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through the
administration of justice

The Coroners Service for Northern Ireland

Working with the Coroners Service for Northern Ireland

www.courtsni.gov.uk

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SECTION 1

Introduction and contact details

1.1 What is a Coroner?

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

1.2 How many coroners are in Northern Ireland?

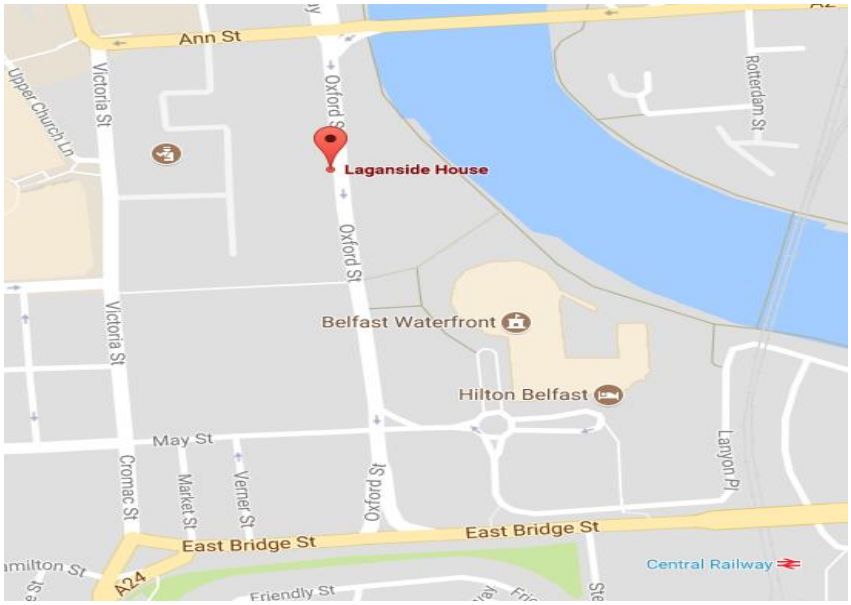
A High Court Judge is designated as the Presiding Coroner for Northern Ireland. There are currently 3 full time, permanent coroners for Northern Ireland:

Ms Suzanne Anderson,
Mr Joseph McCrisken and
Mr Patrick McGurgan.

They are supported by the staff of the Coroners Service for Northern Ireland. In addition, there are 7 County Court Judges who have dual appointments which means they can hear coroners cases.

1.3 Where are the coroners based?

The coroners are based at the Coroners Service for Northern Ireland which is located. On 5th Floor, Laganside House, Oxford Street, Belfast BT1 3LA.



1.4 How can I contact the Coroners Service?

The Coroners Service can be contacted by telephoning 0300 200 7811, or by emailing deathreportingteam@courtsni.gov.uk or coronersoffice@courtsni.gov.uk

1.5 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.

1.6 When and how will a death come to the attention a 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 a coroner because of concerns raised by families or members of the public.

1.7 What does a coroner do when a death is reported?

All deaths reported are investigated by a coroner. The majority are then dealt with immediately and administratively, either by way of a Medical Certificate of Cause of Death (a MCCD) or when a coroner, having received an assurance from a doctor as to the cause of death, notifies the Registrar of Deaths that the death may be registered via a "Form 14" otherwise known as the pro-forma. However, where a question arises over the cause of death or the circumstances leading up to the death, a coroner may order that a post mortem examination be conducted. Although a 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. 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 (CLO) will be assigned to the case. The CLO will keep the family informed regarding the outcome of the post mortem and a coroner's investigation. When a coroner receives a post mortem report, which can be some months after the death, a decision will be made by a coroner either to inform the Registrar of Deaths that the death may be registered via "Form 17", to commence an investigation into the circumstances of the death or to proceed to hold an Inquest.

1.8 What is an inquest?

Where a coroner decides that a death should be investigated an inquest will be held in a public court. The court venue will, where possible, be in the locality where the death occurred.

1.9 What to expect at an inquest?

An inquest is a fact-finding investigation and not a method of apportioning blame, no one is on trial. The role of a coroner is not to find fault, an inquest is not a substitute for a civil or criminal hearing. Members of the deceased's family will be provided with information like statements and reports subject to the view of a coroner. It is not unusual for interested persons to be legally represented although they do not necessarily need to be.

When the next of kin have made a statement, the statement may be read out in court by the court clerk. A coroner may ask the next of kin some questions at inquest.

