Information Sheet

Death Registration and Inquests

In England and Wales, all deaths need to be registered with a Registrar of Births, Deaths and Marriage. Where a doctor is able to issue a medical certificate of the cause of death, a person known as the informant, usually a close relative of the deceased, needs to take the certificate to the Registrar within 5 days of the death. In certain circumstances however, the doctor is not able to issue a death certificate, and the death needs to be reported to the coroner, who subsequently sends information to the Registrar to be used instead of the MCCD to register the death.

The coroner is mandated by the Coroners Act 1988 and the Coroners Rules 1984 to investigate all unexplained or unnatural deaths reported to him/her. The Coroner's investigation is guided by Rule 36 of the Coroners Rules 1984 to gather and establish information in three areas:

- to establish the identity of the deceased;
- to determine when, where and how the deceased came by death;
- to clarify certain registration particulars.

Following referral of an unexpected death the coroner may take a number of different courses:

- If the coroner is satisfied that the death is due to natural causes and a death certificate can be completed, the local Registrar is notified and they can then register the death using the cause given on the MCCD.
- In most cases, the coroner will order an autopsy. The pathologist, following the autopsy, will provide the coroner with a provisional report and, if possible, a provisional cause of death. If the death appears to be from natural causes the coroner will issue a form 100B (known as a "pink B") and release the body to the family.
- If the pathologist cannot give a cause of death or the autopsy reveals an unnatural cause the coroner will open and adjourn an inquest pending the gathering of further information.
- On occasions the Coroner may hold an inquest without an autopsy, although this would be unusual in an unexpected death of a child.

BIRTHS AND DEATHS REGISTRATION ACT 1953
(Form prescribed by Registration of Births and Deaths Regulations 1987)

Registrar to enter No. of Death Entry .....

MEDICAL CERTIFICATE OF CAUSE OF DEATH

For use only by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the deceased's last illness, and to be delivered by him forthwith to the Registrar of Births and Deaths.

Name of deceased .....

Date of death as stated to me ..... day of .... Age as stated to me .....

Place of death .....

Last seen alive by me ..... day of ....

1 The certified cause of death takes account of information obtained from post-mortem.
2 Information from post-mortem may be available later
3 Post mortem not being held.
4 I have reported this death to the Coroner for further action.
(See overleaf)

Please ring appropriate digit(s) and letter

a Seen after death by me.
b Seen after death by another medical practitioner but not by me
c Not seen after death by a medical practitioner.

CAUSE OF DEATH

The condition thought to be the 'Underlying Cause of Death' should appear in the lowest completed line of Part I.

I (a) Disease or condition directly leading to death† .....

(b) Other disease or condition, if any, leading to: **I(a)** .....

(c) Other disease or condition, if any, leading to: **I(b)** .....

II Other significant conditions **CONTRIBUTING TO THE DEATH** but not related to the disease or condition causing it .....

These particulars not to be entered in death register

Approximate interval between onset and death

.....
.....
.....
.....

The death might have been due to or contributed to by the employment followed at some time by the deceased ☐ Please tick where applicable

† *This does not mean the mode of dying, such as heart failure, asphyxia, asthenia, etc: it means the disease, injury, or complication which caused death.*

I hereby certify that I was in medical attendance during the above named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature..... Qualifications as registered by General Medical Council .....

Residence ..... Date.....

For deaths in hospital: Please give the name of the consultant responsible for the above- named as a patient .....

The Inquest

The evidence at the first hearing is normally confined to identification. The coroner's officer (either a civilian officer or a police officer acting on behalf of the coroner) will then gather information from the family, as well as from the general practitioner and other health professionals who know the child, any police officers or other professionals involved in responding to the death, and any other relevant witnesses.
When all enquiries are complete the inquest will be resumed for a full hearing at which the parents would normally be present, and other witnesses (including professionals involved in the investigation) may be called to give evidence, or may provide written evidence. Inquests are public hearings and the press may be present. The evidence at the inquest is directed solely at establishing the particulars outlined above. Having heard and considered all the evidence, the coroner must then reach a verdict on the cause of death. This may be a standard form (e.g. accident, natural causes) or may be in the form of a narrative verdict, a brief factual statement describing how the death arose. In most cases the inquest concludes the investigation and the death is then registered by the Coroner.

Where an inquest is held after a multi-agency case discussion, the report from that discussion should be made available to the coroner to assist in the process of the inquest. Whilst it is not the role of the coroner to apportion blame in the case of an unnatural death, if a coroner identifies evidence suggesting that particular persons (whether parents/carers, professionals, or others) may be responsible, he may refer the case for further criminal investigation. Where the coroner believes that action should be taken to prevent similar deaths he may report the circumstances to a person or body in a position to effect changes (Rule 43), this could include the local Child Death Overview Panel.

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