serving the community
through the administration
of justice

The Coroners Service for Northern Ireland

Working with the Coroners Service for Northern Ireland

www.coronersni.gov.uk

Contents

- Other involvement with the Coroners Service
- Hospital doctors
- Who should report the death
- Steps to take before reporting the death
- What happens after the report is made
- What to do if the death occurs outside office hours
- The Coroner's investigation

Funeral Directors & Embalmers

- Legal duty to report deaths to the Coroner
- Funeral arrangements and preparation of bodies
- Precautions at the scene and in transportation
- Other information
- Fees for Coroners Removals

Homes & Institutions

- What to do when a resident dies in the home
- What deaths need to be reported – the legal duty
- Assistance in the Coroner's investigation

Bereaved families

- What to do when someone dies at home
- What to do when someone dies in hospital
- What if someone dies outside either the home or hospital?
- What if the doctor or police officer says that the death is being reported to the Coroner?
- What other roles might the bereaved family have?
- Registering a death which has been reported to the Coroner

Introduction and contact details

What is a Coroner?

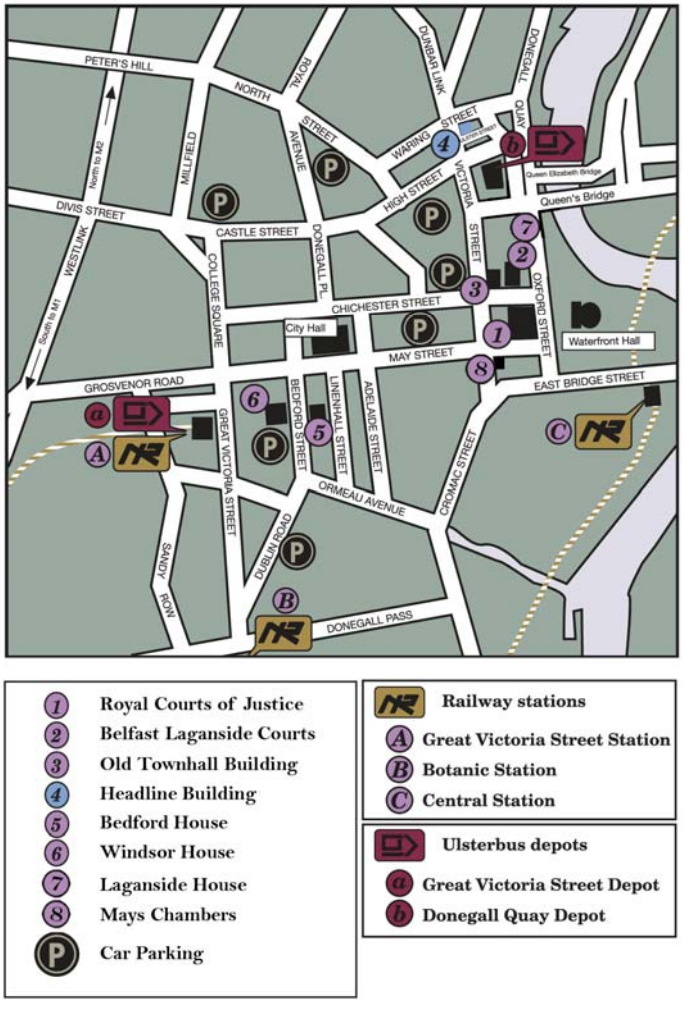
The Coroner is an independent judicial officer who investigates sudden, unexpected, suspicious or unnatural deaths occurring anywhere in Northern Ireland.

How many Coroners are there in Northern Ireland?

The Presiding Judge for the Coroners Service is Mr Justice Weir. There are currently 3 full time, permanent Coroners for Northern Ireland: John Leckey (Senior Coroner), Suzanne Anderson and Brian Sherrard. Joanne Donnelly has also been appointed Coroner for a 3 year fixed term. They are supported by the staff of the Coroners Service for Northern Ireland.

Where are the Coroners based?

The Coroners are based at the Coroners Service for Northern Ireland which is located at 73 May Street, Belfast, BT1 3JL.



How can I contact the Coroners Service?
The Coroners Service can be contacted by telephoning 028 90446800, by faxing 028 90446801 or by emailing coronersoffice@courtsni.gov.uk.

Where does the Coroner's authority come from?
The Coroner's authority mostly derives from the Coroners Act (Northern Ireland) 1959 and the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963.

When and how will a death come to the attention of the Coroner?
The law places a duty on police officers, doctors, undertakers and owners of residential homes to report certain deaths. Deaths will sometimes also come to the attention of the Coroner because of concerns raised by families or members of the public.

What does the Coroner do when a death is reported?
All deaths reported are investigated by the Coroner. The majority are then dealt with quickly and administratively, either by way of a Medical Certificate of Cause of Death (a MCCD or Death Certificate) or upon the Coroner (having received an assurance from a doctor as to the cause of death) notifying the Registrar of Deaths that the death may be registered via "Form 14" otherwise known as the pro-forma.[1] However, where a question arises over the cause of death or the circumstances leading up to the death, the Coroner may order that a post mortem examination be conducted. Although the Coroner will be sympathetic to religious and cultural sensitivities as well as family views regarding such examinations consent is not required. The majority of examinations are carried out at the Northern Ireland Regional Forensic Mortuary in Belfast but some may be carried out by pathologists in the Royal Victoria Hospital. Every effort is made to ensure that the examination is carried out in a timely fashion so that the body can be returned as quickly as possible. Where a post mortem examination is ordered a Coroners Liaison Officer will be assigned who will keep the family informed of any developments. When the Coroner receives the post mortem report, which can be some months after the death, a decision will be made either to inform the Registrar of Deaths that the death may be registered via "Form 17" or to hold an Inquest.[2]

[1] See sample at appendix A.

[2] A sample Form 17 is at Appendix B.

What is an inquest?

Where a Coroner decides that a death should be publicly investigated an inquest will be held in court. The court venue will, where possible, be in the locality where the death occurred. An inquest is a fact-finding investigation and not a method of apportioning blame although it is not unusual for interested persons to be legally represented. The verdict, which deals with who the deceased person was and where, when and how they died, is reached by the Coroner or a jury if one has been summoned. Juries are most commonly encountered in cases involving deaths in the workplace or while in custody.

Mortuaries and Mortuary staff[3]

Introduction

The Coroners recognise that mortuary staff have a difficult, emotionally demanding job that requires both skill and sensitivity. What follows is a guide to what the Coroners require from mortuary staff when dealing with deaths that have been reported to them. First and foremost it should be remembered that when a death has been reported to the Coroner the body falls within the Coroner's jurisdiction and there can be no interference with the body without the Coroner's consent. That said, nothing below should be read in such a way that safe mortuary practice is compromised.

The Coroners Service deals with several mortuaries in a number of different capacities: *Hospital deaths*: Where somebody dies in hospital the body should be taken to the mortuary, without interference, while the Coroner decides how to further the investigation. *Deaths in the community*: Police will often take people who have died outside hospital to a convenient mortuary while waiting for the Coroner to make a decision on the death or, where it is anticipated that an autopsy will be required, to facilitate families in identifying the person. *Coroner's Autopsy*: Where an autopsy is ordered by the Coroner the deceased will be taken either to the Northern Ireland Regional Forensic Mortuary in Belfast or the Royal Victoria Hospital mortuary depending on where the examination is to take place.

In every case, where there is still any question over whether a forensic autopsy will be ordered the body must not be interfered with in any way by mortuary staff. It should be maintained in exactly the same state as it was received by the mortuary. If a forensic autopsy is ordered it is essential that the body is seen by the pathologist exactly as the person was at the time of death. The priority must be to ensure that no forensically significant evidence is lost to the pathologist.

