of any Order under the Children Act 1989 at the time of death.

b. A child who is in the voluntary care of a Local Authority.

c. The death of a child under the age of 12 months (subject to the Sudden Unexpected Death in Infancy Investigation Protocol).

It has been agreed with H M Senior Coroner for Newcastle that the Coroner’s Office is to be notified of the death of any child or young person under the age of 18 years.

This will facilitate advice and guidance as to whether the death is formally reportable and ensure clear and accurate information for bereaved parents at an early stage.

Key issues when considering reporting a death to the Coroner

- If a doctor is aware of circumstances potentially meeting one or more of the criteria that may be relevant to the death it must be reported.

- The reportable issue may not be the sole or direct cause of death nor even the only cause. It is sufficient if it has made a significant contribution. The word significant means more than minimal negligible or trivial e.g. any issue that is regarded appropriate to include within Part II of an MCCD is by definition a significant contribution to the death even though not directly causing it.

- The report of a death to the Coroner does not imply fault or blame. Nor does it mean that there will inevitably be a Post Mortem examination and/or Inquest.

- The doctor reporting the death must be wholly familiar with the patient’s care otherwise relevant information may go unrecognised and thus undisclosed.
• The definition of “unnatural” in connection with a death in hospital is wider than might first be thought.

• An unexpected death from natural causes contributed to by some culpable human failure either commission or omission must be reported e.g. missed opportunities to diagnose and treat.

• Do not consider only the eventual cause of death. Give sufficient thought to the sequence of events leading to the death.

• A decision not to refer a case because of the potential distress to relatives or embarrassment of colleagues is wrong and cannot be justified in law.

• If seeking advice from a Coroner or Coroner’s Officer the advice can only be accurate if the referring doctor has recognised and disclosed all relevant information.

6.13 Where the death has not been certified

A death is reportable where the cause of death has not been certified by a doctor.

There will be circumstances where the doctor is unable to identify with any confidence (and therefore cannot properly certify) the cause of death. It may be that the only method of establishing the cause of death is by post mortem, and such a death must be reported to the coroner.

6.14 Deaths associated with childbirth or termination of pregnancy

Any death from any cause of a woman who is either pregnant, or subsequent to delivery, termination of pregnancy, ectopic pregnancy or miscarriage.

Regulation 41 of the Registration of Births and Deaths Regulations 1987 requires a registrar to report to the coroner any maternal deaths that he has reason to believe has been caused by abortion. Stillbirths are not subject to coroner’s investigation.

6.15 Deaths occurring within 24 hours of admission

Whilst it is not a legal requirement, deaths occurring within 24 hours of admission to hospital and any deaths occurring soon after an operation or interventional procedure should be discussed with the coroner’s office.

6.16 Deaths where a medical procedure or operation has been performed in the preceding year must be discussed with the Coroner to meet requirements for cremation. (see section 8 in addition)
In these cases the treating doctor should not complete form 4.

- The coroner may, however, discuss the case with the treating doctor and advise that the treating doctor can complete Form 4.
- If not, the coroner may order a post-mortem examination or decide an inquest should be opened (often both). The coroner will then send a certificate to the medical referee (Form 6) advising the medical referee that an inquest has been opened or a post-mortem examination has been performed.

All deaths abroad where the body is brought back to be cremated within England and Wales also require a Form 6 to be completed, whether or not the cause of death is unnatural or unknown.

In all cases where the body is cremated the cremation authority must complete an entry in the register.

There are a number of additional forms used less frequently. Occasionally the medical referee may doubt whether the deceased died of natural causes although the coroner is satisfied that he does not need to become involved. In those circumstances, the medical referee has the power to order a post-mortem examination to be performed by a pathologist, subject to the consent of the next of kin. The pathologist will then complete Form 11, giving a cause of death.

7 Failure to give all relevant information to the Coroner

Another issue of concern to coroners is failure to give all relevant information when reporting a death. Paragraph 69 of the GMC’s document ‘Good Medical Practice’ states: ‘you must assist the coroner or procurator fiscal in an inquest or inquiry into a patient’s death by responding to their enquiries and by offering all relevant information. You are entitled to remain silent only when your evidence may lead to criminal proceedings being taken against you.’ You should comply with this when reporting a death to the coroner’s officer.

8 The Current Cremation Regulations

The legal basis for cremation is governed by the Cremation Regulations, 2008. These came into effect on 1st January 2009 and replace the Cremation Regulations 1930. Cremation in England and Wales is administered by the Department of Justice. Further guidance is available at http://www.justice.gov.uk/guidance/cremation.htm.

The purpose of the Regulations is to permit the cremation of bodies at crematoria in England and Wales subject to a number of controls over the process.

8.1 Form Cremation 1

A person wishing to cremate the body of a deceased person applies on a standard form for authorisation to cremate.
• Applicants are normally either the next of kin or the executor of the deceased but they may be other persons if the person died without a close relative or did not leave a will.

