Information Sharing with the Coroner

Version Control

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A copy of this Protocol can be found on the Safeguarding Adult Board Policy and Procedures page at:
http://www.coventry.gov.uk/downloads/download/4349/safeguarding_adults_-_policy_and_procedures

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1.0 Purpose of Protocol

The purpose of this protocol is to establish an effective notification process between those involved in Adult Safeguarding procedures and the Her Majesty's Coroner for Coventry and Warwickshire to:

- Identify deaths possibly caused by abuse, neglect and/or self-neglect;
- Improve the experience of those who are bereaved, in obtaining explanations surrounding the death.

It should be read in conjunction with "Adult Safeguarding: Multi-agency policy and procedures for the protection of adults with care and support needs in the West Midlands" available at www.coventry.gov.uk/safeguardingadults.

Timely reporting to the coroner is crucial to prevent funeral arrangements being delayed and to enable relevant and coordinated enquiries to be implemented e.g. by the police and adult safeguarding.

2.0 Roles and responsibilities

2.1 The Role of the Coroner

Coroners are usually lawyers but in some cases they may be doctors. Coroners are independent judicial officers – this means that no-one else can tell them or direct them as to what they should do but they must follow the laws and regulations which apply. Coroners are helped by their officers, who receive the reports of deaths and make enquiries on behalf of the coroner. The cost of the coroners' service is met by local taxation.

The coroner enquires into deaths which are reported to them. It is their duty to find out the medical cause of the death, if it is not known, and to enquire about the cause of it if it was due to violence or was otherwise unnatural.

The coroner may ask a pathologist to examine the body. If so, the examination must be done as soon as possible. If the examination shows the death to have been a natural one, there may be no need for an inquest and the coroner will send a form to the registrar of deaths so that the death can be registered. If the death is found not to be due to a natural cause then there will be an inquest. An inquest is not a trial. It is a limited inquiry into the facts surrounding a death. The inquest is an inquiry to find out **who has died, and how, when and where they died**.

2.2 Role of Social Work and Mental Health Teams managing Adult Safeguarding cases

Under s42 of the Care Act 2014 local authorities have a duty to make enquiries if it has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

Where the death of an adult with care and support needs is reported and there are concerns that it is possibly due to abuse or neglect by others (intended or unintended), this will be the subject of an adult safeguarding procedure.

As part of these procedures Social Work and Mental Health Teams managing safeguarding cases MUST report to the Police immediately:

- **All deaths where contributory abuse or neglect is suspected** including those involving domestic violence or paid or unpaid carers or supporters in any sector.

- **All deaths that occur during an Adult Safeguarding process or deaths that may be due to abuse or neglect which occur within 30 days of a Safeguarding Adults process being completed** should be discussed with the police immediately when the death is known. It should be noted that deaths are not always notified to adult social care in a timely manner.

As part of safeguarding procedures the Police will decide whether a report to the Coroner is required. This will enable the Coroner and his staff to make informed and timely investigation, post mortem and inquest decisions.

2.3 Role of Police

When the police receive any referral from an outside agency where neglect or abuse is believed to be a contributory factor to the persons death they will notify the Coroner, or the Coroner will contact the police.

If it is established that during the investigation criminal threshold has not been met, the police will inform the Coroner and all interested parties. If a crime has not been substantiated it will be referred back to the agency who made the referral to make relevant enquiries/investigations e.g. adult safeguarding, internal processes, disciplinaries, referrals to professional bodies.

For example : If an adult with care and support needs dies as a result of an incorrect medical procedure and when it is investigated it is established that the death was as an accident or as a result of miscommunication, then it is sent back to the agency for completion of the appropriate investigation i.e. root, cause analysis, GMC referral.

The Coroner will then decide if there will be an inquest. If the Coroner requires a police report for the purpose of inquest this will be completed.

2.4 Role of Health Providers

2.4.1 Role of UHCW

UHCW have a responsibility to inform the Coroner's office when an adult dies within the hospital when there is a concern about the cause of death. Including:

- Unexplained death.
- Sudden unexpected death.
- Death following an accident.
- Death while under detention.
- Deaths where abuse or neglect are suspected.
- Death when under an open Safeguarding enquiry.
- Death was caused by violence.
- Death occurred during an operation or before the person recovered from the effects of an anaesthetic.
- Deaths within 24 hours of admission to hospital
- Death may be caused by an industrial disease or industrial accident.
- Where there is a concern that the care given has contributed towards death

The hospital department where the patient died will inform the Bereavement department that the circumstances under which the patient died indicate the necessity for the Coroner to be informed.
The Bereavement department personnel will inform the certifying doctor of the need to inform the Coroner.

2.4.2 Role of Coventry and Warwickshire Partnership Trust (CWPT)

CWPT have a responsibility to inform the Coroner's office when an adult dies within the hospital or within the community setting when there is a concern about the cause of death. Including:

- Unexplained death.
- Sudden unexpected death.
- Death following an accident.
- Death while under detention.
- Deaths where abuse or neglect are suspected.
- Death when under an open Safeguarding enquiry.
- Deaths within 24 hours of admission to hospital
- Where there is a concern that the care given has contributed towards death

Deaths are usually reported to the Coroner by the Police, or by a Doctor called to the death if it is sudden/unexplained.