Contacting the Coroner

Although mortuary staff do not have a specific statutory duty to inform the Coroner of deaths, staff should not hesitate to contact the Coroner should they have concerns regarding any aspect of a death or its investigation or when other queries arise.

[3] Much of this guidance is taken from "Care and Respect in Death Good Practice Guidance for NHS Mortuary Staff" which can be accessed in full at www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=15420&Rendition=Web

Receipt and maintenance of the deceased

On arrival into the mortuary the deceased person must be securely labelled with his or her identity, or, if it is yet to be established, the circumstances of their receipt. It is preferable to use a wrist or ankle band for this purpose. The body must be kept covered and stored in a manner that will keep it best preserved.

Each mortuary must have procedures in place to ensure that:

a) all bodies, organs and tissues are tracked from arrival until release;
b) bodies and related belongings may be located at any time;
c) bodies are released to the correct recipient;
d) bodies are maintained in the best possible condition and protected from interference, accidental damage or avoidable deterioration.

The police will complete a form P1 for the pathologist. The body should not be undressed or otherwise interfered with until either a) it is clear that no autopsy is to be ordered or b) there is to be a post mortem and the body is in the mortuary that will prepare it for the autopsy. In every case a careful note should be made of the deceased's belongings which should be kept securely and fully labelled. In cases in which police indicate that crime is suspected the technician must give the pathologist the option of viewing the body while still clothed. More detailed instructions may be issued by the pathologist or police. If in doubt the Coroner's advice should be sought.

Dealing with bereaved families

Families who wish to see the body of their loved one should, as a rule, be able to do so albeit within the mortuary's normal opening hours by arrangement. If, however, the person's body is damaged, the family must be fully and sensitively advised of that fact. It is not for mortuary staff to decide if viewing should be allowed unless there is a health and safety risk that prevents it. If an issue arises as to viewing it should be referred to the Coroner.

There may be circumstances in which viewing of, or contact with, the deceased is inappropriate, such as where it is necessary to preserve evidence. The police will alert mortuary staff to any such restrictions on viewing but they must not be put in place simply because the body is damaged. Should any issue arise the Coroner should be contacted.

Where possible, in addition to offering direct physical viewing, the mortuary should offer alternative means of viewing such as behind a glass screen or on a video link. Where such options exist families must be made aware of them.

Mortuary staff should seek to accommodate the cultural and religious practices of families except where this can not be done without jeopardizing the integrity of the death investigation or because of safety considerations.

Identification

It is the responsibility of the police acting as the Coroner's agent to establish identity on behalf of the Coroner. This is usually done visually but sometimes involves the taking of fingerprints, samples for DNA comparison or the use of dental records. The police may ask the Coroner for guidance on what is appropriate identification in the circumstances. The police must be facilitated in this important role. Identification must normally take place before the body is prepared for autopsy – if for any reason this is not possible the Coroner must be consulted.

An identified body must immediately be securely labeled with a wrist and/or ankle band. If labeling has already occurred its accuracy must be verified by PSNI and mortuary staff.

Release

The police have authority to arrange for the removal of a deceased to any mortuary on the direction of the Coroner when an autopsy has been ordered.

Where no autopsy is to take place and the death is dealt with by medical certificate of cause of death or pro-forma a body that has been placed in a mortuary for safe keeping while the death is investigated should only be released upon the mortuary staff being shown the relevant documentation above or when the method of disposal has been confirmed directly to it by the Coroners Service.

Following autopsy a body should not be released by the mortuary staff without the express consent of the Coroner which will generally follow receipt of the C1 form giving a preliminary cause of death and, in homicide cases, discussion with the police.

Organs and/or tissue that have been removed during autopsy must be carefully labelled and stored. If they are to be sent for analysis the date, time and authority for their release must be logged and arrangements must be made for secure transit and return. Once the organs and/or tissue are no longer required by the pathologist they may not be disposed of or otherwise dealt with in the absence of an express instruction from the Coroner who will liaise with the deceased's family before taking action.

In every case a body or other bodily material must only be released to a funeral director. A note must be taken detailing the time of release, the recipient and the authority for the release.

A PM3 form is issued by the pathologist when the completed post mortem report is submitted to the Coroner. This form advises the Coroner that the pathologist has completed his investigations in relation to retained organ and tissue.

Police and Police Officers and NIAS

The relationship with the Coroner

Where the PSNI is called to attend the scene of a death, the PSNI will act as the Coroners' agent for the purpose of reporting the death, taking possession of the body, reporting information and gathering evidence.

The duty to report

The law is framed so that every unexpected, unnatural or questionable death should be reported to the Coroner who must be informed as soon as the investigating officer attends the scene. The Coroners Office can be contacted on 028 90446800.

The statutory duty

Section 8 of the Coroners Act (Northern Ireland) 1959 provides:

> "Whenever a dead body is found, or an unexpected or unexplained death, or a death attended by suspicious circumstances, occurs, the superintendent within whose district the body is found, or the death occurs, shall give or cause to be given immediate notice in writing thereof to the coroner within whose district the body is found or the death occurs, together with such information also in writing as he is able to obtain concerning the finding of the body or concerning the death."

Preliminaries: Role of the officer at the scene, reporting the death, taking possession of the body

Establish that death has occurred: Before involving the Coroner life should have been pronounced extinct. (The Coroner only has jurisdiction with regard to the deceased.) In deaths that appear to result from homicide, suicide or accident the Police Forensic Medical Officer should be tasked to pronounce life extinct if this has not already been done. In non suspicious cases life may be pronounced extinct by any other suitably qualified person. A body should not be moved from a scene until life is formally pronounced extinct.

Establish whether the Coroner ought to be informed by reference to the statutory duty. Police officers are often called out to non-suspicious deaths in the home and elsewhere. Even these deaths are reportable if it is not possible for a death certificate to be issued by a doctor. Should police be

content that there are no circumstances warranting suspicion that the death was unnatural, and provided family members are present and raise no issues regarding the death, inquiries should be made as to whether the deceased has been seen and treated by a doctor within the last 28 days. If so, contact should be made with that doctor with a view to establishing whether a Medical Certificate of Cause of Death (MCCD otherwise known as a Death Certificate) can be issued. Once a certificate is issued the police need have no further dealings with the death and the Coroner does not need to be involved. If for any reason a certificate cannot be issued then the death must be reported to the Coroner.

A police officer who attends the scene of an unexpected death must always consider the possibility that the death arose unnaturally through the intervention of another person (murder, manslaughter, and assisted suicide), suicide or accident – all of which must be reported. In every case immediate thought should be given as to whether further assistance is required to rule out the necessity for a criminal investigation. If there is any concern that the death may be suspicious then CID and SOCO must be tasked and the Coroner informed as discussed below.

All deaths **in prison or custody** must be considered suspicious in the first instance and must not only be reported to the Coroner but the State Pathologist must be given an opportunity to attend the scene.

Good practice demands that the officer considering whether there is a duty to report to the Coroner should attempt to:

- Compile a detailed account from witnesses as to the circumstances surrounding the death.
- Ensure, where possible, that the body is identified by a responsible person who knew the deceased. A full note on identification can be found at the end of this section.
- Carry out a visual examination of the body and make a note of anything that might be unusual.
- Carry out a visual examination of the scene and make general notes of the position of the body etc.
- Obtain the deceased's medical history from those who knew him/her well.
- Where it seems possible that the death was natural in origin, contact the deceased's medical practitioner to ascertain if the deceased had any symptoms and if he/she was receiving any treatment. If police are called to a death outside normal office hours e.g. weekends, the officer should make all reasonable attempts to contact the deceased general medical practitioner for information and advice.
- The only cases that will not involve the Coroner are those in which a medical certificate of cause of death is issued. If the

officer ascertains that a certificate either will not be issued or it is impossible to contact the deceased's GP then he or she must:

1. Take possession of the body on behalf of the Coroner and immediately report the death on 028 90446800. Remember that where a death is reportable to the Coroner nothing may be done with or to the body without the Coroner's consent. The deceased's family, if present, should be kept fully informed of all that is taking place.

