Current Practice

FORENSIC MEDICINE AND TOXICOLOGY

Reference to the Coroner

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Accurate recording of causes of death is important for the national statistics on which so many calculations and decisions depend.

Before any death is registered the cause of death must be ascertained as exactly as possible. Only two persons can issue a certificate of cause of death—the doctor in attendance on the last illness and the coroner. The coroner's counterpart in Scotland is the procurator fiscal. The doctor has a statutory obligation to sign a certificate, but "attendance" and "last illness" have not been judicially defined.

The requirement to report to the coroner is even more indefinite. It has been said that a doctor, as such, has no special duty to report a death, and that his obligation ends with completion of the certificate, it being for the registrar to notify the coroner if it appears that an inquiry is needed. On the other hand, it is the duty of every person who is "about the body" to notify the coroner of circumstances requiring the holding of an inquest, which would often include the doctor.

Though the legal position may be hazy, it is universal practice for a doctor called to a death which he cannot certify to inform the coroner's officer immediately. This minimizes delay in making inquiries and consequent distress to relatives. Any person may inform the coroner of a suspicious death, but in practice reports come from four sources: (1) registrars of deaths; (2) prisons; (3) police; and (4) doctors and hospitals.

In 1964, out of 534,700 deaths in England and Wales, 110,000 were reported to coroners, and 25% of these came to inquest.

Reports from Registrars

A registrar can act only on a certificate of cause of death which suggests an unnatural cause, or on a certificate which is defective. Study of the relevant regulation may help a doctor to word his certificates so as to avoid unnecessary references from registrars to the coroner.

By Regulation 82 (1) of the Registration (Births, Stillbirths, Deaths, and Marriages) Consolidated Regulations, 1954, a registrar who has been informed of the death of any person within 12 months of its occurrence must report the death to the coroner in any of the following circumstances:

- (a) where the deceased was not attended during his last illness by a registered medical practitioner;
- (b) if the registrar has been unable to obtain delivery of a duly completed certificate of the cause of death;
- (c) where it appears to the registrar from the particulars contained in the medical certificate, or otherwise, that the deceased was not seen by the certifying practitioner either after death or within 14 days before death;
- (d) where the cause of death appears to be unknown;

(e) if the registrar has reason to believe that the death was unnatural or caused by violence or neglect, or by abortion, or was attended by suspicious circumstances;

(f) where it appears to the registrar that the death occurred during an operation or before recovery from the effects of an anaesthetic; or

(g) if it appears to the registrar from the contents of any medical certificate that the death was due to any industrial disease or industrial poisoning.

Ambiguous Death Certificates

Suggestions for the completion of medical certificates of cause of death are given at the beginning of the book of forms. Experience has shown that certain ambiguous diagnoses regularly lead to needless reference to the coroner by the registrar. The following are examples:

Fibrosis of the Lung; Fibroid Lung. These imply to the registrar industrial pulmonary disease. The causative pathological process, such as tuberculosis, must always be mentioned.

Cerebral Haemorrhage. The cause, such as hypertension, should be included.

Gangrene. Gangrene formerly had an association with infective gangrene after injury. The aetiology must be specified—for example, arteriosclerotic gangrene.

Septicaemia. The cause should be stated, when known. If it is unknown the septicaemia should be stated to be "primary" or "of uncertain origin."

Cirrhosis of Liver. When caused by alcoholism the coroner should be informed direct. If not due to alcoholism the cause should be specified—for example, "nutritional" or "post-infective."

Care should be taken over Part II of the death certificate. It is intended for recording significant conditions "contributing to the death, but not related to the disease or condition causing it." Fracture of the neck of the femur is an injury which commonly leads to a registrar's reference to the coroner. When the fracture has occurred, say, a year before death in a woman aged 85 it is unlikely to have made a direct contribution to death and need not be recorded in Part II. Similarly, a spontaneous fracture due to secondary deposits of neoplasm may be regarded as part of the disease and not as an incident in its own right.

Death in Prison

Death in prison, whether natural or otherwise, is required by statute to be notified to the coroner (Coroners Act, 1887, s. 3; Coroners (Amendment) Act, 1926, s. 13 (2) (b)). This applies only to prisoners and not members of the prison staff. The coroner must be informed of the death of a prisoner in a hospital to which he has been sent for treatment. It is for the coroner to decide whether "in prison" refers to the status

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as prisoner or to the locality of the death. Prison death notifications are normally made by the prison governor.

Reports from Police

Most notifications to the coroner by police concern violent deaths—accidents, suicides, homicides—but reports of old people living alone and found dead from natural causes may also come from this source.