• The applicant needs to sign a statement of truth at the end of the application form.

• The applicant is given the opportunity to inspect forms 4 and 5, prior to cremation. They may also nominate somebody else to inspect forms 4 and 5. This is a new provision in the 2008 regulations. **Be aware that some of the information requested in the forms (particularly questions 9 and 12 on Form 4) may have been given to you by the deceased in confidence. If this information is included in the form it may be disclosed to the applicant for cremation if they choose to inspect the form. If this would cause a breach of confidence you may give the information requested to the cremation referee on a separate sheet of paper attached to the form explaining your reasons for this and stating that the information should not be disclosed.**

8.2 **Form Cremation 4 - Medical Certificate**
The doctor who treated the deceased person during their last illness will complete a medical certificate detailing a number of facts about the nature of the final illness and give a cause of death.

8.3 **Form Cremation 5 – Confirmatory Medical Certificate**
The doctor who completed form 4 will pass the completed form to another doctor, the countersigning doctor. This doctor must not have been involved in the treatment of the deceased person, nor be a partner or relative of the first doctor nor be a relative of the deceased.

• This doctor will examine the form 4 and question the first doctor and others involved in treating or caring for the deceased.

• He or she will also examine the body. He or she will then give the cause of death on form 5.

• Forms 4 and 5 will then both be sent to the medical referee at the crematorium, together with the Form 1.

It is the medical referee’s duty to study the 3 forms and make any further enquiries that might be necessary before authorising the cremation, using Form 10.

• The medical referee may also refuse to authorise the cremation. If so, he or she must give reasons for that decision.

**Deaths referred to the coroner** - In these cases the treating doctor should not complete form 4.

• The coroner may, however, discuss the case with the treating doctor and advise that the treating doctor can complete Form 4.
• If not, the coroner may order a post-mortem examination or decide an inquest should be opened (often both). The coroner will then send a certificate to the medical referee (Form 6) advising the medical referee that an inquest has been opened or a post-mortem examination has been performed.

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In all cases where the body is cremated the cremation authority must complete an entry in the register.

There are a number of additional forms used less frequently. Occasionally the medical referee may doubt whether the deceased died of natural causes although the coroner is satisfied that he does not need to become involved. In those circumstances, the medical referee has the power to order a post-mortem examination to be performed by a pathologist, subject to the consent of the next of kin. The pathologist will then complete Form 11, giving a cause of death.

8.4 Notes on the completion of Forms 4 & 5
• Prior to the completion of forms 4 & 5 a medical certificate for cause of death must have been issued. Guidance notes on this are available at Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales
• These are formal legal documents, all questions must be answered and no abbreviations should be used.
• You must write legibly.

8.4.1 Form 4
• Question 5 The ‘usual medical practitioner’ of the deceased is normally regarded as their General Medical Practitioner. Where the deceased has been an in-patient in hospital for a short period of time therefore the answer to this should be ‘no’ – you should then fill in the box detailing your role in the deceased’s medical care.

• Question 6 The minimum period of hospital care to enable you to complete form 4 and to satisfy this requirement is 24 hours. If you have not looked after the deceased for this long then you should either get somebody else who has to complete the form or, if they were not in hospital for more than 24 hours, inform the coroner.

• Question 8 You must be able to state that you have physically seen the body after death, what kind of examination you made and specify when you did this.

• Question 9 You must describe in this box the observations of yourself and others leading up to and at the time of death. You are required to
describe the symptoms and conditions which led to your conclusions about the cause of death.

- **Question 10** If the answers to the two parts of this question are both ‘yes’ then the cause of death in question 11 should be the findings of the post mortem. In this circumstance, completion of Form 5 is not required.

- **Question 11** You must describe the cause of death using recognised terms. You must give the pathological cause of death e.g. 1a) myocardial infarction, 1b) Atherosclerotic coronary artery disease, 1c) Hypercholesterolemia, not the mode of death e.g. ‘cardiac arrest’ or ‘heart failure’. Under normal circumstances the cause of death should be that which was set out in the medical certificate of cause of death sent to the Registrar of Deaths.

- **Question 12** ‘Operation’ should be taken to include any interventional procedures e.g. the insertion of a stent.

- **Questions 13** you need to specify whether any ‘operation(s)’ shortened the life of the deceased. If the answer to this is ‘yes’ you must refer the death to the coroner for consideration and possible investigation.

- **Questions 14 and 15** Specify full names and contact details.

- **Questions 17, 18 and 19** You must be able to answer ‘no’ to all parts of these or explain why you have answered ‘yes’ in the box.

- **Question 23** about pacemakers or any other implanted device containing a battery, radioactive implants and ‘Fixion’ nails must be answered in all cases. Inert implants such as hip prostheses do not need to be mentioned.