   Depending on the circumstances other responsibilities may arise not directly of concern to the Coroner for example ensuring that premises are secure and ensuring that minors and animals are cared for.

2. Provide the Coroner with information concerning the finding of the body or concerning the death by telephoning the Coroners Office on 028 90446800 at any time. Staff are available to take the call each weekday from 9am to 5pm and at weekends from 9.30am to 12.30pm. At all other times the officer must leave the information on the answering service so that the Coroner can consider the circumstances at the earliest possible time. The information should include:

   Name, address, date of birth and occupation of the deceased.
   Next of kin – Name and Contact details.
   Medical history including the name and contact details of deceased G.P.
   Circumstances of death (including where the body has been removed to if outside office hours) and the police serial number to assist with follow up calls.

   The reporting officer will provide an assurance that, if appropriate, the scene of the death has been preserved or that a proper investigation has occurred including labeling the body in situ, the taking of photographs and collection of forensic evidence at the scene has or will be done that use of appropriate body bags has been carried out and that all relevant agencies have been contacted. Consideration should always be given as to whether a pathologist ought to be called to the scene and in prison deaths this is the required procedure. The Coroner will also expect the officer or one of the other agencies to have taken possession of any medication, drugs or paraphernalia, weapons or other articles which could be connected with the death and that such item are properly labeled and stored.

3. Complete a Form P1 for the pathologist who will require this prior to the autopsy. The officer will also complete a Form 19 for the Coroner which must be forwarded to the Coroners within 7 days of the death.

Removal of the deceased to the mortuary

Removal: On the Coroner's instructions the reporting officer will arrange for transportation of the body to the local mortuary (if the deceased lived outside Belfast) or to the Regional Mortuary at Belfast based in the grounds of the Royal Victoria Hospital. The Coroner will invariably order that the body should only be removed after police consider it appropriate to do so. Outside office hours the reporting officer must leave full details of the death on the Office answering system. If the death is not being treated as suspicious police should remove the body to the most convenient mortuary so that appropriate inquiries may be made by the Coroner the next morning. If the death may have resulted from homicide the police must contact Belfast Regional Control to have the Regional Mortuary at Belfast opened and the body should be deposited there without delay. A Coroner is available at all times of the day and night should it be necessary to seek instructions – outside normal working hours the on call details can be obtained from the recorded message on 028 90446800 in the coroners office.

In exceptional circumstances there may be occasions, outside normal working hours, when a deceased GP cannot be contacted but the family advise that the deceased has a recognized severe or terminal illness and that they have been attended by a GP for this illness. After discussion with the locum or out of hours doctor the officer may consider allowing the body to be removed to the family undertakers premises, on the strict instructions that the body must not be tampered with until the Coroner makes the necessary enquiries. The officer must remember to advise the coroners service where the body is resting . If the officer is in any doubt the coroner is available outside normal office hours, the contact details can be obtained by telephoning 02890446800.

In all other circumstances the body should be removed from the scene by an on-call funeral director having, if appropriate, been first sealed in a body bag using evidential seals. The details of the sealing tag should be recorded at the time of sealing and an appropriate identifying label placed on the exterior of the body bag.[4] In Belfast there is a contracted funeral director who is responsible for all coroners removals within certain boundaries. Belfast Regional Control can provide advice as to who should be called. For deaths that occur outside this boundary only funeral directors who have previously been approved by the Coroner can do such removals. Local police stations should hold the approved list for their area. In circumstances where the on call undertaker has not yet been called and the family of the deceased have already contacted their family funeral director the officer will allow the appropriate removal by that undertaker.

[4] A copy of the procedure to be followed when using a sealed body bag is set out at Annexe B.

Contacting the mortuary: The PSNI officer must make contact with the appropriate mortuary to ensure that the technician or other receiving person is in attendance to admit the body. The PSNI officer should also liaise with any Senior Investigating Officer in charge, with regard to any specific requirements regarding storage and handling of the body at the mortuary.

Procedure at the mortuary: The PSNI officer must accompany the body to the mortuary where the death is a suspicious one. In other circumstances the mortuary admission sheet must accompany the body and the PSNI officer must complete the mortuary admission sheet including any specific requirements regarding the storage of the body prior to postmortem examination. Where appropriate the PSNI officer will inform the mortuary technician if the body must not be removed from the body bag for postmortem until a PSNI officer is present. The technician should be advised by the officer whether formal identification has taken place at the scene. The PSNI officer will also advise the mortuary technician in good time of any additional requirements to be carried out prior to the commencement of the postmortem examination e.g. forensic evidence gathering, photographs required, removal of clothing etc. No items found with or upon the person of the deceased may be returned to relatives or passed to any other individual without the express consent of both the PSNI Senior Investigating Officer and the Coroner.

Role where the Coroner has directed an autopsy be performed

Each autopsy requires an officer to be present, if not during the procedure itself, then in the environs of the mortuary. The officer should liaise with the State Pathologists's Department on 02890 247271 to establish the time that the autopsy will take place and ensure that he attends in good time. If the autopsy is to take place in the Royal Victoria Hospital the officer should phone 02890633679 to make the arrangements as above.

The officer must have a complete form P1 for the Pathologist setting out the details required for the postmortem examination and forward this form to the pathologist before the commencement of the postmortem examination.

Where a death has occurred in a hospital a full clinical summary will be given to the officer. This should be taken to the pathologist prior to the autopsy. The officer should ensure that NO notes are given to them by the Ward unless specifically requested by the Pathologist.
In all other deaths the officer should obtain a clinical summary from the GP which should include details such as the deceased's relevant past medical history and current medications. If an officer is unclear or if there are difficulties obtaining the documents the officer should contact CSNI for advice and assistance.

Prior to post mortem the police officer must inform:

- Any relative of the deceased who has notified the coroner of his desire to be represented at the post-mortem examination;
- The deceased's regular medical attendant;
- If the deceased died in a hospital, the hospital;
- If the death of the deceased may have been caused by any accident or disease of which notice is required, or in respect of which death notice of any inquest is required under any enactment to be given to a Government Inspector, the Government Inspector concerned;
- Any government department which has notified the coroner of its desire to be represented at the examination;
- If the superintendent has notified the coroner of his desire to be present or to be represented at the examination, the superintendent will be informed of the date, hour and place at which the examination will be made, unless it is impracticable to inform any such persons or bodies, or to do so would cause the examination to be unduly delayed.

The above are entitled to be represented at a post mortem examination by a registered medical practitioner, or if any such person is a registered medical practitioner he shall be entitled to attend the examination in person. The superintendent may be represented by a police officer.

The officer must obtain the Coroner's consent for the attendance of any other individual at the postmortem examination where such attendance is considered to be necessary or desirable. The pathologist should also be advised.

The officer should wherever possible be in a position to personally identify the body to the Pathologist as being the body removed from the scene to the mortuary and postmortem.

