Guidance notes for E-Reporting

Introduction

The routine reporting of deaths to the office of HM Coroner for South Wales Central will be done electronically (E-Reporting) as from 1st June 2018.

The reporting of deaths electronically holds significant advantages for both reporting Doctors and also the Coroner's office. Deaths can be reported at any time of the day or night and will lead to a more efficient work flow within the Coroner's Office and a more efficient allocation of scarce resources to the more complex and challenging of cases.

E-Reporting does not prevent or preclude a direct conversation between the reporting Doctor and the Coroner's Officer. Coroner's Offices will still be actively investigating deaths on behalf of HM Coroner and, in many cases, that will still require a discussion with the reporting Doctor.

HM Coroner for South Wales Central has issued guidance in relation to the types of cases he expects to be reported to his office. A copy of this guidance is attached.

The form for reporting deaths is attached to this document and should be submitted via the NWIS Secure portal.

The Form

The following is intended as helpful guidance on the various sections of the form which will need to be completed.

1. Reason for Referral

It is important that only those deaths that are ***required*** to be reported are in fact reported. For that reason it is helpful for the Coroner's Office to know

why a death is being reported. Please see the Referral of Deaths to HM Coroner SOUTH WALES CENTRAL GUIDANCE.

2. Name of Admitting Consultant / Consultant Responsible for care

This is important so the Coroner's Office know the details of the Consultant in charge of the care of the deceased at the time of death. All referrals must either be made by the Consultant in charge of the patient at the time of death or with his/her knowledge. In the event of an inquest, a statement from the Consultant and / or the attendance of the Consultant will be required.

3. Patient & NOK Details

It is crucially important that this is accurate and comprehensively filled in and includes contact details for the next of kin. This enables the Coroner's Officer to contact the family which happens in all cases.

4. Place, Date & Time of Death

These are important details as they will be used for the purposes of registration of the death.

5. Summary of Previous Medical History, including GP details and any prescribed medication

This is important so that the reviewing Coroner can understand as much as possible any information known about previous medical history and

prescribed medication and the inclusion of the GP details allows the Coroner's Officer to speak to the General Practitioners Surgery as part of the routine enquiry.

6. Date of Admission and Nature of Admission (Acute / Elective etc) – was this an unplanned admission after recent discharge? If so, from what healthcare facility was the patient discharged?

This assists the Coroner to understand the nature of the admission to hospital and to understand the background of any relevant hospital care. It also assists in understanding the nature of the death i.e. whether it was expected or not.

7. Working diagnosis on admission and the rationale for that:

    - This is of fundamental importance to enable the reviewing Coroner, who will not be medically qualified, to understand the though process of the treating Doctor when the patient was admitted and the rationale for that.

8. Summary of events during admission

    - This should be as full and as comprehensive as possible setting out clearly and chronologically the events during admission. It should be written in simple language without unnecessary medical terminology or abbreviations. This needs to be fully understood by the Coroner's Officer in the first instance and later the Coroner neither of whom are medically qualified.

9. Circumstances of death

    - This is important in understanding *how* the death occurred in the event that it may shed some light on the likely cause of death.

10. Was the death expected / unexpected?

- It is helpful to know whether or not the death was expected. If a death was expected, it might follow that the cause of the death is known (on the *balance of probabilities i.e. more likely than not*)
- However, just because a death is "unexpected" does not mean that the cause of the death cannot be given – based on the medical history, the clinical picture and circumstances of the death etc.

11. Was there any delay in the admission of the patient?

- This requires a "yes" or "no" answer.
- If there has been a delay, please provide details of that delay and comment whether or not that is likely to have caused or contributed to the death.

12. Was there any delay in recognising the patients condition?

- This also requires a "yes" or "no" answer
- If there has been has been a delay, please provide details of that delay and comment whether or not that is likely to have caused or contributed to the death.

