



CHIEF CORONER

GUIDANCE No. 31

DEATH REFERRALS AND MEDICAL EXAMINERS

1. A key part of the regime set out in the Coroners and Justice Act 2009 is the introduction of a system of medical examiners to cover all deaths within England and Wales. As from April 2019 there is now in place a National Medical Examiner for England & Wales and the roll-out of a non-statutory scheme of medical examiners covering deaths in NHS hospitals. It is envisaged that the non-statutory scheme will cover all hospitals by the end of March 2020 and that there will be a move by the Government towards placing the scheme on a statutory footing and then a further development of the statutory scheme to cover deaths within hospitals and within the community.
2. As part of the process set out above, the Notification of Deaths Regulations 2019 were laid before Parliament on 15th July 2019 and will come into force on 1st October 2019.
3. The Regulations make clear that a registered medical practitioner must notify the relevant senior coroner (the senior coroner appointed for the coroner area in which the body of the deceased person lies) of a person's death if they come to know of the death and in certain types of cases. Hitherto there have been no such regulations and the circumstances of reporting of deaths by medical practitioners to coroners has varied across coroner areas. To address this some senior coroners have issued local guidance to medical practitioners within their area. As with immediate effect any locally issued guidance or direction should be withdrawn and the principles set out in this document used by all coroners to ensure greater consistency over death reporting.
4. Guidance has been provided by the MOJ to registered medical practitioners. A link to that guidance is attached to this document along with the published regulations. As a result of this national guidance there should be no local guides to doctors as to reportable deaths, so as to ensure national consistency.

5. To state the obvious, if coroners, based on reports of death, have a cause for concern about any possible issues in a hospital (and in due course, in the community) they should raise this with their local medical examiner, or the regional medical examiners (or the National Medical Examiner and the Chief Coroner) as appropriate and agree any action. Effective dialogue is key. Local reporting criteria should not be imposed by a coroner in order to deal with these sorts of issues.
6. More information about the National Medical Examiner and the Regional Medical Examiners can be found here:

<https://improvement.nhs.uk/resources/establishing-medical-examiner-system-nhs/>

You can contact the National Medical Examiner on: nme@nhs.net My office will provide more detailed contact information for Regional Medical Examiners in due course.

7. As a result of the Notification of Death Regulations a senior coroner should expect to receive notification of deaths in the following circumstances:

(a) the registered medical practitioner suspects that that the person's death was due to—

(i) poisoning, including by an otherwise benign substance;

(ii) exposure to or contact with a toxic substance;

(iii) the use of a medicinal product, controlled drug or psychoactive substance;

(iv) violence;

(v) trauma or injury;

(vi) self-harm;

(vii) neglect, including self-neglect;

(viii) the person undergoing a treatment or procedure of a medical or similar nature; or

(ix) an injury or disease attributable to any employment held by the person during the person's lifetime;

(b) the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph (a);

(c) the registered medical practitioner—

(i) is an attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person; but

(ii) despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown;

(d) the registered medical practitioner suspects that the person died while in custody or otherwise in state detention;

(e) the registered medical practitioner reasonably believes that there is no attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person;

(f) the registered medical practitioner reasonably believes that—

(i) an attending medical practitioner is required to sign a certificate of cause of death in relation to the deceased person; but

(ii) the attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death;

(g) the registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so.

5. In the regulations;

“attending medical practitioner” means a registered medical practitioner required under section 22(1) of the Births and Deaths Registration Act 1953 to sign a certificate of cause of death in relation to a deceased person;

“certificate of the cause of death” means the certificate required to be signed by a registered medical practitioner under section 22(1) of the Births and Deaths Registration Act 1953;

“controlled drug” has the same meaning as in the Misuse of Drugs Act 1971;

“employment” means any employment, whether paid or unpaid, including—

(a) work under a contract for services or as an office holder; and

(b) work experience provided pursuant to a training course or in the course of training for employment;

“medicinal product” has the same meaning given by regulation 2 of the Human Medicines Regulations 2012;

“psychoactive substance” has the same meaning as in the Psychoactive Substances Act 2016.