2.4.3 Role of GPs

(See also GP Notebook, the BMA and GMC guidance from which the following extracts are obtained)

GP Notebook says to refer to the Coroner when:

- There is no statutory duty to report any deaths to a Coroner. GPs are nevertheless encouraged to report voluntarily any death that they judge would need to be referred to the Coroner by the registrar of births and deaths.

- Reporting to the Coroner - GPs should indicate whether you have reported the death to the Coroner by ringing option 4 on the front of the certificate and initial box A on the back. You should report to the Coroner any death that you cannot readily certify as being due to natural causes.

- a death should be referred to the Coroner if;

    - the cause of death is unknown
    - the deceased was not seen by the certifying doctor either after death or within 14 days before death
    - the death was violent or unnatural or was suspicious
    - the death may be due to an accident (whenever it occurred)
    - the death may be due to self-neglect or neglect by others
    - the death may be due to an industrial disease or related to the deceased's employment
    - the death may be due to an abortion
    - the death occurred during an operation or before recovery from the effects of anaesthetic
    - the death may be suicide
    - the death occurred during or shortly after detention in police or prison custody

- In addition to this list, the registrar of births and deaths is required to report to the Coroner any death for which a duly completed medical certificate of cause of death is not obtained

The GMC has written guidance about confidentiality after a patient's death.

- There are circumstances in which doctors should disclose relevant information about a patient who has died, for example, to help a Coroner, procurator fiscal or other similar officer with an inquest or fatal accident inquiry

- GPs should always consider whether the release of information is relevant and proportional.

Fees

The British Medical Association has so far been unable to agree a system for remuneration of this mandatory work and advises that the GP should produce this report as otherwise you may be summoned to court. There is nothing within the Coroners Act that clearly stipulates payments for reports or statements of fact.

The links to the online guidance are:
http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality_70_72_disclosure_after_patient_death.asp

http://www.gpnotebook.co.uk/simplepage.cfm?ID=530186303

http://www.bma.org.uk/support-at-work/pay-fees-allowances/fees/fee-finder/fee-finder-coroners/non-payment-of-coroners-fees

2.5 Role of Care Quality Commission (CQC)
CQC have a memorandum of understanding with the Coroners' Society of England and Wales which states: "All registered providers are under a legal duty under the (Registration) Regulations (RR 2009) (Regulation 16) to notify CQC of the death of a user of the service where the death has occurred during the carrying on of a regulated activity or where the death may have resulted from a regulated activity. This includes any patient who at the time of death is detained or liable to be detained under the Mental Health Act 1983". When Inspectors receive death notifications they are categorised as either expected or unexpected deaths. If CQC have concerns they would liaise with the provider and commissioners and would find out if there is any police or Coroner involvement.

If the police or Coroner were investigating the death CQC would liaise with them to advise that CQC had interest in the death and then would decide if any CQC regulatory action was required.

2.6 Role of Strategic Commissioning Team, City Council
Where Commissioning Teams identify circumstances where there are concerns about individual deaths or patterns of deaths in a provider service these should be referred into adult safeguarding and the Provider Escalation Panel (PEP). Consideration will need to be given to police involvement in that process so that where appropriate a police referral to the Coroner's Office can be made in accordance with para 2.2 above.

Of particular concern will be:

- Where a contract with a care service has been suspended or terminated, due to significant concerns about care quality
- Any service identified where there "appears to be a high death rate" e.g. multiple deaths in a short period of time.

2.7 Role of Registrar
Guidance about reportable deaths to the Coroner from Registrars guidance states:
Where a registrar is informed of a death and any of the circumstances below apply, He /she must report the death to the coroner:

(a) where the deceased was not attended during his/her last illness by a medical practitioner; or

(b) where the registrar has been unable to obtain a duly completed certificate of cause of death; or
(c) where it appears to the registrar, from the particulars contained in the medical certificate or otherwise, that the deceased was seen by the certifying medical practitioner neither after death nor within 14 days before death; or
(d) where the cause of death appears to be unknown; or
(e) where the registrar has reason to believe the death to have been unnatural or to have been caused by violence or neglect, or by abortion, or to have been attended by suspicious circumstances; or
(f) where the death appears to the registrar to have occurred during an operation or before recovery from the effect of an anaesthetic; or
(g) where the death appears to the registrar from the contents of any medical certificate to have been due to industrial disease or industrial poisoning.

3.0 Data Protection and the Coroner

It should be noted that whilst the Data Protection Act 1998 applies only to living people there is still a duty in common law to protect the confidentiality of the dead. The Data Protection Act will apply to living relatives and third parties.

The general principles of information sharing as laid down in the Data Protection Act 1998 state clearly that information should only be shared for valid lawful purposes

4.0 How are deaths reported to the Coroner?

Deaths are usually reported to the Coroner by the police or by a doctor called to the death if it is sudden. A doctor will also report a patient's death if unexpected. In other cases, the local registrar of deaths may make the report.

