Q: If a service user dies while they are subject to the Metal Capacity Act deprivation of liberty safeguards (MCA DOLS), does the care provider have to notify the coroner? What happens then?

A: It may be a good idea for providers to tell the local coroner’s office when one of their service users dies while subject to deprivation of liberty. Local coroners may expect this as a matter of course. Whoever reports the death, the coroner will investigate and hold an inquest.

Since July 2013, coroners in England and Wales have been legally required to investigate all deaths of people in “state detention” (as well as violent or unnatural deaths, or where the cause of death is unknown). That is essentially because people who are detained are in a particularly vulnerable position, so special care should be taken to establish what happened.

The Chief Coroner has said state detention includes the use of MCA DOLS in hospitals and care homes. It probably also includes deprivation of liberty in other settings authorised by the Court of Protection.

Obviously, coroners can only investigate these deaths if someone tells them about them.

There is no statutory duty on care providers to refer deaths to the coroner. But everyone has a common law duty to help coroners identify deaths that ought to be investigated.

In practice, most deaths are reported to the coroner by doctors. But because care providers are best placed to know whether someone who dies in their care is subject to deprivation of liberty, it may make sense for them to tell coroners when that happens. If providers rely on other people (eg the person’s doctor) reporting these deaths to the coroner, there is a risk they will go unreported, for which providers might be criticised.

In addition, the Department of Health (DH) issued guidance in 2011 saying that coroners in some areas have said they expect providers to report these deaths to them as a matter of course. The local authority’s MCA DOLS team should be able to tell providers if that is the case in their area and whether any specific procedures have been agreed locally. (The DH guidance also said that, if in doubt, it is always preferable to report the death.)

Providers may want to contact the coroner’s office by phone in the first place, as soon as possible after the death. The coroner’s office will tell the provider what more (if anything) it wants the provider to do.

There are currently around a hundred separate coroners’ areas in England and Wales, each with its own senior coroner, support staff and one or more local offices. Each coroner’s area should have a website (or a page on a local authority’s website) giving their contact details. Doctors who are asked to attend deaths should also be able to help with contact details.

In all cases, it is a good idea to make sure the doctor who attends the death is aware that the person who has died was subject to deprivation of liberty at the time, so they know the coroner will need to investigate. The doctor is likely to need to contact the coroner’s office themselves.
Providers will probably want to explain to the person’s family that the coroner always has to investigate deaths of people deprived of their liberty and it does not necessarily mean that anything sinister is suspected about their relative’s death.

The coroner will contact the person’s next of kin or their personal representative (e.g., the executor of their will) to explain what is going to happen. The Ministry of Justice has published a Guide to Coroners services explaining what coroners do and what people can expect of them. ([www.gov.uk/government/uploads/system/uploads/attachment_data/file/283939/guide-to-coroner-service.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283939/guide-to-coroner-service.pdf))

Families normally won’t be able to register the person’s death and obtain a full death certificate until the coroner’s investigation is finished. But the next of kin or personal representative can ask the coroner for an interim certificate confirming the person has died, as evidence for probate or for banks, insurance companies, pension providers etc.

The purpose of a coroner’s investigation is to determine who died, and how, when, and where it happened.

The coroner may order a post-mortem examination. But if the death was due to natural causes, the coroner may decide it isn’t necessary.

As part of an investigation, coroners might ask for statements from members of staff involved in the person’s care, or who found the person’s body. They might also ask their coroners officers to make inquiries on their behalf, by interviewing people about what happened.

In deprivation of liberty cases, the coroner’s investigation must involve an inquest. An inquest is a public hearing to examine the evidence about the person’s death and determine how, when and where they died. Coroners will say if they need providers to submit written evidence to the inquest, or if anyone from the provider is required to attend as a witness.

After some inquests, coroners write to people they think should take steps to help prevent further similar deaths in future. That could include a care provider. People who get such a letter must reply within 56 days saying what action they are going to take (and when), or else explaining why they do not intend to take the action recommended.

Reporting a death to the coroner is not, of course, a substitute for calling the police to report an unexpected or suspicious death. Nor does it change a care provider’s obligations to tell other people. So, for example, providers may well need to inform the Care Quality Commission or the Care and Social Services Inspectorate Wales, in line with the rules which apply to all service users’ deaths. Care homes will also want to tell the local authority which granted the MCA DOLS authorisation.