8. The regulations also provide that a registered medical practitioner who must notify a relevant senior coroner of a person’s death under these regulations must do so as soon as is reasonably practicable after the duty arises.
9. If at that time there are exceptional circumstances to justify doing so, the registered medical practitioner may notify a relevant senior coroner orally, otherwise the registered medical practitioner must notify the relevant senior coroner in writing. A registered medical practitioner who notifies a relevant senior coroner orally must, as soon as reasonably practicable afterwards, confirm in writing to the relevant senior coroner the information given orally. If your coroner area does not already practice written notification (by whatever means) and relies on doctors telephoning the office to report deaths, you should begin work immediately towards a written notification system. It is a matter for you and your Local Authority how you organise this.
10. When notifying a relevant senior coroner, a registered medical practitioner must provide such of the following information as is known to the registered medical practitioner:
 - (a) *the registered medical practitioner’s—*
 - (i) *full name;*
 - (ii) *postal address;*
 - (iii) *telephone number; and*
 - (iv) *email address;*
 - (b) *the deceased person’s—*
 - (i) *full name;*
 - (ii) *date of birth;*
 - (iii) *sex;*
 - (iv) *address or usual place of residence;*
 - (v) *occupation;*
 - (c) *the name and address of—*
 - (i) *the deceased person’s next of kin; or*
 - (ii) *where there is no next of kin, the person responsible for the body of the deceased person;*

- (d) the circumstances in regulation 3(1) which apply to the death;*
- (e) the place of death;*
- (f) the date and time of death;*
- (g) where the deceased person was under the age of 18, the name and address of—
 - (i) a parent of the deceased person; or*
 - (ii) another person who had parental responsibility for the deceased person;**
- (h) the name of any consultant medical practitioner who attended the deceased person during the period beginning with the fourteenth day before death and ending with the person's death.*

11. When notifying a relevant senior coroner, a registered medical practitioner, in addition to providing the information set out in paragraph 7 above:
- (a) must provide any further information the registered medical practitioner considers to be relevant; and*
 - (b) may provide any other information.*
12. In the regulations, “consultant medical practitioner” means a registered medical practitioner who is listed in the Specialist Register of the General Medical Council.
13. It is the firm view of the Chief Coroner that coroners (and in particular, senior coroners) should forge good collaborative working relationships with Medical Examiners in their area in much the same way as they have with Registrars. Medical Examiners are now part of the wider death oversight and investigation system in England and Wales. Their duties are different to coroners but they are the counterpart for coroners and coroners and their staff should work in a spirit of partnership and mutual respect with the Medical Examiner.

HHJ MARK LUCRAFT QC
CHIEF CORONER
19 September 2019

2019 No. 1112

MEDICAL PROFESSION, ENGLAND AND WALES

CORONERS, ENGLAND AND WALES

The Notification of Deaths Regulations 2019

<i>Made</i> - - - -	<i>10th July 2019</i>
<i>Laid before Parliament</i>	<i>15th July 2019</i>
<i>Coming into force</i> - -	<i>1st October 2019</i>

The Lord Chancellor makes the following Regulations in exercise of the powers conferred by section 18(1) of the Coroners and Justice Act 2009(a).

In accordance with section 18(2) of that Act, the Lord Chancellor has consulted the Secretary of State for Health and Social Care and the Chief Coroner.

Citation, commencement and meaning of “relevant senior coroner”

1.—(1) These Regulations may be cited as the Notification of Deaths Regulations 2019 and come into force on 1st October 2019.

(2) In these Regulations, “relevant senior coroner” means the senior coroner appointed for the coroner area(b) in which the body of the deceased person lies.

Duty to notify a relevant senior coroner of a death

2.—(1) A registered medical practitioner must notify the relevant senior coroner of a person’s death if—

- (a) the registered medical practitioner comes to know of the death on or after the coming into force of these Regulations; and
- (b) at least one of the circumstances described in regulation 3(1) applies.

(2) But the duty in paragraph (1) does not apply if the registered medical practitioner reasonably believes that the relevant senior coroner has already been notified of the death under these Regulations.

Circumstances in which the duty to notify arises 3.—

(1) The circumstances are—

- (a) the registered medical practitioner suspects that that the person’s death was due to—

(a) 2009 c. 25; section 18 was amended by S.I. 2018/378.

(b) For the meaning of “coroner area”, see section 48 of the Coroners and Justice Act 2009.

- (i) poisoning, including by an otherwise benign substance;
- (ii) exposure to or contact with a toxic substance;
- (iii) the use of a medicinal product, controlled drug or psychoactive substance;
- (iv) violence;
- (v) trauma or injury;
- (vi) self-harm;
- (vii) neglect, including self-neglect;
- (viii) the person undergoing a treatment or procedure of a medical or similar nature; or
- (ix) an injury or disease attributable to any employment held by the person during the person's lifetime;
- (b) the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph (a);
- (c) the registered medical practitioner—
 - (i) is an attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person; but
 - (ii) despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown;
- (d) the registered medical practitioner suspects that the person died while in custody or otherwise in state detention^(a);
- (e) the registered medical practitioner reasonably believes that there is no attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person;
- (f) the registered medical practitioner reasonably believes that—
 - (i) an attending medical practitioner is required to sign a certificate of cause of death in relation to the deceased person; but
 - (ii) the attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death;
- (g) the registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so.