Whenever a death has been reported to the Coroner, the registrar must wait for the Coroner to finish his or her enquiries before the death can be registered and burial or cremation arranged. These enquiries may take time, so it is always best to contact the Coroner's office before any funeral arrangements are made.

With effect from Monday 3 April 2017 the Coroners and Justice Act 2009 was amended so that people subject to authorisations under the Deprivation of Liberty Safeguards (known as DoLS) under the Mental Capacity Act 2005,will no longer be considered to be 'otherwise in state detention' for the purposes of Section 1 of the Coroners and Justice Act 2009.

The effect of this is that, for any death that occurs on or after the 3rd April 2017 and where the deceased was subject to a DoLS authorisation, the coroner will no longer have a duty to conduct an inquest in every case. The death need only be reported to the coroner where the cause of death was unnatural or violent, including where there is any concern about the care given having contributed to the person's death.

This change will also apply in all other cases where the deceased was subject to a deprivation of liberty authorisation (other than DoLS) under the provisions of the Mental Capacity Act 2005.

All deaths of people subject to DoLS should be reported to the DoLs administrator.

5.0 Communication from the Coroner to Coventry City Council, Adult Safeguarding Team

The Coroner may inform Community Services, via the Safeguarding Adults Office (SafeguardingAdultsTeamGCSX@coventry.gcsx.gov.uk), of:

- Any deaths that they conclude have occurred because of Adult Safeguarding concerns i.e. those involving concerns of abuse or neglect of adults with care and support needs.

- Any providers that come to his / her attention where a preventable death of an individual has occurred.

The case will be passed to the appropriate operational team for consideration under the Adult Safeguarding Adults Procedures for enquiries to take place and/or for consideration of a Safeguarding Adult Review. Strategic Commissioning will be involved where decisions need to be made about the quality of providers.

6.0 Communication from Coventry Safeguarding Adults Board (CSAB) to the Coroner

Where a Safeguarding Adult Review involving a death is being undertaken the Chair of the Serious Case Review Committee should consider the need to notify the Coroner as outlined and for the reasons set out above. (See Coventry Safeguarding Adults Board, Safeguarding Adult Review procedures).

6.1 A Safeguarding Adult Reviews
A Safeguarding Adult Review is a multi-agency review undertaken by the Safeguarding Adults Board (SAB) under Section 44 of the Care Act 2014. A review will take place if there is a case of an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) where:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

(2) Condition 1 is met if—
(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—
(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—
(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases.

6.2 Should the Serious Case Review Sub Group make a referral to the Coroner and the Coroner chooses to investigate, the Serious Case Review Panel will nominate a single point of contact for all communication. This is to ensure that there are:

- agreed methods of communication and timings of police investigations, inquests and Safeguarding Adult Reviews in order to ensure streamlined processes and avoid duplication, contamination of evidence and distress to bereaved families and any staff directly involved.
- an agreed single point of contact for a multi-agency media strategy.

6.3 The Coroner may also make a referral to the Coventry Safeguarding Adults Board for a Safeguarding Adult Review if s/he believes the criteria are met. The Board will consider the request in line with procedure.

7.0 Out of City Communication

7.1 Where an incident occurs out of City it is the responsibility of the host authority to instigate safeguarding investigations and manage communication with the relevant Coroner. Where a provider service is involved the host authority should also notify other authorities that may be using the provider both of the death and of all communications with the Coroner, in accordance with the relevant data sharing protocol.

Example: An individual is placed in Warwickshire by Coventry. Warwickshire has lead responsibility for coordination of safeguarding procedures so liaises with the Warwickshire Coroner but they must also involve Coventry Adult Social Care in safeguarding procedures and inform Coventry of all communications with the Coroner.

8.0 Contact Details

8.1. Coventry Coroner

9.00am - 4.00pm Monday to Thursday, 9.00am - 3.30pm Friday
The Register Office, Cheylesmore Manor House, Manor House Drive
Coventry, CV1 2ND
Tel: 024 7683 3345
Fax: 0207 716 3755
Email: coroners@coventry.gov.uk

8.2 Information Governance – Coventry City Council

Place Directorate
Council House, Earl Street, Coventry, CV1 5RR
Tel: 024 7683 3323
Secure email: infogov@coventry.gcsx.gov.uk
Email: infogov@coventry.gov.uk

8.3 Legal Services – Coventry City Council

3rd Floor, Broadgate House, Broadgate, Coventry, CV1 1FS
Email: adultdutyadvice@coventry.gov.uk
Tel: 024 7683 1902

8.4 Safeguarding Adults Team – Coventry City Council

Room 48, Civic Centre 1, Little Park Street, Coventry, CV1 5RS
Tel: 024 7683 3419/2346
Email: SafeguardingAdultsTeamGCSX@coventry.gcsx.gov.uk

9.0 Review of the Protocol

Every 3 years by CSAB

Appendix 1

REPORTING THE DEATH OF SOMEONE WHO DIES IN ADULT SAFEGUARDING PROCEDURES TO THE CORONER