13. Was there any delay in the commencement of appropriate treatment?

- This also requires a “yes” or “no” answer
- If there has been has been a delay, please provide details of that delay and comment whether or not that is likely to have caused or contributed to the death.

14. Was there any adverse drug reaction?

- This also requires a “yes” or “no” answer
- If there has been has been an adverse drug reaction, please provide details in simple terms and comment whether or not that is likely to have caused or contributed to the death.

15. Did the patient develop an infection whilst in hospital?

- This also requires a “yes” or “no” answer
- If there has been has been an infection, please provide details of that in simple terms and comment whether or not that is likely to have caused or contributed to the death.
- Please identify, so far as possible, the source of the infection and whether it has originated from an unnatural source i.e. poor hygiene, avoidable infection etc

16. Did the deceased sustain an injury whilst in hospital?

- This also requires a “yes” or “no” answer.
- Any injury which has been sustained in hospital should be disclosed together with a comment as to whether or not it has

caused or contributed to the death. If it is felt that it has not, a brief explanation is required.

17. Did the deceased suffer a complication during surgery or other intervention?
    - This also requires a "yes" or "no" answer.
    - Please provide details of any surgical / intervention complication and comment on whether it caused or contributed to death

18. Did the deceased suffer any complication which cannot be explained as an accepted consequence of diagnosis or treatment?

    - This also requires a "yes" or "no" answer.
    - Please provide details of any complication, other than surgical, which cannot be explained as an accepted consequence of diagnosis or treatment.

19. Unplanned transfers for one speciality to another (Including ITU)

    - This also requires a "yes" or "no" answer.
    - Please provide details of any transfers to assist the coroner understanding the chronology of the patient's clinical course.

20. Has there been anything in this patient's clinical course which has been described as a "Never Event"?

- This also requires a “yes” or “no” answer.
- Please provide details of such an event, eg. Misplaced NG tube, incorrect medication given, surgery on the wrong part of the body etc.

21. Has the patient been subject to detention under the Mental Health Act, subject to a POVA referral, a DoL etc.

- This also requires a “yes” or “no” answer.
- Please provide details.

22. Has any family member, or any person acquainted with the patient, expressed any concern regarding the case given by the hospital or by any other healthcare professional?

- This also requires a “yes” or “no” answer.
- Please provide brief details of any concerns which may have been raised

23. Having regard to the above, do you consider it more likely than not that the management of this patient has caused or made a significant contribution to the death?

- This also requires a “yes” or “no” answer.

- Please provide details / opinion as to why the management has either caused or made a significant contribution to the death.

24. Is the death related to an industrial exposure? (coal dust, asbestos, chemicals, toxins etc)

- This also requires a "yes" or "no" answer.
- Please detail whatever is known about the exposure.

25. Proposed cause of death

- This part of the form should be filled in to record what in the opinion of the referring clinician, is the likely cause of the death
- The legal test is "*to the best of the clinicians knowledge and belief*" and is given on the basis of the "*balance of probability*" i.e. more likely than not.
- It is particularly helpful to the coroner to know why a cause of death cannot be proposed.
- A brief rationale for the cause of death of death offered, or why a cause cannot be given, is required in all cases.

Details of the reporting Doctor

- This should wherever possible be the Consultant with the responsibility of the care of the patient. More junior members of the team may make the referral but only with the express consent and agreement of the Consultant who must have been spoken to and consulted with in relation to any probable cause of death.

Discussed with Pathologist

- This also requires a “yes” or “no” answer and the name of the pathologist.

NOTE

- In cases which have been referred, and in which the cause of death can be given (on the balance of probability, to the best of the Dr’s knowledge and belief) and the case will require there to be an inquest i.e. the death is unnatural or violent or in state detention, an overview statement should be provided at this stage.
- Such cases might include simple falls, simple trauma cases, industrial deaths (eg lifetime diagnosis of mesothelioma etc)
- The coroner *may* be able to complete the inquest without asking you for any further statement.