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|  | **Form E-95**  **HM Coroner Referral**  **Community/Hospice Death** |  |

**Please complete electronically and e-mail as a WORD document to the relevant Coroners’ Office:**

**Cornwall:** [cornwallcoronersofficers@devonandcornwall.pnn.police.uk](mailto:cornwallcoronersofficers@devonandcornwall.pnn.police.uk)

**Exeter:** [exetercoronersofficers@devonandcornwall.pnn.police.uk](mailto:exetercoronersofficers@devonandcornwall.pnn.police.uk)

**Plymouth:** [plymouthcoronersofficers@devonandcornwall.pnn.police.uk](mailto:plymouthcoronersofficers@devonandcornwall.pnn.police.uk)

**& Torbay**

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| Contact Details | **Cornwall:** The Lodge, Penmount, Newquay Road, Truro, Cornwall, TR4 9AA Tel: 01872 227191  **Exeter:** Devon County Hall, Topsham Road, Exeter, EX2 4QD Tel: 01392 225690  **Plymouth, Torbay and South Devon**: Derriford Business Park, Plymouth, Devon, PL6 5QZ Tel: 01752 487401/403/404 |

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| Referral Date |  | Referral Time |  |

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| **Details of Referring Doctor** | | **In my absence, you may speak to:** |
| Name |  |  |
| GP Practice/Hospice |  |  |
| Contact Number |  |  |
| Email Address |  |  |

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| **Deceased** | |
| Full Name |  |
| Date of Birth |  |
| Home Address |  |
| Location of deceased |  |
| Occupation (\*consider industrial disease\*) |  |

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| **Death Verification** | | | |
| Date of Death |  | Time of Death |  |
| Place of Death |  | | |
| Confirmed by |  | | |

|  |  |
| --- | --- |
| **Next of Kin** | |
| Name |  |
| Relationship |  |
| Address |  |
| Contact Number |  |

| **Circumstances relating to Death** | |
| --- | --- |
| Reason for Referral – (please consult the Guidance for registered medical practitioners on the Notification of Deaths Regulations 2019 – MoJ) |  |
| Past Medical History (and relevant medication) |  |
| Circumstances of death (include details of any trauma or injury, medical procedure or treatment (including chemotherapy) or industrial disease that did, or may have, contributed to death): **Please give comprehensive circumstances regarding events leading to death (this box will expand as you type):** | |

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| **Cause of Death** | | |
| Are you able to offer a **natural** cause of death (COD) to the best of your knowledge and belief? | | Yes/No – **if yes please provide below.** |
| If the cause of death is not natural ***but is known*** to the best of your knowledge and belief, please supply this below. The Coroner may accept this information instead of requesting a post mortem examination | | |
| Please complete the medical COD in the correct 1a, 1b, 1c and 2 WHO format  where possible indicate the interval of approximate time (e.g. how long patient known to have had that condition in hours, days, months, years) | | |
| 1a |  | |
| 1b |  | |
| 1c |  | |
| 2 |  | |
| Have you attended upon the deceased for their last illness? | | Yes/No |
| If so, was that attendance within the last 14 days? | | Yes/No  Date: |
| If you have seen the deceased but not within the last 14 days, when seen? | | Date: |
| Are you aware of any concerns raised by the family? | | Yes/No/Unknown |
| If not, have you seen, or are you willing to see, the deceased after death? | | Yes/No:  Date seen: |
| Do you have any concerns that this death may be unnatural? | | Yes/ No  If yes, what is that concern? Please explain in the ‘Additional/Supporting Information’ box below |

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| **Additional/Supporting Information** |
| Please include any concern expressed by the family or any person acquainted with the deceased or healthcare professional regarding the care received by this patient: |

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| **Identification (required if death from unnatural/unknown/industrial cause)** |
| I viewed the deceased at …………………………….……(location) on……………………………………(insert date) and can confirm the identity as per the details given in this report. I am able to identify the deceased by virtue of being……………………………………….(insert relationship i.e. treating doctor/nurse/carer) known to me for a period of……………………..(insert time known) ***N.B It is not appropriate to identify a deceased not previously known to you.***  Full Name: GMC No/Role: |

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| **Statement of Truth** | |
| ***I believe that the facts stated in this report are true to the best of my knowledge and belief*** | |
| **Preferred option – personal email** | **Back-up option – practice/hospice joint email** |
| Email this referral to us as a WORD document from your own personal inbox and we will accept your email as an electronic signature | [cornwallcoronersofficers@devonandcornwall.pnn.police,uk](mailto:cornwallcoronersofficers@devonandcornwall.pnn.police,uk)  [exetercoronersofficers@devonandcornwall.pnn.police.uk](mailto:exetercoronersofficers@devonandcornwall.pnn.police.uk)  [plymouthcoronersofficers@devonandcornwall.pnn.police.uk](mailto:plymouthcoronersofficers@devonandcornwall.pnn.police.uk) |
| **Signature:** |

**\*\*Please send a patient profile with this report to document consultations (last 6 months) and current medication\*\***