After the autopsy: At the conclusion of the postmortem examination the pathologist will give the officer the form (C1) setting out details of the preliminary cause of death and of the retention of any tissue samples or organs at the examination. The officer must:

- **Contact the CLO** by telephone on the number provided in the PSNI room in the mortuary or on 02890446800 to inform them of the name of the Pathologist, next of kin details and the preliminary findings of the pathologist. This should include any other relevant information, for example, whether organs or tissue have been retained.
- **Contact the next of kin** if directed by the CLO. In most circumstances the CLO will be the direct contact with the family from this point onwards with the exception of deaths where a PSNI family liaison officer (FLO) has been appointed e.g. murders, road traffic

collisions. The CLO will instruct the FLO on what information to provide and to seek the next of kins wishes for the release of any retained tissue or organs for their future release. The officer should also advise the family, on the instructions of the CLO, that the body can be released to their family undertaker.

- **Immediately transmit the C1** to the Coroner's Liaison Officer by fax on 028 90446801 and then forward the original to the Coroners office through OCMT. .
- At this stage the CLO will be able to advise you whether or not an Inquest file will be needed (see below for the required contents of the file).

Release of the deceased's body: Once the Coroner's authority to release the body has been obtained the CLO will inform the mortuary technician who will then contact the nominated funeral director to advise that the body is available for collection.

Form 19: A completed Form 19 must be forwarded to the CLO no later than 7 days after the death. All officers must advise their local Occurrence Case Management Team (OCMT) of the death. From this point onwards all documents and contact should be made through the OCMT and the officer should respond to all requests for information within the time limits set by the CLO or Coroner. These will be advised in each letter. PSNI and CSNI have entered into a 'Working Practices Agreement' on file progression and contact which all officers should make themselves familiar with.

Where there is to be an inquest

The inquest file: Most reported deaths are dealt with administratively by the Coroner but where the Coroner informs the police that there is to be an inquest the officer in charge of the case must provide the Coroner with an inquest file within the time limits set in the working practices agreement. The file must contain the following:

a) Statements from all relevant witnesses
b) A witness address list.
c) Copies of all maps, photographs, expert reports, videos and notes.
d) All other relevant information and documents relevant to the inquest.

More specifically each file must contain the following statements :-

Investigating officer – the statement of evidence should always describe the scene as found on your arrival, the details of the doctor pronouncing life extinct and the time that this was done, identification of the body to you, its removal to the mortuary and identification of the body by you to the pathologist. The Coroner will require continuity between the discovery of the body and its arrival with the pathologist. The statement should deal with any lines followed, forensic issues, persons charged, prosecutions or

continuing enquiries. Any exhibits referred to should be given the prefix C1, C2 etc.

Next of kin – this statement must include the deceased's full name, date and place of birth, marital status. If the deceased is under 16 years of age, the parents' full names and occupations should be included. Also in the case of a married / widowed woman, the husband's full name and occupation should be given. It is preferable for this statement to be made by the next of kin. If this is not practical then another person close to the deceased will be acceptable but the Coroner will still require the next of kin's contact details. If the person making this statement has been involved in the discovery or identification of the deceased this should also be covered.

Other witnesses – any person witnessing the death or the background circumstances leading to it. These must be as detailed as possible. If the deceased is found dead the Coroner will require a statement from the person finding the body and the last known person to see them alive. A statement should be taken from the doctor who pronounced life extinct. A statement should also be recorded from the deceased's GP providing a full clinical summary. This will be particularly relevant if the death is apparently due to suicide. In such cases the statement should address the deceased's medical history, any history of depression, the medication prescribed at the time of death and referrals to Psychiatrists or Community Psychiatric Teams. Even if the deceased has no medical history the Coroner will still require a statement to confirm that is the case.

Each case requires individual consideration as to the contents of the file. The following guidance is intended as general guidance on the most frequently encountered deaths and the basic information that the Coroner will require:

Cases of apparent suicide
Copies of any notes left by the deceased and where and by whom they were located. Each must be given an exhibit number. If the note indicates reasons for their action e.g. pressure of work or bullying, a statement will be required from anyone relevant mentioned therein. Computers, videos, audiotape and mobile telephones should also be checked for relevant evidence which, if found, must be seized, recorded and exhibited. If photography or mapping branch attends a scene, a copy of their material should be included, as should a detailed statement from the deceased's GP and Psychiatrist should one have been seen. In certain cases of suicide, the Coroner may seek the views of the family as to whether they wish an inquest to be held before making a decision. You must not ask for the families views unless directed by a Coroner but If the family have discussed this with you unprompted please also advise the Coroner of their wishes as soon as possible.

Cases involving drugs or alcohol
Statements regarding substances and materials in and around the deceased, what consideration was given to the possible involvement of a third party in the death and information gathered regarding the source of illegal supply. Statement from the deceased's General Practitioner as to their patient's general health and alcohol/drug history. Statement from any medical expert or counselor engaged with the deceased regarding drug/alcohol use and treatment strategy. The officer in charge should include reference in his or her statement to whether the deceased was registered with his GP as an addict and whether they were known to the police?

Road Traffic Collisions
Copies of the rough sketch, collision report, the authorised officer and/or DOE Examiner report, map, photographs and video. It is very important that the Coroner is advised and kept informed of any file submitted or to be submitted to the PPS. It is also important that the Coroner is advised of any recommendation made regarding prosecution. Please also indicate whether a Forensic Scientist was tasked to the scene, and if so, the name of the Forensic Scientist. The investigating officer should also include reference to any previous road traffic collisions at the particular scene and to any discussions that the police have had with the DRD regarding road safety in the area.

Death in hospital or during a hospital procedure
Local arrangements exist in some areas where the Coroners office will request statements directly form the Administration unit of the hospitals rather than through the investigating officer. The CLO will have advised you of this at the outset of the Coroners investigation. In some circumstances you may be asked to obtain these statements. Statements must be taken from all staff involved in the care of the patient prior to death including where appropriate, the operating team and/or consultant in charge of the deceased's care in the hospital. These statements should be obtained via the Hospital administration unit also.

Death in the workplace
Most of these investigations will be taken forward by the Health and Safety Executive but the police must provide the statements discussed above dealing with the next of kin and all police involvement.

Missing persons
Where a person has been reported as missing and their death is related to their disappearance (most often a confused patient leaving hospital or an elderly person leaving a nursing home) the Coroner will require full details of the actions that were taken to locate the deceased. The missing person log should be forwarded, together with a statement from the officer in charge of the missing person investigation, a statement from the last person to see the deceased alive and statements from the family, home or institution that the deceased left. Medical evidence should be obtained

regarding the deceased's state of mind and general health at the time of their disappearance.

Deaths in prison
Statements from prisoners and staff regarding the circumstances surrounding the death. A statement from the prison doctor regarding the deceased's medical history and a copy of all reviews or documentation held by the prison relating to the deceased medical care while in custody. The statement from the investigating officer should include the background of the prisoner including the offence for which the prisoner is in custody. The file should contain statements from the other agencies tasked, particularly those involved in crime scene investigation and forensic examinations.

Additional responsibilities in respect of the Coroner's ongoing investigation

Case progression – PSNI investigation
The officer will keep the Coroner informed and provide regular updates on the progress of the investigation and will provide copies of relevant documents connected with the investigation on an ongoing basis as are required by the Coroner and in accordance with the Working Practices Agreement.

The PSNI officer will formally notify the coroner in writing when the police investigation is complete or suspended and let the coroner know their intended course of action. As part of the coroners file the officer will supply a witness list with the current addresses of the witnesses.