(2) In this regulation—

“attending medical practitioner” means a registered medical practitioner required under section 22(1) of the Births and Deaths Registration Act 1953 to sign a certificate of cause of death in relation to a deceased person;

“certificate of the cause of death” means the certificate required to be signed by a registered medical practitioner under section 22(1) of the Births and Deaths Registration Act 1953;

“controlled drug” has the same meaning as in the Misuse of Drugs Act 1971^(b);

“employment” means any employment, whether paid or unpaid, including—

- (a) work under a contract for services or as an office holder; and
- (b) work experience provided pursuant to a training course or in the course of training for employment;

(a) For the definition of “state detention”, see section 48 of the Coroners and Justice Act 2009.

(b) 1971 (c. 38).

“medicinal product” has the same meaning given by regulation 2 of the Human Medicines Regulations 2012(a);

“psychoactive substance” has the same meaning as in the Psychoactive Substances Act 2016(b).

Notifying the relevant senior coroner

4.—(1) A registered medical practitioner who must notify a relevant senior coroner of a person’s death under regulation 2(1) must do so as soon as is reasonably practicable after the duty arises.

(2) If at that time there are exceptional circumstances to justify doing so, the registered medical practitioner may notify a relevant senior coroner orally, otherwise the registered medical practitioner must notify the relevant senior coroner in writing.

(3) When notifying a relevant senior coroner, a registered medical practitioner must provide such of the following information as is known to the registered medical practitioner—

- (a) the registered medical practitioner’s—
 - (i) full name;
 - (ii) postal address;
 - (iii) telephone number; and
 - (iv) email address;
- (b) the deceased person’s—
 - (i) full name;
 - (ii) date of birth;
 - (iii) sex;
 - (iv) address or usual place of residence;
 - (v) occupation;
- (c) the name and address of—
 - (i) the deceased person’s next of kin; or
 - (ii) where there is no next of kin, the person responsible for the body of the deceased person;
- (d) the circumstances in regulation 3(1) which apply to the death;
- (e) the place of death;
- (f) the date and time of death;
- (g) where the deceased person was under the age of 18, the name and address of—
 - (i) a parent of the deceased person; or
 - (ii) another person who had parental responsibility for the deceased person;
- (h) the name of any consultant medical practitioner who attended the deceased person during the period beginning with the fourteenth day before death and ending with the person’s death.

(4) When notifying a relevant senior coroner, a registered medical practitioner, in addition to providing the information specified in paragraph (3)—

- (a) must provide any further information the registered medical practitioner considers to be relevant; and
- (b) may provide any other information.

(a) S.I. 2012/1916.

(b) 2016 (c. 2).

(5) A registered medical practitioner who notifies a relevant senior coroner orally under paragraph (2) must, as soon as reasonably practicable afterwards, confirm in writing to the relevant senior coroner the information given orally.

(6) In this regulation, “consultant medical practitioner” means a registered medical practitioner who is listed in the Specialist Register of the General Medical Council.

Signed by authority of the Lord Chancellor

Edward Argar
Parliamentary Under Secretary of State

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations impose a duty on registered medical practitioners to notify a senior coroner of a person's death under certain circumstances. The senior coroner to be notified is the senior coroner appointed for the area in which the body of the deceased person lies (the "relevant senior coroner").

Regulation 2 provides that the duty applies where the registered medical practitioner comes to know of the death on or after the coming into force of these Regulations and at least one of the circumstances set out in regulation 3 applies in relation to the death.

But the duty does not apply if the registered medical practitioner reasonably believes that the relevant senior coroner has already been notified of the death under these Regulations.

Regulation 3 describes the circumstances referred to in regulation 2.

Regulation 4 sets out the requirements which apply when notifying the relevant senior coroner. This regulation provides when the coroner must be notified, how the coroner may be notified and what information must be given to the relevant senior coroner.

An impact assessment has not been produced for these Regulations as no impact, or no significant impact, on the private or voluntary sectors is foreseen.

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A copy of MOJ Guidance to accompany these Regulations can be found at <https://www.gov.uk/government/publications/notification-of-deaths-regulations-2019-guidance>