A person who has been notified by a coroner to attend the inquest hearing is under a legal obligation to answer any questions surrounding the death. A person who may be responsible for the death is not obliged to answer any questions which might incriminate them and a coroner will give them a warning about this.

Narrative findings, which answer the questions of who the deceased person was , where, when and how they came by their death, will be provided by a coroner or a jury if one has been summoned. A coroner will sit with a jury in cases involving deaths in the workplace or if a person died while in custody.

SECTION 2

Mortuaries and mortuary staff[1]

2.1 Introduction

Coroners recognise that mortuary staff has a difficult and emotionally demanding job that requires both skill and sensitivity. What follows is a guide to what a coroner will 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 a coroner the body falls within a coroner's jurisdiction and there can be no interference with the body without a coroner's consent.

The Coroners Service deals with several mortuaries in a number of different ways:

Hospital deaths: Where somebody dies in hospital the body should be taken to the mortuary, without interference, while a 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 a coroner to make a decision on the death or, where it is anticipated that a post mortem will be required, to facilitate families in identifying the person. Police can arrange for the remains to be taken to a local undertaker with the explicit instruction not to interfere with the body until a coroner makes a direction. It is generally the case that this can be done in non-suspicious cases (where a doctor, when available may be able to issue either a death certificate or a pro-forma letter)

Coroner's Post-mortem: Where a post mortem is ordered by a coroner the deceased will normally be taken to the Northern Ireland Regional Forensic Mortuary.

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

[1] 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: http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Care-and-respect-in-death.pdf

2.2 Contacting a coroner

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

2.3 Receipt and maintenance of the deceased

On arrival into the mortuary the identity of the deceased person must be checked, or, if it is yet to be established, the circumstances of their admission to the mortuary. 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 a pathologist. The body should not be undressed or otherwise interfered with until either a) it is clear that no post-mortem 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 post mortem. In every case a careful note is made of the deceased's belongings which is kept securely and fully labelled. In cases in which police indicate that crime is suspected the technician must give a pathologist the option of viewing the body while still clothed. More detailed instructions may be issued by a pathologist or police officer. **If in doubt a coroner's advice should be sought.**

2.4 Dealing with bereaved families

Families who wish to see the body of their loved one should, be able to do so 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 a 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 a 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 cannot be done without jeopardizing the integrity of the death investigation or because of safety considerations.

2.5 Identification

It is the responsibility of the police acting as a coroner's agent to establish identity on behalf of a 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 a 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 post mortem – if for any reason this is not possible the Coroner must be consulted.

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

2.6 Release

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

Where no post mortem 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 provided with the relevant documentation above or when the method of disposal has been confirmed directly to it by the Coroners Service.

Following post mortem a body should not be released by the mortuary staff without the express consent of a coroner which will follow receipt of the C1 form giving a preliminary cause of death and, in homicide cases, discussion with a coroner, senior investigating police officer and a pathologist. The CLO will advise the mortuary staff by telephone and in writing that the body can be released

Organs and/or tissue that have been removed during post mortem 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 a pathologist, they may not be disposed of or otherwise dealt with in the absence of an express instruction from a 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 a coroner. This form advises a coroner that a pathologist has completed his investigations in relation to retained organ and tissue.

SECTION 3

Police and Police Officers and NIAS

3.1 The relationship with a coroner

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

3.2 The duty to report

The law is framed so that every unexpected, unnatural or questionable death should be reported to a coroner who must be informed as soon as the investigating officer attends the scene. The Coroner's Office can be contacted on 0300 200 7811 or by email to deathreportingteam@courtsni.gov.uk

3.3 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 or delegated officer within whose district the body is found, or the death occurs, shall give or cause to be given immediate notice in writing thereof to a 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."

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

Establish that death has occurred: Before involving a coroner life must have been pronounced extinct. (A coroner only has jurisdiction with regard to the deceased.) In deaths that appear to be suspicious, 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 must not be moved from a scene until life is formally pronounced extinct.

Establish whether a 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) can be issued. Once a certificate is issued the police need have no further dealings with the death and a coroner does not need to be involved If for any reason a certificate cannot be issued then the death must be reported to a 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 CSI must be tasked and a coroner informed.

All deaths **in prison or custody** must be reported to a coroner and the state pathologist must be given an opportunity to attend the scene.