Witness Summons
The Coroner will decide which witnesses he wishes to summon to give evidence at an inquest. The Coroners office will prepare witness statements and forward them to the OCMT for service. Service of any witness summons pursuant to section 17 and 19 of the Coroners Act (Northern Ireland) 1959 will be effected by a constable either personally or by recorded delivery post. Where a summons is returned unserved the officer will be advised by Coroners Service and will be asked to obtain an up to date address and reserve. On some occasions this may be at very short notice as the inquest. The officer should expedite this request to avoid the inquest being adjourned.

Attendance at inquests
The Coroner will liaise with the PSNI Ops Planning offices before listing an inquest to endeavour to ensure the suitability of the date for the purpose of police witness availability. It may not always be possible to suit all witnesses. You must ensure that any pre-booked leave has been noted by ops planning as an adjournment may not be granted if you are booked on such a date.

Identification Issues

One of the key roles of the police in death investigation is the identification of the deceased. It is not only a matter of extreme urgency but also one where great care and sensitivity is required. It is essential that the deceased be quickly and accurately identified and that the identification be maintained at all stages.

The Body Recovery and Identification Team should also be tasked in complex cases where, for example: a) the body recovery operation is considered to be arduous; b) identification is considered to be a complicating issue (eg where foreign nationals are involved or the deceased is severely disrupted; c) in the event of the discovery of buried human remains or a suspected burial site.

The Body Recovery and Identification Team must liaise with the Coroner as to the progress of the recovery and identification. In some instances it may be necessary for the Team to assist the Coroner in an Identification Commission.

In every case:

- the police must compile an accurate report of the scene, including the position of the body, and establish whether the body has been moved prior to the arrival of the police
- the police must bring any issues or doubts surrounding identification to the attention of the Coroner prior to release of the body.

In the vast majority of cases it should be relatively straightforward to identify the deceased who will be known to and identifiable by a close relative. The deceased's family may wish to nominate someone other than the direct next of kin to identify the deceased and this is permissible provided the officer is satisfied the identifier was sufficiently acquainted with the deceased. Identification of a loved one is a traumatic experience and officers should conduct the exercise with regard to that fact. In every case the process should be explained and any injuries that may cause distress should be discussed in advance. It is essential that the identifier is absolutely certain regarding the identity. If any doubts are expressed these should be brought to the Coroner's attention.

Where a visual identification is impossible either due to the condition of the deceased's body or the unavailability of a suitable identifier, the police must alert the Coroner who will consider alternative methods after discussion with the pathologist. The Coroner will base identity on one primary identifier such as fingerprints, dental examination or DNA or more than one secondary

identifier such as scars, marks, tattoos, jewellery, personal belongings, clothing and unique physical characteristics.

Even where more than one person has died in a single but commonplace incident it may still be possible to rely on visual identification for those who are readily recognizable. Where it is not possible the police must consider alternative methods. In cases involving multiple deaths families should be informed that their loved ones may not be released for burial by the Coroner until all involved have been positively identified by one means or another, or, alternatively, an individual's identity has been incontrovertibly established by scientific means.

In the event of a mass disaster entailing multiple deaths it is imperative that police adhere to the guidance issued by the Police Service for Northern Ireland.

Should difficulties arise at any stage of an investigation into identity the officer may contact the Coroners Service for further guidance.

Doctors and Northern Ireland Ambulance Service (NIAS) (General Introduction)

Doctors should also refer to the General Medical Councils guidance 'Good Medical Practice' at www.gmc-uk.org and the Dept of Health, Social Services and Public Safety publication 'Guidance on Death, Stillbirth and Cremation Certification" which includes in detail when and how to contact the Coroner, Extra-Statutory lists of diagnoses which should be referred to the Coroner and a sample pro-forma that may be printed and copied. www.dhsspsni.gov.uk

What deaths need to be reported – the legal duty

There is a general requirement under Section 7 of the Coroners Act (Northern Ireland) 1959 to report a death to the Coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.

The duty to report arises if a medical practitioner has reason to believe that the deceased died directly or indirectly as a result of;

Violence
Misadventure
Unfair means
Negligence
Misconduct
Malpractice
Natural illness or disease if not seen and treated for it by a doctor within 28 days prior to death
Administration of an anaesthetic
Unexpected death in infancy (SUDI)

Quite apart from the statutory duty to report doctors have a recognised professional obligation to facilitate the Coroner's investigation:- please refer to Paragraph 69 – General Medical Councils guidance for Doctors "Good Medical Practice" www.gmc-uk.org)

In practice the vast majority of deaths reported by doctors concern patients for whom a MCCD (Death certificate) could have been written had it not been for the fact that they had not been seen and treated by the certifying doctor within the 28 days before death. These cases will be dealt with administratively by the Coroner after verbal reassurance from a doctor familiar with the deceased as to cause of death.

There are, of course, cases in which the need to report will be obvious such as where it is suspected that the death resulted directly or indirectly from the deceased being harmed by another whether intentionally or unintentionally,

self harm and accident. In cases that might have resulted from crime the doctor should immediately inform the police and allow them to take the matter forward with the Coroner.

In general if a doctor has any doubts or concerns about how death has come about then a report ought to be made. While it is undesirable to attempt to list definitively those cases which ought to be reported some of the most common are deaths resulting from:
Assaults
Suicides
Drug or alcohol abuse
Road traffic accidents
Work related accidents
Slips or trips
Hypothermia
Industrial disease[5]

Particular issues can arise where the deceased was receiving or had recently received medical attention. It is necessary to report deaths which occur:

On the operating table
While under an anaesthetic
Following a medical procedure (even where the possibility of death occurring was a recognised risk of the procedure)
Following a medical or nursing mishap
Where negligence has been alleged
Where a patient has had an accident or adverse incident in the hospital environment
Where family members have raised concerns regarding the patient's care

General Practitioners

The Coroners Service receives most reports of deaths from General Practitioners and their cooperation is of pivotal importance both to the successful operation of the Service and the facilitation of bereaved families.

The general rule – what to report and the information to have at hand

Where a General Practitioner has seen and treated a deceased person for the condition they died from within 28 days of the death then they may issue a **Medical Certificate of Cause of Death** provided no circumstances exist that invoke the obligation to report.

[5] See "Registrar's extra-statutory list of diagnoses which should be referred to the coroner" page 8 of Guidance of Death, Stillbirth and Cremation Certification – www.dhsspsni.gov.uk

In all other circumstances the doctor must contact the Coroners Service to discuss the way forward. In more troubling cases, particularly those raising suspicions of crime, the doctor should immediately inform the police and allow them to take the matter forward with the Coroner.

Where a GP reports a death he or she should be in a position to provide the Coroner with

- The patient's full name, address and date of birth
- Details of the patient's next of kin
- Time and date of the death
- Circumstances of the death
- The patient's medical history including the date last seen
- Medication history
- Full details of the patient's last illness and death
- Any known concerns expressed by family members
- Concerns harboured by the reporting doctor or other staff
- If death relates to an industrial disease (e.g. asbestos exposure) – deceased's relevant occupational history including occupation and place of work, if the family have commenced any legal proceedings or if any claims have been settled, if a definitive tissue diagnosis has been made or what other investigations have been carried out to establish the diagnosis, and if the deceased attended a specialist Respiratory Clinic
- Any known risks of infection should a PM be required e.g. HIV, TB, Hepatitis, Swine Flu.
- Details of Pace-makers or other radio implants in-situ
- Conclusions as to the cause of death
- Contact details for the GP should the Coroners Service or State Pathology Service wish to clarify further information concerning the death

Where possible the deceased's family should be kept fully informed about the decision to contact the Coroner and the Coroner's decision.

Contacting the Coroner - How the Coroner will deal with the death

In some cases the Coroner may consider that the death is such that it may be concluded with a Medical Certificate of Cause of Death. The Cause of Death stated will have been agreed after taking in to account all circumstances surrounding the death.

