Chief Coroner

GUIDANCE No.47

THE 2024 DEATH CERTIFICATION REFORMS

Introduction

1. The implementation of the statutory medical examiner system, and the related rationalisation and reform of the death certification system, took effect on 9 September 2024. Those reforms affected coroners' responsibilities and ways of working. A table summarising the main changes from the coronial perspective is at Annex 1, and copies of the forms that have been created /amended for use by coroners as a result of the reforms is at Annex 5.

2. The principle underlying the reformed system is that where a death is natural and did not occur in custody or state detention, scrutiny should be provided by the medical examiner, and where s1 Coroners and Justice Act 2009 (CJA 2009) is engaged, scrutiny should be provided by the coroner. There is therefore a clear delineation between medical and judicial certification of death.

3. The purpose of this note is to help coroners understand the reforms and to encourage consistency in implementation.

The death certification process

4. Coroners should ensure they are familiar with The Medical Certificate of Cause of Death Regulations 2024[1] (the MCCD Regulations), which are key to the death certification process.

5. As a result of those Regulations, non-coronial deaths will usually be certified by an 'attending practitioner' (i.e. a registered medical practitioner who attended the deceased person during their lifetime[2]) who is able to establish the cause of death to the best of their knowledge and belief. The medical certificate of cause of death (MCCD) that is completed by the attending practitioner will be scrutinised by a medical examiner. If the medical examiner confirms that the MCCD is accurate, it will be used for death registration.

6. When a death is being registered following certification on the medical side of the system, any concerns the registrar may have about the cause of death will not be

[1] https://www.legislation.gov.uk/uksi/2024/492/contents/made

[2] This is much less restricted than before the reforms. Prior to 9 September 2024, only a registered medical practitioner who had attended the deceased person in their last illness could certify the death, and the registrar would have been required to refer the death to the coroner if that medical practitioner had not seen the deceased either in the 28 days prior to death, or after death.

sent to the coroner. Such concerns will instead be raised by the registrar with the medical examiner, who will refer the case to the coroner where appropriate.

7. A death will be referred to a coroner where:

    i) there is no attending practitioner;
    ii) the attending practitioner cannot establish the cause of death;
    iii) the medical examiner is unable to confirm the proposed cause of death; or
    iv) The Notification of Deaths Regulations 2019 (NOD Regulations) apply[3];

8. As was the case before the statutory medical examiner system took effect, when a coroner receives a death referral, the coroner will decide whether there is a duty to investigate, and may undertake preliminary enquiries before making that decision. The process thereafter will depend on the circumstances. Where the death did not occur in custody or state detention and the coroner decides without commencing an investigation that it was natural, a case will progress through the death certification system as follows:

    a) Where the referral to the coroner came from an attending practitioner.

    Using form CN1A, the coroner should notify the attending practitioner (copying in the medical examiner's office) that the coroner does not have a duty to investigate the death. The CN1A includes a space to provide reasons for the coroner's decision not to investigate, as required by the MCCD Regulations[4]. Coroners should provide sufficient information for the attending practitioner to be able to understand why the coroner considers the death to be natural. In addition, if the coroner holds information that would assist the attending practitioner to certify the cause of death but that cannot be included on Form CN1A, it would be helpful to attach it (it will obviously cause delay if the attending practitioner has to collect the same information independently, or has to re-refer the death to the coroner because the cause of death cannot be established). However, the coroner should not state the cause of death on Form CN1A, as that is not for the coroner to determine. Where there has not been a coronial investigation, the cause of death will be determined on the medical side of the death certification system (i.e. by an attending practitioner and/or medical examiner).

    b) Where the referral to the coroner came from a medical examiner.

    Using form CN1A, the coroner should notify both the attending practitioner and medical examiner's office that the coroner does not have a duty to investigate the death[5]. The coroner should set out the reasons for that decision, as explained at (a) above.

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[3] The NOD Regulations have been amended, but the circumstances under which a referral to a coroner will be made under them remain substantially the same as prior to 9 September 2024.

[4] See regulation 4(4).

[5] Although the coroner's duty under regulation 10 of the MCCD Regulations is only to inform the medical examiner, and the medical examiner has a duty to inform the attending practitioner, it is more efficient for both notifications to be made simultaneously via the CN1A form. I have therefore agreed with the National Medical Examiner that my guidance will advise coroners to follow that process.

c) Where the referral came from someone who is not an attending practitioner or medical examiner (e.g. a family member, police officer, or medical practitioner who did not attend the deceased person during their lifetime).

Attempts should be made to find an attending practitioner who can complete an MCCD without undue delay. If an attending practitioner is found, the coroner should send the attending practitioner form CN1A (copying in the medical examiner's office), which will confirm that the coroner does not have a duty to investigate the death[6]. The attending practitioner can then complete an MCCD, which will be scrutinised by a medical examiner in the usual way.

If an attending practitioner cannot be found, the coroner will need to decide how to proceed. One option would be to ask a medical examiner to certify the death. To be able to go down this route, the coroner would need to ask a medical practitioner who is not an attending practitioner to provide a notification to the coroner in accordance with the NOD Regulations (if they have not already done so). A notification under the NOD Regulations is required by the MCCD Regulations before a coroner can refer a case to a medical examiner for a medical examiner's MCCD[7] (ME MCCD). An example of a request that a coroner could send to a medical practitioner who is not an attending practitioner is provided at Annex 2.