The police officer should, in all deaths reportable to a coroner:

- 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 a 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 a coroner and immediately report the death on 0300 200 7811 or deathreportingteam@courtsni.gov.uk Remember that where a death is reportable to a coroner nothing may be done with or to the body without a coroner's consent. The deceased's family should be kept fully informed of all that is taking place and the family should be encouraged to make contact with their chosen funeral director who will liaise with NIRFM on behalf of the family.

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

2. Provide a coroner with information concerning the finding of the body or concerning the death by telephoning the Coroner's Office on 0300 200 7811 or deathreportingteam@courtsni.gov.uk at any time. Staff are available to take the call each weekday from 9am to 5pm and at weekends/bank holidays from 9.30am to 12.30pm. At all other times the officer must leave the information on the answering service or email the office so that a coroner can consider the circumstances at the earliest opportunity. The information should include:

Name, address, date of birth and occupation of the deceased. Next of kin – Name and Contact details.

Medical history and whether the deceased has a pacemaker fitted and include 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 and where the remains are being held.

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 labelling 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 the pathologist is required to attend the scene. A 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 labelled and stored.

3. Complete a Form P1 for the pathologist who will require this prior to the post mortem. The officer must also complete a Form 19 for a coroner which must be forwarded to the coroner promptly.

3.5 Removal of the deceased to the mortuary

Removal: On a coroner's instructions the police officer will arrange for transportation of the body to the mortuary using the Coroner's Contracted undertaker or to the Northern Ireland Regional Forensic Mortuary (NIRFM) in Belfast based in the grounds of the Royal Victoria Hospital. A 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 or email the office. 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 a coroner the next morning. If the death may have resulted from homicide the police must contact Belfast Contact Management Centre to have the Regional Mortuary at Belfast opened and the body should be deposited there without delay. A Coroner is available 24/7 should it be necessary to seek instructions – outside normal working hours the on call details can be obtained from the recorded message on 0300 200 7811.

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 a 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 a coroner is available outside normal office hours, the contact details can be obtained by telephoning 0300 200 7811.

In all other circumstances the body should be removed from the scene by the Coroner's Contracted undertaker 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[2]. There is a contracted funeral director who is responsible for all coroners removals within certain boundaries. Belfast Contact Management Control can provide advice as to who should be called.

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

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

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. The officer should have a NIRFM admission sheet which has been completed by the investigating officer. 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 post-mortem examination. Where appropriate the PSNI officer will inform the mortuary technician if the body must not be removed from the body bag for post-mortem 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 post-mortem 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 a coroner.

3.6 Role where the Coroner has directed an post mortem be performed

Each post mortem 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' Department on 02890 247271 to establish the time that the post mortem will take place and ensure that he attends in good time.

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

Where a death has occurred in a hospital a full clinical summary will be given to the officer. This should be taken to a pathologist prior to the post mortem. The officer should ensure that **NO** original notes are given to them by the Ward, a Pathologist may ask for the notes but a copy should be obtained.

In all other deaths the officer should obtain a clinical summary from the GP on the agreed form, which can be accessed from http://www.courtsni.gov.uk/en-GB/Documents/Clinical%20Summary%20template%20April%202016.pdf

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 a coroner of its desire to be represented at the examination;

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 officer must obtain a coroner's consent for the attendance of any other individual at the post-mortem 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 post-mortem.

After the post mortem: At the conclusion of the post-mortem 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 0300 200 7811 and send through the C1 and Form 19 immediately.
- 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.
- At this stage the CLO will be able to advise you whether or not an Inquest file is required(see below for the required contents of the file).

Release of the deceased's body: Once a 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 (statements must be received by a coroner within 8 weeks, with the exception of murders and road traffic collisions). PSNI and CSNI have entered into a 'Working Practices Agreement' on file progression and contact which all officers should make themselves familiar with.

3.7 Role where there is to be an inquest

The inquest file: Most reported deaths are dealt with administratively by a coroner but where a coroner informs the police that there is to be an inquest the officer in charge of the case must provide a coroner with an inquest file within eight weeks of the date of death. 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.

Where statements are not received within eight weeks, a coroner will hold a preliminary hearing where the officer or his/her Inspector will be call to court to explain the delay.

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. A 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 a 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 a 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 must be included, as should a detailed statement from the deceased's GP and Psychiatrist should one have been seen. In certain cases of suicide, a 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 counsellor 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?