However, the vast majority of deaths reported by GPs concern individuals with recognized health conditions which, although not appropriate for disposal by MCCD (due to the fact that the patient has not been seen and

treated within 28 days) fully explain the death and may be dealt with under the **PRO-FORMA SYSTEM**.

Where the Coroner has agreed to this disposal the GP must fill out and sign the pro-forma, blank copies of which should be held in each surgery.

(Guidance and a blank pro-forma can be found on the Department of Health and Social Services and Public Safety website –www.dhsspsni.gov.uk – under publications "Guidance on Death, Stillbirth and Cremation Certification").

The completed pro-forma will form part of the permanent record of the death and accordingly each section should be completed and the document signed at the bottom. Under the section requesting circumstances of the death the GP should include a detailed narrative. Insufficient detail will lead to the document being returned.

Once completed the pro-forma should be faxed without delay to **028 90446801.**

(The original should then be posted to;-

Coroners Service for Northern Ireland,
May's Chambers,
73 May Street,
BELFAST.
BT1 3JL.

Only once a pro-forma has been agreed will the Coroner release the body and allow the family to proceed with its arrangements.

In cases requiring further investigation where the Coroner orders a **Post-Mortem Examination** the GP will be asked to supply a **clinical summary** for the Pathologist detailing the patient's medical history
Again, it is important that the summary contains sufficient relevant detail regarding the deceased's medical history to inform the pathologist of pre-existing conditions of significance in order to establish an accurate Cause of Death.
Details should include any known conditions that may pose a Health & Safety risk for mortuary staff such as HIV, hepatitis or active TB.

In every case the GP must detail:-

a) The patient's current medication
b) Relevant Past Medical History, Family History and known co-morbidities

The content of such summaries will, of course, vary depending on the nature of the death. In a suspected suicide, for instance, the summary should detail whether the deceased suffered from a depressive illness or had previous

suicidal ideations or episodes of self-harm. It should also include reference and contact details for referrals to other professionals such as Psychiatrists.

The completed Clinical Summary may be collected from the surgery by a Police Officer or faxed directly through to the Mortuary (after agreement with the Coroners Service).
Please supply the clinical summary promptly. The post-mortem can not be commenced until it has been made available to the Pathologist.

The Coroners Service will send the final Post Mortem Report to the deceased's GP when it is completed (this may take a few months). The family of the deceased will be advised of this and may wish to discuss the findings with the GP.

Locum GPs And NIAS

Most deaths that occur outside surgery hours are now dealt with by locum GPs or "Out of Hours" Services who rarely know the deceased and who are unable to certify. As a result a large number of deaths are reported that require the Coroners Service to liaise with the deceased's GP on the next available working day

Where a locum GP declares life extinct and no suspicious circumstances appear to exist he or she should attempt to make contact with the deceased's GP to establish whether it is possible to issue a death certificate or, if not, whether a pro-forma is feasible. Where a death certificate is to be issued the death need not be reported.

Where it is not possible to contact the deceased's GP, or where the deceased's GP is not willing to issue a death certificate then the death must be reported to the Coroner.

During office hours the Coroners Service will give instructions on how to proceed. Out of hours the locum GP should record the death on the Coroners Service answering machine and contact the police and ask them to place the body in a local mortuary. The Coroners Service should be informed of the name of the officer involved and the mortuary to which the deceased has been brought. The Coroners Service will then liaise directly with the deceased' GP to discuss how to proceed.

There may be occasions, outside normal working hours, when a GP cannot be contacted but the family advise that the deceased has a recognized severe or terminal illness and that they have been attended by a GP for this illness. The officer may consider allowing the body to be removed to the family undertaker's premises, on the strict instructions that the body must not be tampered with until the Coroner makes the necessary enquiries. The officer must remember to advise the Coroners Service where the body is resting.

It is always helpful, and would be considered good practice, for a GP to inform the Out-of-Hours Service of any imminent deaths eg of terminally ill cancer patients, or end-stage lung disease, in advance to prevent unnecessary reporting (see paragraph 48 and 50 in GMC Good Medical Practice).

In more troubling cases, particularly those raising suspicions of crime, the locum should immediately inform the police and allow them to take the matter forward with the Coroner.

Other involvement with the Coroners Service

GPs will often be called upon to assist the Coroner as the investigation into the death proceeds. Most commonly this will involve the provision of a Statement to police as to when life was pronounced extinct or the deceased's medical history.
In some instances GPs will be called to give evidence at inquests. If so you will be notified well in advance in order to be in a position to arrange locum cover. Reasonable expenses for attendance at Inquests are payable by the Coroners Service on receipt of the completed form which will accompany the Summons to attend. There are standard fees for certain expenses the details of which will be provided with the summons to attend.

As mentioned above once the Coroners Service receive the final written Post Mortem Report, the deceased's GP will be invited to assist families by talking through the results should the family wish them to do so.

Should the Pathologist uncover any information that may require a family to be medically screened the Pathologist will usually contact the GP directly, and will at the same time make the Coroner aware of his findings and subsequent contacts.

If you as the deceased's GP wish to attend the Post Mortem examination you should contact the Coroners Service to obtain the Coroners permission to do so. Your contact details will be passed to the mortuary staff who will inform you of the time of the examination.

Hospital doctors

Who should report the death

It is preferable for the reporting doctor to have treated the patient. In hospital, there may be several doctors in a team caring for the patient who will be able to certify the cause of death.

It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Foundation level doctors should not complete MCCDS unless they have received training.

It is the responsibility of the doctor on duty at the time a patient dies to report the death to the Coroner and to do so promptly before going off duty. A death occurring a night does not usually need to be immediately reported to the Coroner. The body should be moved to the Hospital mortuary for overnight storage and the Coroner's office contacted promptly the following morning.

However, if the deceased or their family have agreed to donation of organs for transplantation there is a need to obtain consent of the Coroner before removal of organs and the Duty Coroner should be contacted.

Steps to take before reporting the death

The doctor who assumes responsibility for dealing with the death must view the body before completing a MCCD or reporting the death to the coroner.

A doctor who is familiar with the patient's medical history and who is able to give an explanation of why death occurred should speak to family members. This will provide an opportunity for the family to express any concerns before a death certificate is completed. A written record of any concerns should always be made and retained with the medical records.

The family should be advised if the death is being referred to the Coroner with an explanation why.

Before reporting the death to the Coroner the doctor must become familiar with the patient's medical notes and records and be in a position to tell the Coroner:

- The patient's full name, address and date of birth
- Details of the patient's next of kin
- Time and date of the death
- Date and time of admission to the hospital
- The patient's medical history
- Name and address of the patient's GP
- The name of the consultant in charge of the patient's care and other medical staff involved in any surgical procedure
- Full details of the patient's last illness and death
- Concerns expressed by family members
- Concerns harboured by the reporting doctor or other staff
- Conclusions as to the cause of death
- If death relates to an industrial disease (e.g. asbestosis) deceased's relevant occupational history including occupation and place of work,

if the family have commenced any legal proceedings or have any claims been settled , details of any tissue diagnosis or other methods of investigation and if the deceased attended a specialist Respiratory Clinic.

- Any known Health and Safety issues that may put mortuary staff at risk e.g. HIV, active TB, Hepatitis etc
- Details of any pace-maker or similar device
- Final conclusions as to the cause of Death

What happens after the report is made

The Coroner may agree that the death can be dealt with by a **Medical Certificate of Cause of Death (MCCD or Death Certificate)** once the Cause of Death has been agreed. This should then be promptly completed in the usual manner and made available for the relatives to collect.

