PETERBOROUGH SAFEGUARDING ADULTS BOARD

Practice Guidance : Working with the Coroner

1. Introduction

The purpose of this guidance is to establish a two way process between Adult Social Care and the Coroner in Safeguarding Adult cases. It will identify the information sharing process between both agencies to improve decision making. This will prevent harm to other adults at risk of abuse and improve the experience facing the bereaved in obtaining explanations surrounding the death of a loved one.

2. The Role of the Coroner

Coroners enquire into the deaths reported to them. It is their duty to find out the medical cause of the death, if it is not known, and to enquire about the cause of it if it was due to violence or otherwise appears to be unnatural. Coroners are independent judicial officers, which means that no other person can tell them or direct them as to what they should do, but they must follow the laws and regulations which apply. Coroners are usually lawyers but in some cases they may be doctors. Each Coroner must have a deputy and between them they have to be available at all times. Coroners are helped by their officers, who receive reports of deaths and then make enquiries on behalf of the Coroner.

3. Communication to the Coroner

The Contracts, Procurement and Monitoring Team will:

Email the coroners office when a contract with a care provider has been suspended or terminated and when a temporary suspension has been lifted. This will make the coroner aware of providers about which there are significant concerns, so if they are notified that an adult at risk of abuse, who received a service from these providers, has deceased they will make further enquiries. Such enquiries will involve the Contracts, Procurement and Monitoring Team, the individual Social Worker and the deceased family.

The Adult Social Care Team Manager leading the Safeguarding process will:

- Advise the Coroner of **all serious incidents which may result in death** at the earliest opportunity. This information will be used by the

coroner and their staff in the event of the death to make investigation, post mortem and inquest decisions at the time required.

- Report **all deaths where contributory abuse or neglect is suspected** to the coroner immediately – particularly those involving domestic violence or services in the statutory, independent or voluntary sector. This will enable the coroner and their staff to make investigation, post mortem and inquest decisions.

- Refer **deaths that occur during a Safeguarding Adults process** to the coroner immediately the death is known. This will enable the coroner and their staff to make investigation, post mortem and inquest decisions.

- Refer **all deaths that occur immediately after a Safeguarding Adults Process has been completed within the last 30 days** to the coroner immediately the death is known.

- Notify the coroner when a **Large Scale Investigation** is started. This will enable the coroner to be aware of providers about which there are significant concerns, they will then know if further enquires are required should a death from that provider come to their attention. Such enquiries will involve contact with the Contracts, Procurement and Monitoring Team, the individual Social Worker and the deceased persons family.

- Inform the coroner of **services where it is identified there appears to be a high death rate.** This will enable the coroner to be aware of services about which there are significant concerns, they will then know if further enquires are required should a death from that service come to their attention. Such enquiries will involve contact with the Contracts, Procurement and Monitoring Team, the individual Social Worker and the deceased persons family.

All of the above relates to self funding service users, individuals funded by Peterborough or any other authority and Continuing Health Care funded individuals.

4. Communication from the Coroner

The coroner will inform Adult Social Care – via the Safeguarding Adults Strategic Manager of **any deaths that they view to be due to Safeguarding Adults concerns**. This will enable Adult Social Care to consider the case under the Safeguarding Adults Multi Agency Procedures for an individual investigation, large scale investigation or serious case review.

The coroner will inform Adult Social Care – via the Safeguarding Adults Strategic Manager of **any services that come to their attention which may be failing** and which has resulted in the death of an individual. This will enable Adult Social Care to consider if an investigation or serious case review is required under the Safeguarding Adults Multi Agency Procedures – or if commissioning and contracting decisions need to be made.

The coroner will inform Adult Social Care – via the Safeguarding Adults Strategic Manager of **any service which they identify as having a high**

death rate. This will enable the Adult Social Care to consider if a large scale investigation or serious case review is required under the Safeguarding Adults Multi Agency Procedures – or if commissioning and contracting decisions need to be made.

5. Out of Borough Communication

It is the responsibility of the authority where the abuse occurred to communicate with the coroner and receive communication from the coroner.

For example: an individual placed in a Birmingham service by Peterborough – Birmingham has the lead responsibility for Safeguarding so will liaise with the coroner BUT they must inform Peterborough of all communication.

It is also the responsibility of this authority to notify other authorities who may be using that service of communication to and from the Coroner. This should be via the Contracts, Procurement and Monitoring team.

For example: Peterborough notifies the Coroner of a concern related to a service in Birmingham. This service is providing services to individuals placed by Birmingham and Coventry. Peterborough must inform Birmingham and Coventry of their communication with the Coroner.

6. Serious Case Reviews

The coroner may have specific questions arising from the death of an adult at risk. These are likely to fall within one of the following:

- where there is an obvious and serious failing by one or more organisations
- where there are no obvious failings but the action taken by organisations require further exploration/explanation
- where a death has occurred and there are concerns for others in the same household or setting (such as a care home), or
- when a death occurs outside the requirement to hold an inquest but follow up enquiries/actions are identified by the Coroner or his/her officers.

In the above situations the Peterborough Safeguarding Adults Board will give serious consideration to instigating a serious case review.

Serious case reviews are undertaken on only the very serious safeguarding incidents or where it is clear multi agency working has not been effective. They are carried out so lessons can be learned and multi agency working can be improved.

Peterborough Safeguarding Adults Board, when conducting a serious case review, may request information from the Coroner if it is relevant to the case.

In line with Peterborough's Safeguarding Adults Board procedures, all agencies involved in a serious case review will be asked to contribute too and be informed of the findings and will be expected to learn lessons identified from the review.

7. Deprivation of Liberty

If a service user dies while a Deprivation of Liberty Safeguard is in place then the Managing Authority must inform the Coroner as it is considered a “death in custody”.

In care homes or private hospitals the managing authority is “the person registered or required to be registered under the Care Standards Act”.
In NHS hospitals this is “the body responsible for the running of the hospital in which the person is resident”.

If the service user was in supported living accommodation, the managing authority is the Court of Protection.

8. Contacts:

Adult Social care

Safeguarding Adults Strategic Manager
Andrew MacTaggart
Telephone: 01733 452434
Email: Andrew.mactaggart@peterborough.gov.uk

Coroners Office

Telephone: 01733 452372
Generic email account – hmcoroner@peterborough.gov.uk