GP Statement

A statement must be obtained from the deceased's GP at the earliest opportunity as GP records are sent off for storage when the GP closes his file.

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 a coroner is advised and kept informed of any file submitted or to be submitted to the PPS. It is also important that a 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 DfI regarding road safety in the area.

Death in hospital or during a hospital procedure

Arrangements exist where a coroner's office will request statements directly from the Litigation unit of the hospitals rather than through the investigating officer. The CLO will have advised you of this at the outset of a coroner's investigation. In some circumstances you may be asked to obtain these statements. Statements must be taken and sent to a coroner within eight weeks 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 and or the community setting. These statements should be obtained via the Hospital administration unit also.

Where statements are not received within eight weeks, a coroner will hold a preliminary hearing where the Doctor will be call to court to explain the delay.

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) a 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.

3.8 Additional responsibilities in respect of the Coroner's ongoing investigation

Case progression – PSNI investigation

The officer will keep a 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 a 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 a coroner know their intended course of action. The officer will supply a witness list with the current addresses and telephone numbers of the witnesses.

Notification to a witness to attend court

A coroner will decide which witnesses he requires to attend to give evidence at an inquest. Notification will be sent to the witness using Notice 17A of the Coroners Act (NI) 1959.

A coroner has the power to fine an individual for non-attendance at court of up to £1000.

Attendance at inquests

A coroner will liaise with the PSNI Ops Planning offices before listing an inquest 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.

3.9 Exhumation

The issue of an exhumation order falls to a coroner where the circumstances so dictate.

3.10 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 a coroner as to the progress of the recovery and identification. In some instances it may be necessary for the Team to assist a 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 a 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 a 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 a coroner who will consider alternative methods after discussion with the pathologist. A 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 a coroner until all involved have been positively identified, 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

Section 4

The role of the Prisoner Ombudsman where a death has occurred in prison custody

4.1 Role of Prisoner Ombudsman

Where a death occurs in prison custody, the Office of the Prisoner Ombudsman conducts an independent investigation into the circumstance surrounding the death.

Section 5

General Practitioners, Hospital 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 publication 'Guidance on Death, Stillbirth and Cremation Certification" which includes in detail when and how to contact a coroner, extra-statutory lists of diagnoses which should be referred to a coroner and a sample pro-forma that may be printed and copied:
https://www.health-ni.gov.uk/

5.1 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 a 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)
Or any circumstances which require investigation

Quite apart from the statutory duty to report doctors have a recognised professional obligation to facilitate a coroner's investigation: please refer to – 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 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 a 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 a 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[3]

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.

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

[3] See "Registrar's extra-statutory list of diagnoses which should be referred to the coroner" Guidance of Death, Stillbirth and Cremation Certification www.health-ni.gov.uk

doctor should immediately inform the police and allow them to take the matter forward with a coroner.

Where a GP reports a death he or she should be in a position to provide a 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 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 Department wish to clarify further information concerning the death
- Where the remains are resting

The deceased's family should be kept fully informed about the decision to contact a coroner and a coroner's decision.

5.2 Contacting a coroner - How the Coroner will deal with the death

In some cases a 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 a coroner has agreed to this, 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 website https://www.health-ni.gov.uk/ 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 emailed without delay to; deathreportingteam@courtsni.gov.uk

The original should then be posted to:

Coroners Service for Northern Ireland
5th Floor, Laganside House
23 – 27 Oxford Street
Belfast BT1 3LA

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

In cases requiring further investigation where a coroner orders a **Post- Mortem Examination** the GP will be asked to supply a **clinical summary**, **on the agreed template which is available on the** www.courtsni.gov.uk website 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 sent directly through to the Mortuary.

Please supply the clinical summary promptly. The post-mortem cannot be commenced until it has been made available to the Pathologist.

The Coroner's 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.

Guidelines for Death Certification in patients who die within 30 days of Systemic Anti-Cancer Therapy (SACT)

If a patient dies within 30 days of SACT and the cause is assessed by their treating team as progressive disease from malignancy with no contribution from SACT a death certificate can be issued

If SACT (or any other treatment) is felt to have contributed or possibly contributed to the death then the case should be discussed with a coroner.

If a death certificate has been issued and on review there it is felt that a strong reason that the cause of death on the death certificate should be amended discussion with the family and with a coroner should take place.

5.3 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 a coroner 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 a coroner 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 where the remains are resting. The Coroner's 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 recognised 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 (refer to 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 a coroner.