Best practice would recommend recording clearly in the deceased's notes any discussion with the Coroner, decision made and exact Cause of Death as it appears on the MCCD.

Alternatively the Coroner may decide to deal with the death administratively under **"Form 14" (Pro Forma Letter).** Provided this approach has been *agreed* with the Coroner the body may be released for burial. If the Coroner agrees this approach you will be asked to;-

- draft a completed but unsigned MCCD (Death Certificate) giving the Cause of Death as agreed and a signed clinical summary letter explaining the circumstances of the death (including any relevant investigations and results).

- please always check to see if deceased had a pacemaker or radio implant in situ if so inform the Coroners Office immediately by telephone and record on the letter accompanying the unsigned certificate

- **fax these documents promptly to the Coroner on 028 90446801**

- PLEASE DO NOT GIVE THESE DOCUMENTS TO FAMILY MEMBERS

- Finally send the original documents to

  The Coroners Service,
  May's Chambers,
  73 May Street,
  Belfast,
  BT1 3JL.

In some cases the Coroner will direct a **post mortem** to investigate the death further and establish a Cause of Death.
The Police act as the Coroner's agent to assist in transporting the body to the appropriate mortuary, identifying the deceased and recording information. In these circumstances you should:

- Maintain the body as it was on the time of death, keeping all invasive medical equipment in situ e.g. IV lines, catheters, syringe-drivers etc
- Keep the deceased's family fully informed (although no consent is required for a Coroner's post mortem)
- Inform the next of kin that a Liaison Officer from the Coroners Service will be in touch shortly to inform them of progress
- Promptly draft a detailed, relevant clinical summary to assist the pathologist carrying out the PM – the summary should either accompany the body, or be faxed directly to the mortuary (on the instruction of Coroners Office Staff) and should include sufficient details of the deceased's medical history (if known) including medication, procedures and investigations undertaken to allow a relevant examination to take place.
- Liaise with police who will arrive at the hospital to act as the Coroner's agent. The police officer will require a member of staff to formally identify the body and to provide brief particulars of the background to the death;
- Update the patient's medical records with the steps taken above.

What to do if the death occurs outside office hours

As mentioned above, in routine cases there is no need to report a death to the Coroner during the night. The body should be moved to the mortuary for overnight storage and the coroner's office contacted promptly the following morning. Maintain the body as it was on the time of death, leaving all medical equipment in situ. If you are aware of any health & safety risks to mortuary staff such as HIV or active TB please ensure the Coroners Service is informed immediately and the clinical summary is clearly marked with this information.

If you as the deceased's doctor wish to attend the Post Mortem examination you should contact the Coroners Service to obtain the Coroners permission to do so. Your contact details will be passed to the mortuary staff who will inform you of the time of the examination.

A Coroner is, however, always on call and can be reached, if necessary, on 028 90446800. Where there is a need to obtain the consent for the transplantation of organs, or some other

complicating factor arises, the death should be reported to the coroner as soon as possible. In cases that might have resulted from crime the doctor should immediately inform the police and allow them to take the matter forward with the Coroner.

The office is staffed Weekdays 9:00am-5:00pm
Weekends and public holidays 9.30am-12.30pm
(Except Christmas Day when the office is closed)
Outside normal office hours a recorded message will provide contact details for the duty Coroner or messages may be left on the answering machine.

The Coroner's investigation

Where the Coroner is considering holding an **Inquest** into a death which occurred in hospital it is likely that medical staff will be asked to make Statements. In some instances these are taken by the police but in most cases they are taken by hospital administration.

You may be required to attend an inquest as a witness. If so you will be summoned in enough time for you to make arrangements for cover. Every effort will be made to ensure that medical staffs are facilitated. Reasonable expenses are recoverable from the Coroners Service on completion of the claim form which will be enclosed with your Summons. There is a standard fee set for certain expenses details of which will be enclosed with the summons to attend.

Funeral Directors & Embalmers

Legal duty to report deaths to the Coroner

Most deaths are reported to the Coroner by doctors and police officers but it should be remembered that funeral directors and embalmers have a statutory duty to report deaths to the Coroner if they have reason to believe there are circumstances which require further investigation or, more specifically, when he or she has reason to believe that the person died, either directly or indirectly, as a result of:

Violence
Misadventure
Unfair means
Negligence
Misconduct
Malpractice
Natural illness or disease if not seen and treated for it by a doctor within 28 days prior to death

The importance of this role should not be underestimated. In the past those involved in preparing the body after death have identified suspicious marks or other causes for concern which have been missed by doctors. Any such issues should be reported to the Coroner. In one case a funeral director spotted injuries which led to a murder conviction where a doctor had issued a death certificate.

Funeral arrangements and preparation of bodies

It is vital that bereaved families are kept accurately informed of progress when the deceased person has not yet been released for burial. In particular, funeral directors should advise families that it is not possible to arrange a funeral until the body has been released by the Coroner.

In cases where you believe that an autopsy is not required and where a funeral director or embalmer has taken possession of a body work on its preparation should not begin unless and until sight is had of a death certificate or there is reliable confirmation that a pro forma has been agreed. Definitive confirmation can be obtained from the Coroners Service.

In cases where an autopsy is ordered or the body is to be taken to the mortuary for storage (until that decision on how to proceed has been made by the coroner), you should follow the instructions of the police officer in charge at the scene. At this stage you will be acting on behalf of the coroner and must be on the approved list of undertakers held by the PSNI. The exception to this is if the family have specifically requested your appointment to the PSNI officer at the scene.

If an autopsy is ordered and you have been appointed as Funeral Director by a family you should contact the mortuary to register your interest and to provide your contact details. The Northern Ireland Regional Forensic Mortuary can be contacted on 02890247271 and the Royal Victoria Hospital mortuary is 02890633679.

When a Coroners Post Mortem examination is carried out the family will have a Coroners Liaison Officer assigned to them. The CLO will contact the family immediately after the post mortem examination to inform them of the preliminary findings and to discuss any organ and tissue retention. The family will also be advised that the CLO will inform the mortuary that the body can be released when the body is ready for collection. The mortuary staff will then contact you once the body is ready. Preparations may begin immediately on a body that has been released following a post mortem examination ordered by the Coroner.

Precautions at the scene and in transportation

In some of our smaller communities police officers occasionally take evidence of the deceased person's identity from a funeral director who may know the deceased. While this can be helpful in providing leads as to the next of kin it should not be offered or accepted as a formal identification.

Funeral directors must adhere closely to police instructions regarding the necessary precautions to be followed in transporting bodies to the mortuary. A mistake at this stage can lead to important evidence being lost. The PSNI body bag protocol is attached for your information should you require it.

Any problems that arise in transit or handling of a deceased person should be carefully noted and brought to the attention of the Coroner in order to account for any post mortem injuries.

Other information

Burial, cremation and out of country orders are obtainable from the Coroners Service during the hours of 9.30 am to 4.30pm (weekdays) and 9.30 to 12.30 pm (weekends and public holidays – except Christmas Day when office closed). For your convenience it is best to place an order by telephone in advance of attending the office to ensure that it is possible to issue the order and to have it ready for your collection. Out of hours you can place your order in advance on the office answer machine - 02890446800. Information required will be:

- name of deceased
- name of Funeral Director
- type of order required - ie burial/cremation/out of country
- If Proforma letter case – the office must be in possession of the proforma form before a cremation order can be released. A pacemaker form will accompany this order.

- If an out of country order is required you must ensure the office has the Funeral Director's name and address, the name of the deceased and if a death certificate has issued a copy of it.

