# Meeting Feedback Form

**Name**: Pauline Love

**Meeting**: Meeting with the Coroner, EMAS and Derbyshire constabulary

**Date**: 16.11.17

**Venue**: Derby Office at St. Katherine's House, St. Mary's Wharf, Mansfield Road, Derby

**Feedback**:

Meeting with the Coroner, EMAS and Derbyshire constabulary went well - a long meeting 2 hours 15 -

I'll give you the outcome and then how it came about.

EXPECTED deaths: verification by GP, DHU (Dr or qualified nurse who has done verification of death course), any other nurse who has done course i.e. Community matron, RGN in nursing home.

UNEXPLAINED deaths: - unnatural (e.g., fall downstairs, overdose, hanging, injury to the body etc)

- Unknown identification of the patient

- No known NOK present or known

- Body decomposition

- Vulnerable adults (care homes or home)

The police will see these

UNEXPLAINED deaths (where the above criteria are not met): EMAS will attend - they will call police who will go through a pro forma with them and advise the undertaker to take the body to the mortuary (not funeral directors) they will them inform the coroner as we do with the e mailed forms.

The initial conversation was that all 3 of us said we were not specifically contracted to verify death, were all overworked and under resourced and struggling. There was an apology for not inviting us to the previous meeting. We discussed possible crime scenes and GP's lack of training in forensics. We discussed Forensic medical examiners seeing all deaths but who would pay for it? Chief Coroner and Jeremy Hunt will be putting in place the medical examiners in March 2019 so GP's will no longer be verifying death (we think) and that the ME will have assistants - interestingly there are about 40% of deaths referred to coroner per day - about 70 (he feels this is not enough though) he does PM's on 12-20 of these per day. We looked at where monies would come from and who legal and ethical responsibility it is in certain circumstances. It was not helped by the DoH stating that paramedics should not be verifying all deaths but they should be caring for the living - I said the same for GP's and the police wish to catch murderers and thieves etc.

Rob is going to look at processes within Derbyshire and other areas, the constabulary are going to look at their process and get the call handlers asking specific questions.  EMAS are going to see what happens in other areas also.  I will ask my Macmillan GP Advisor colleagues what happens in their areas for completion of the process that will put on paper formally.

A request though please:

1. Can the LMC re-iterate that the Chief Coroner is responsible for mandating the referral form when we are in doubt of cause of death and that GP's have to fill them in and not rely on a phone call to coroner's office? Rob has to justify his actions and there needs to be an audit trail.

2.  Anyone expected to die should be seen by the GP (to me this is good practice to best patient care) and to enable the death certificate to be signed - as you know a GP should have seen the patient no longer than 2 weeks prior to death but not all GP's are seeing patients whose they know are expected to die.

I have 4 pages of notes but we kept going around in a few circles.

I felt that the compromise was fair and just and it is what we should be doing for our patients for whom we have cared in their last days of life.

**Actions**:

**Attendance worth**: Yes