5.4 Other involvement with the Coroners Service

GPs will often be called upon to assist a 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.

Expenses in line with policy for attendance at Inquests are payable by the Coroners Service on receipt of the completed form which will accompany the notice to attend. There are standard fees for certain expenses the details of which will be provided with the notice 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 a pathologist uncover any information that may require a family to be medically screened a 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 GP wish to attend the Post Mortem examination you should contact the Coroners Service to obtain a coroner's permission to do so. Your contact details will be passed to the mortuary staff who will inform you of the time of the examination.

5.5 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.

It is the responsibility of the doctor on duty at the time a patient dies to report the death to a coroner and to do so promptly before going off duty. A death occurring at night does not usually need to be immediately reported to a 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 has 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.

5.6 Steps to take before reporting the death

Ideally, the doctor who assumes responsibility for dealing with the death or a doctor from the same practice should 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 a coroner with an explanation why.

Before reporting the death to a coroner **the doctor must** become familiar with the patient's medical notes and records and be in a position to tell a 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, and Hepatitis etc.
- Details of any pace-maker or similar device
- Final conclusions as to the cause of Death

5.7 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)** 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 a coroner, decision made and exact Cause of Death as it appears on the MCCD.

Alternatively a coroner may decide to deal with the death administratively under **"Form 14" (Pro Forma Letter).** Provided this approach has been agreed with a coroner the body may be released for burial. If a 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 (electronic signature is acceptable) 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 Coroner's Office immediately by telephone and record on the letter accompanying the unsigned certificate
- email these documents promptly to the Coroner's office at; deathreportingteam@courtsni.gov.uk

PLEASE DO NOT GIVE THESE DOCUMENTS TO FAMILY MEMBERS

Finally send the original documents to:

The Coroners Service,
5th Floor, Laganside House
23- 27 Oxford Street
Belfast BT1 3LA

In some cases a coroner will direct a **post mortem** to investigate the death further and establish a Cause of Death.

The Police act as a 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 Coroner's 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 a 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.

5.8 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 a coroner during the night. The body should be moved to the mortuary for overnight storage (or to a local undertaker where the death is not being treated as suspicious) 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 0300 200 7811. 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 a 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 or emailing the office on deathreportingteam@courtsni.gov.uk

5.9 The Coroner's investigation

Where a 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 litigation department.

You may be required to attend an inquest as a witness. If so you will be put on notice to attend in sufficient time for you to make arrangements for cover. Every effort will be made to ensure that medical staff is facilitated. Reasonable expenses are recoverable from the Coroners Service on completion of the claim form which will be enclosed with your notice. The Trusts have confirmed that time out to attend inquest is covered and therefore loss of earnings cannot be claimed for this. There is a standard fee set for certain expenses details of which will be enclosed with the notice to attend.

Section 6

The Role of Northern Ireland Fire and Rescue service

6.1 Role of the NIFRS

Northern Ireland Fire and Rescue Service (NIFRS) have a statutory duty to protect life and property in the event of fire and to rescue persons in the event of Road Traffic Collisions and other emergencies. NIFRS is also tasked within the promotion of fire safety, the education of the community to keep them safe from fire, and the enforcement of fire safety duties in Northern Ireland.

Where NIFRS personnel have attended the scene of a sudden death, the Assistant Chief Fire Officer (Prevention and Protection) will nominate a Disclosure Officer who will liaise directly with the coroner's office and ensure that all information that has been collated by NIFRS will be disclosed on request of a coroner.

Where the sudden death involves a fire in premises, NIFRS will internally conduct a Fatal Fire Review (FFR). The findings of the FFR will also be disclosed to a coroner when requested. The Coroner's office will inform NIFRS of the details of any hearings and a member of the FFR team will attend any subsequent inquest. A copy of a coroner's final report is made available to NIFRS FFR team.

The coroner's office will also liaise with the NIFRS Station Commander (Legal) at NIFRS Headquarters in relation to the requests for Fire Service Personnel attendance at any subsequent hearings.

Section 7

Funeral Directors & Embalmers

7.1 Legal duty to report deaths to the Coroner

Most deaths are reported to a coroner by doctors and police officers but it should be remembered that funeral directors and embalmers have a statutory duty to report deaths to a 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 has identified suspicious marks or other causes for concern which have been missed by doctors. Any such issues should be reported to a coroner for example, in one case a funeral director spotted injuries which led to a murder conviction where a doctor had issued a death certificate.