You should sign and date the form, provide your local contact address, print your name in Block Capitals and provide your contact telephone number in the box for the purpose. You must also provide your GMC number and registered medical qualifications. Dental practitioners cannot complete cremation forms.

**8.4.2 Form 5**

- You must have been fully registered for more than 5 years and must hold a license to practice before you may complete this. In future, you will need to have held a medical license for at least 5 years. For doctors whose primary medical qualification is from outside the UK and part of whose clinical experience is in the EEA or elsewhere, regulations exist in respect to eligibility to complete form 5. If this may apply to you then, before completing a form 5, you should ensure that you are entitled to do so. Details are available from the Department of Justice website [http://www.justice.gov.uk/guidance/cremation.htm](http://www.justice.gov.uk/guidance/cremation.htm).
• You must be demonstrably independent of the Doctor who has completed Form 4.

• You may not:
  o Be a relative of the deceased
  o Be a relative or partner of the Doctor who signed form 4
  o Be a colleague in the same clinical team as the doctor who signed Form 4

• You must see and examine the body of the deceased.

• You must see and question the Doctor who completed Form 4.

• The cause of death which you write on Form 5 does not have to be the same as that given on Form 4 but if there is a difference you must explain any discrepancy.

Form 5 is not required when:

• A post mortem has been performed by a medical practitioner appointed by the cremation authority who has issued Form 11.

• A post mortem has been carried out and the cause of death has been certified by the coroner on Form 6.

• An inquest has been opened and the coroner has issued Form 6.

• The death occurred in hospital, the deceased was an in-patient there, a post mortem has been carried out by a medical practitioner qualified to do so and the doctor knows the result of that examination before they complete Form 4 (Both questions 10 on Form 4 must have been answered in the affirmative).

Completion of Cremation forms should be given high priority, they must be promptly returned to minimize the risk of causing delay to funeral arrangements. If you are in doubt about any aspect of the processes of death certification, referral to the coroner or completion of cremation forms you should seek advice from a senior colleague immediately.

If, at any stage, you believe that an error in the process may have occurred please take immediate action. The individuals with whom you may need to liaise would include: the Consultant under whose care the patient was admitted, the on call member of the Medical Director’s team (Trust switchboard), the Registrar of Deaths at the Civic Centre (Death certification), the Coroner, via the Coroner’s officer (Trust switchboard) or the Cremation referee.

You are reminded that fees for the completion of cremation forms should be declared as income to HMRC.
9 Training

Trainees are instructed on issuing death certificates at undergraduate level, are often assessed in finals and reminded at induction.

10 Equality and Diversity

The Trust is committed to ensuring that it does not unlawfully discriminate against anyone in the implementation of this policy.

11 Monitoring Compliance

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Method</td>
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<tr>
<td>To monitor the Bereavement log to ensure that all appropriate bereavements have been referred to the coroner and that a reason has been recorded for referral to the Coroner</td>
<td>Audit</td>
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</tbody>
</table>

12 Consultation and review

This policy has been reviewed by the Trust’s solicitor following discussion with the coroner.

13 Implementation

Staff will be notified of any changes to the policy through Trust Monthly Newsletter.

14 References

Mental Capacity Act 2005 (including the Deprivation of Liberty Amendment 2009)

Author: Medical Director
### PART 1

1. **Assessment Date:** 16/06/16

2. **Name of policy / strategy / service:** Reporting of deaths to the coroner

3. **Name and designation of Author:** Mr Andrew Welch, Medical Director

4. **Names & designations of those involved in the impact analysis screening process:**

5. **Is this a:**
   - Policy ✔
   - Strategy □
   - Service □

   **Is this:**
   - New □
   - Revised ✔

   **Who is affected**
   - Employees □
   - Service Users ✔
   - Wider Community □

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*
   
   This policy aims to ensure that all appropriate staff are aware of the requirements for reporting deaths to the coroner and to ensure required documentation is processed in a timely manner to prevent avoidable delays.

7. **Does this policy, strategy, or service have any equality implications?** Yes ✔ No □

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
8. **Summary of evidence related to protected characteristics**

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address <em>(by whom, completion date and review date)</em></th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? <em>(by whom, completion date and review date)</em></th>
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<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
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<td>Sex (male/ female)</td>
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<td>Religion and Belief</td>
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<td>Sexual orientation including lesbian, gay and bisexual people</td>
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<td>Age</td>
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<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
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<td>Gender Re-assignment</td>
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<tr>
<td>Marriage and Civil Partnership</td>
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<tr>
<td>Maternity / Pregnancy</td>
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</table>

9. **Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?**

   No gaps identified.

10. **Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.**

   Do you require further engagement? Yes ☐ No ☑

11. **Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?**

    No
PART 2

**Name:**
Dr A Gascoigne, Consultant Physician

**Date of completion:**
16 June 2016

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)