Please note - Funeral Directors should be aware that in cases of murder or suspected murder the Coroner will usually not issue a cremation order.

Fees for Coroners Removals

Where you have removed a body on the instructions of the PSNI for a coroners investigation you will be paid a standard fee for the removal and return of the body, reasonable mileage (in excess of the removal fee allowance), reasonable waiting time for two attending staff (if circumstances required waiting rather than a return to base) and a fee for a body bag where used. You should complete the proforma invoice which can be obtained from the Coroners Service and submit within 28 days of the removal, where possible. (Separate arrangements apply for the Greater Belfast area where a contract has been awarded for Coroners removals).

Where you are instructed by PSNI as acting for the Coroner you must not attempt to influence the family on their appointment of a funeral director. You must make it clear to the family that you have been called in relation to the removal only. If the police have already discussed this matter with the family they may have contacted you on the families behalf for both purposes. This is acceptable, as long as the police have made these arrangements. Your association's code of ethics will also apply.

Homes & Institutions

This advice applies equally to care homes, nursing homes and hostels.

What to do when a resident dies in the home

In most cases it will be sufficient to telephone for the resident's doctor who will be able to advise on the next course of action. Where, however, there are any unusual circumstances surrounding the death, such as where the resident has had an accident, has self harmed or crime is suspected, the police ought to be contacted immediately. In every case the resident's next of kin (and social worker if one is appointed) should be informed as soon as possible. The Regulation and Quality Improvement Authority should also be informed of deaths arising from adverse incidents in the home or deaths occurring within the home in which the Coroner has directed a post mortem.

What deaths need to be reported – the legal duty

The proprietor of a home has a statutory duty to report a death to the Coroner if he or she has reason to believe there are circumstances which require further investigation or, more specifically, when he or she has reason to believe that the person died, either directly or indirectly, as a result of:

Violence
Misadventure
Unfair means
Negligence
Misconduct
Malpractice
Natural illness or disease if not seen and treated for it by a doctor within 28 days prior to death

In general a doctor or police officer who is called out will assume this responsibility but if the proprietor harbours any doubts or concerns that this has not been done, or considers that there is further information relevant to the death, this should be reported direct to the Coroner. Proprietors should bring any relevant information to the attention of the doctor or police in attendance. In particular it is necessary to be absolutely transparent regarding:
Accidents
Self harm
Drugs (all medication should be retained until police say otherwise)
Medical treatment
Family concerns
Alcohol or drug abuse
Assaults

Assistance in the Coroner's investigation

Managers of homes and institutions will often be asked for statements concerning the deceased and the death which will normally be taken by police officers. On occasion staff and managers will be summoned to attend court. If this happens witnesses will be alerted well in advance in order that appropriate cover may be organised.

Bereaved families

What to do when someone dies at home

In normal circumstances the deceased's doctor should be contacted who will attend to confirm death. If the death has occurred in suspicious circumstances, for example, if someone else has contributed to the death, it has arisen as the result of an accident or of self harm then you must contact the police. The doctor or police will contact the Coroner if required.

What to do when someone dies in hospital

The doctors who have been treating the deceased person will advise on the issue of a death certificate or if the death is to be reported by them to the Coroner. If there are concerns regarding the death they should be brought to the Coroner's attention by informing the doctor or if this is not possible the Coroner can be contacted directly and this should be without delay.

What if someone dies outside either the home or hospital?

In these circumstances the police and a Funeral Director, after consulting the Coroner, will transport the body to a hospital mortuary while a decision is made as to how to proceed.

What if the doctor or police officer says that the death is being reported to the Coroner?

Doctors and police officers have a legal duty to report certain deaths to the Coroner. Before doing so they will explain why they are taking that action. Once a death is reported it is up to the Coroner how to proceed. Often the Coroner will simply agree a way forward with the deceased's doctor, but this can take some time to achieve, especially at weekends. If the Coroner directs that the deceased be taken for post mortem you will be contacted by a Coroners Liaison Officer immediately after the post mortem examination has taken place who will explain the preliminary outcome of the examination, when the body will be released for burial, and issues surrounding organ retention and next steps. **Information about post mortem examinations can be found in the leaflet 'Coroners Postmortem Examination for Relatives'. (www.coronersni.gov.uk)** Every effort is made to ensure that bodies are released for funeral as soon as possible but you should not make any firm arrangements until advised by the undertaker that it is time to do so.

The post mortem examination is usually carried out at the Northern Ireland Regional Forensic Mortuary in Grosvenor Road, Belfast. In some cases it may be carried out in the adjacent Royal Victoria Hospital Mortuary. Post mortem examinations are carried out at the earliest possible time following the Coroners direction and the body will be released to a family's funeral director as soon as possible. If however a family wish to see the body of their loved one at this time, they may do so, but only on prior arrangement with the mortuary. This can only be facilitated during normal opening hours and for reasons that would preclude waiting for the body to be released.

(In some circumstances it may not be possible to see the body prior to release, for instance if there are health and safety risks or suspicious circumstances and a police investigation is underway.) You can contact a Coroners Liaison Officer to discuss this should you need assistance.

Normally any personal belongings of the deceased will be given to the funeral director. If there are any queries you should speak to the undertaker in the first instance or in some cases the investigation officer may be able to provide further help,.

The Coroners Liaison Officer who has been designated to you will keep you informed of the processes and stages in the Coroner's investigation. More information can be found in the leaflet 'The Coroners Liaison Officer'. (www.coronersni.gov.uk)You are free to contact your CLO during office hours if you have any questions or concerns.

What other roles might the bereaved family have?

In cases reported to the Coroner it will be necessary to have the deceased person formally identified. In most instances this falls to a close family member. The police will talk you through the process.

In some instances the police, acting for the Coroner, may ask a family member to provide a statement. The content of the statement will vary depending on the circumstances. The Coroner will be interested to learn from the statement about any concerns you have regarding the death.

Where the Coroner decides to hold an inquest into a death a family member will usually be called to give evidence. If this happens the family member will be informed by the Coroners Service and the police will send a summons which will tell the person when and where they should attend. If you are nervous about giving evidence you should tell a member of the Coroner's staff. Every effort will be made to minimise anxiety. More information is provided in the leaflet 'Coroners Inquest'

Registering a death which has been reported to the Coroner[6]

Unless a death certificate has been issued by a doctor, a death reported to the Coroner can only be registered after the Registrar has received documentation from the Coroner stating how the investigation into the death has concluded.

When the Registrar's office receives this documentation it will contact the deceased's next of kin and invite them to have the death registered.

[6] For further information on the registration process go to www.groni.gov.uk.

If a post mortem examination has been ordered it may be some considerable time before the death can be registered. To help during this time a 'Coroner's Certificate of Evidence of Death' will be sent to the family . This certificate will help when dealing with some financial matters but families should be aware that not all financial institutions will accept this form.

In the event of an inquest, families will be able to obtain a full death certificate from the Registrar of Deaths within 5/7 days of the hearing.

Links

Coroners Service Website
http://www.coronersni.gov.uk/

Coroners Service Leaflet
http://www.coronersni.gov.uk/publications/Coroners_Service.pdf

Coroners Liaison Officer Leaflet
http://www.coronersni.gov.uk/publications/Coroners_liaison_leaflet.pdf

Coroners Inquest
http://www.coronersni.gov.uk/publications/inquest.pdf

Post Mortem Information
http://www.coronersni.gov.uk/publications/postmortem.pdf

Guidance on Death, Stillbirth and Cremation Certification
www.dhsspsni.gov.uk

The British Medical Association
www.bma.org.uk

The MDU
www.the-mdu.com

Good Medical Practice
www.gmc-uk.org