7.2 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 a coroner.

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

In cases where an post mortem 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 a coroner and must be on the

approved list of undertakers held by the PSNI. The exception to this is if the family has specifically requested your appointment to the PSNI officer at the scene.

If an post mortem 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 coroner's 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 a coroner.

7.3 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 someone 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 a coroner in order to account for any post mortem injuries.

7.4 Other information

Burial, cremation and out of country orders are obtainable from the Coroner's Service during the hours of 10.30 am to 4.30pm (weekdays) and 9.30 to 12.30 pm (weekends and public holidays - except Christmas Day when office closed).Orders can be ordered by telephone or by emailing deathreportingteam@courtsni.gov.uk

The following information is required by the office:

- name of deceased
- name of Funeral Director
- type of order required - i.e. burial/cremation/out of country

- If pro-forma letter case – the office must be in possession of the pro-forma 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 a coroner will usually not issue a cremation order.

7.5 Fees for Coroners Removals

Where you have removed a body on the instructions of the PSNI for a coroner's investigation you will be paid a standard fee for the removal and return of the body along with reasonable mileage (in excess of the removal fee allowance), You should complete the pro-forma invoice which can be obtained from the Coroner's Service and submit it within 28 days of the removal.

Where you are instructed by PSNI as acting for a coroner you must not attempt to influence the family on the 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.

Section 8

Homes & Institutions

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

8.1 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 a coroner has directed a post mortem.

8.2 What deaths need to be reported – the legal duty

The provider of a home has a statutory duty to report a death to a 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
Or any circumstances which require investigation.

In general a doctor or police officer who is called out will assume this responsibility but if the provider has 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 a coroner. Providers 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

8.3 Assistance in a 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 notified to attend court. If this happens witnesses will be alerted well in advance in order that appropriate cover may be organised.

Section 9

Bereaved families

9.1 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 a coroner if required.

9.2 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 a coroner. If there are concerns regarding the death they should be brought to a coroner's attention by informing the doctor or if this is not possible a coroner can be contacted directly and this should be without delay.

9.3 What if someone dies outside either the home or hospital?

In these circumstances the police, after consulting a coroner, will make the arrangements to transport the body to a hospital mortuary while a decision is made as to how to proceed.

9.4 What if the doctor or police officer says that the death is being reported to a coroner?

Doctors and police officers have a legal duty to report certain deaths to a coroner. Before doing so they will explain why they are taking that action. Once a death is reported to a coroner, he will make a decision on how to proceed. Often a coroner will simply agree a way forward with the deceased's doctor, but this can take some time to achieve, especially at weekends. If a coroner directs that the deceased be taken for post mortem you will be contacted by a CLO immediately after the post mortem examination has taken place who will explain the preliminary outcome of the examination, when the body will be released to the family and issues surrounding tissue and organ retention and next steps. **Information about post mortem examinations can be found in the leaflet 'Coroners Post-mortem Examination for Relatives'** www.courtsni.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 a coroner's direction and the body will be released to a family's funeral director as soon as possible. If a family wishes to see the body of their loved one at this time, this may be facilitated, 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 CLO to discuss this should you need assistance.

Personal belongings of the deceased will be given to the family 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 assistance.

The CLO who has been assigned 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.courtsni.gov.uk). You can contact your CLO during office hours if you have any questions or concerns.

9.5 What other roles might the bereaved family have?

In cases reported to a 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 a 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.

The decision on whether an inquest shall be held, rests entirely with the Coroner. Where a coroner decides to hold an inquest into a death a family member will usually be called to give evidence and can ask questions at the inquest hearing. If this happens the family member will be informed by the Coroner's Service which will tell the person when and where they should attend. If you are nervous about giving evidence you should speak to your appointed CLO. Every effort will be made to minimise anxiety. More information is provided in the leaflet 'Coroner's Inquest'

9.6 Registering a death which has been reported to a coroner[4]

Unless a death certificate has been issued by a doctor, a death reported to a coroner can only be registered after the Registrar has received the notification to the Registrar to allow the death to be registered.

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.

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 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.courtsni.gov.uk

Guidance on Death, Stillbirth and Cremation Certification
https://www.health-ni.gov.uk

The British Medical Association
www.bma.org.uk

The MDU
www.the-mdu.com

Good Medical Practice
www.gmc-uk.org

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