Reports from Doctors

The coroner is required by law to inquire into violent or unnatural death, or sudden death of which the cause is unknown. The following list indicates the circumstances in which a report to the coroner should be made.

Abortion. Death after natural, spontaneous abortion is so unusual that criminal interference must always be suspected when a patient dies from an abortion.

Accidents. Death from accident must always be reported to the coroner, whether the accident occurred at home, at work, while travelling, or during sport. The commonest accidental cause of death is fracture of the neck of the femur in elderly persons.

Alcoholism (Acute or Chronic). A frequent cause of death in alcoholism is rupture of oesophageal varices in cirrhosis of the liver. A death from falling downstairs when drunk would be regarded as accidental rather than alcoholic.

Anaesthetics. Deaths apparently due solely to the anaesthetic must be reported. These cases are difficult to investigate. Many of them occur from hypoxia during transit from the theatre to the ward after the completion of an operation. A detailed report from the anaesthetist will be required by the coroner.

Drugs. Deaths from drugs taken for any reason (in therapy, in addiction, or suicidally) must be reported. The coroner's court plays an important part in elucidating unsuspected fatal side-effects in drugs. Bone marrow aplasia or liver necrosis suspected to be due to drugs should form the basis of a report to the coroner. A recently recognized complication of treatment with monoamine oxidase inhibitors is the paroxysmal hypertension which may be produced by the ingestion of substances containing tyramine, such as cheese or meat extracts. Deaths from cerebral haemorrhage have been described. Accidental overdosage is, fortunately, rare but must be reported.

Industrial Disease. Deaths due to any industrial disease or poisoning must be reported to the coroner. Pneumoconiosis is an example, but the Government pamphlets listing the prescribed diseases should be consulted. These are reproduced in most textbooks of forensic medicine.

Medical Mishaps. Death caused by an operative error must always be reported. It makes no difference whether the death occurs on the operating-table or in the ward afterwards. Failure to ligate blood vessels, tying of a ureter in mistake for the uterine artery, and perforation of a viscus during endoscopy are all examples. Death of a seriously ill person when an operation, properly performed, is part of the treatment need not be reported. Most postoperative deaths are cleared by the coroner without an inquest unless there is evidence of error. Complaints by relatives that there has been

negligence in treatment should always be referred to the coroner if death ensues. Usually this is a protection for the doctor.

Pensioners. The death of a person in receipt of a Service disability pension should be notified.

Deaths from *poisoning* (accidental, suicidal, homicidal, or in industry) and *suicide* (by any means) should be reported to the coroner, and also *stillbirths* when there is doubt whether the child was born alive.

It is no longer necessary to report the death of a patient in a mental hospital or that of a foster child unless it is due to one of the above causes.

The 24-hour rule was a rule by which the death of a patient within 24 hours after an operation or after admission to hospital was automatically reported to the coroner. This rule, which was not based on any legal requirement, has largely been discontinued. The true test is whether the death is violent, unnatural, or of unknown cause.

Other Matters

The coroner must be informed when it is proposed to remove a body out of England, and this includes removals to Scotland, Northern Ireland, the Isle of Man, but not Wales. The information usually comes from the funeral director.

During the holiday season it frequently occurs that a patient dies while his doctor is abroad and no doctor is able to give a certificate of cause of death. Reference to the coroner is inevitable. This situation can be avoided by ensuring that, before the doctor goes away, a deputy sees any patient expected to die.

Any doctor in doubt as to procedure can always consult his coroner. The existence of doubt about the cause of death means that the coroner should make a full inquiry, including a post-mortem examination. No coroner can give "permission" to a doctor to sign a death certificate, though this is sometimes claimed.

The coroner's authority to remove human tissue for grafting or other purposes must be sought when it appears that the death is one which should be referred to him (Human Tissue Act, 1961, s. 1 (5)). In addition, consent of the executors or next of kin is essential.

Any death of which the cause is unknown may be unnatural and should be reported. Sudden death in a previously healthy woman of childbearing age, for instance, is unlikely to be from natural causes. The only common natural disaster that occurs in this group is rupture of an aneurysm of the circle of Willis. Such deaths must always be approached with suspicion, since they may be due to abortion or barbiturate poisoning.

Accidental coal-gas poisoning is often overlooked, particularly in the elderly, who may have been dead long enough for the prepaid gas supply from the meter to become exhausted. The characteristic pink colour is not always easy to detect.

There is no doubt that the medical profession as a whole is becoming more conscious of the importance of accuracy in recording causes of death. The number of notifications to coroners is steadily increasing year by year. Information should in the first instance be to the coroner's officer. When there is no whole-time coroner's officer in the area, or his telephone number is unknown, a call to the nearest police station is all that is required.