Having received a notification under the NOD Regulations, the coroner could make a referral to a medical examiner using form CN1B[8]. This should include the coroner's reasons for the referral, i.e. why the coroner considers the death to be natural and either that no attending practitioner can be found to complete an MCCD, or no attending practitioner can complete an MCCD within a reasonable timeframe. In addition, the coroner must make available to the medical examiner a copy of the information relied upon in making the referral[9]. This does not mean the coroner has to provide the medical examiner with every document the coroner holds relating to the death. The coroner should provide the information that is needed by the medical examiner to understand why the coroner considers the death to be natural and why there is no viable route to an attending practitioner's MCCD. When completing form CN1B, the coroner should not provide a cause of death (as in referring the death to the medical examiner, the coroner will be deciding that the cause of death should be established on the medical side of the system, if possible). If the medical examiner considers that they cannot certify the death, the medical examiner will re-refer the case to the coroner.

Where the coroner either does not receive a notification under the NOD Regulations (and therefore cannot refer the death to a medical examiner for an ME MCCD) or considers that attempts to obtain a notification would be disproportionate, it would in my view be reasonable for the coroner to decide to commence an investigation on the basis that the cause of death is unknown. If the coroner is then satisfied that s4 CJA 2009 applies, the

[6] See 8(a) for information on completing form CN1A.
[7] See regulation 15 of the MCCD Regulations.
[8] Or if the name of the medical examiner is unknown, the form can be sent to the medical examiners' office.
[9] See regulation 15(3) of the MCCD Regulations.

coroner should discontinue the investigation (with or without a post-mortem examination) and complete form CN2 to enable the death to be registered.

Freedom of Information Act requests

9. The work of medical examiners is not exempt from Freedom of Information (FOI) requests, other than where the usual FOI exemptions apply. When a coroner provides information to an attending practitioner and/or medical examiner with a form CN1A or B, it is not the coroner's responsibility to prevent that information from being disclosed onwards. However, if a case is sensitive, coroners could decide to redact any sensitive information within the shared documents that is not relevant to determining the cause of death.

When the coroner decides to investigate

10. The MCCD Regulations provide that where the coroner receives a referral from a medical examiner and decides to investigate the death, the coroner must notify the medical examiner of that decision[10]. There is no specific form for the notification and no requirement to provide reasons for the decision, so a short email to the medical examiner will be sufficient (an example is provided at Annex 3). It would be helpful if the coroner could copy in the relevant attending practitioner, if there is one, to save the medical examiner from then having to relay the decision.

11. Although there is no requirement for the coroner to notify the medical side of the system of a decision to investigate where an attending practitioner makes a referral, it is important from the perspective of collaborative working for coroners to provide that information (the example at Annex 3 could also be used for this purpose).

Ping pong

12. The MCCD Regulations make it possible for cases to be referred between the attending practitioner and/or medical examiner and the coroner on more than one occasion. This could happen where the coroner does not consider they are under a duty to investigate a death, but the attending practitioner does not feel able to certify the death, or the medical examiner does not feel able to confirm the cause of death.

13. Whilst it may be reasonable for a case to be referred more than once between the coronial and medical side of the system (for example because new or additional information is provided), it will not be helpful for bereaved families if investigations are substantially delayed by disagreements between coroners and medical practitioners.

14. Where difficulties arise, I consider that it would be appropriate for the coroner to commence an investigation on the basis that they have reason to suspect the cause of death is unknown. The coroner can then do any further investigation that the coroner considers to be necessary and, if appropriate, can discontinue the investigation and complete form CN2 to enable the death to be registered.

[10] See regulation 10(5) of the MCCD Regulations.

Method of referral

15. There is no specific form for attending practitioners or medical examiners to use when referring deaths to coroners, or re-referring deaths. Coroner areas will already have processes in place to accept referrals, but the reform of the death certification system has provided an ideal opportunity to reconsider areas' processes. In my view, the most efficient way to receive death referrals is via a Civica or WPC portal and I would encourage all coroners to use these portals to their full potential.

16. Coroners will need to ensure that when a re-referral is made by an attending practitioner or medical examiner, the new information is added to the original case file. Where the portal is used, this can be achieved through discussion with WPC and Civica.

Discontinuance

17. Prior to 9 September 2024, when a coroner discontinued an investigation the cause of death used for registration purposes was either taken from an MCCD or a pathologist's report following a post-mortem examination. If neither of those existed, the death was registered as 'uncertified'.

18. Following the reforms, where a coroner has commenced an investigation, responsibility for determining the cause of death for registration purposes sits with the coroner. This is the case even if the coroner discontinues the investigation without a post-mortem examination.

19. When a coroner discontinues an investigation, they should:

    i) Complete form CN2 and send it to the registrar;
    ii) Send a Notice of Discontinuance to the family; and
    iii) Issue either Form Cremation 6 or an Order for Burial, to enable disposal of the deceased person's body.

Post-mortem examinations during preliminary enquiries

20. The Coroners and Justice Act 2009 introduced the concept of the 'investigation' and made it possible for coroners to conduct a post-mortem examination during preliminary enquiries before deciding whether their duty to investigate was engaged. This led to a divergence of practice within the coroner system, with some coroners always commencing an investigation before conducting a post-mortem examination on the basis that they had reason to suspect the cause of death was unknown, and others conducting a post-mortem examination at the preliminary enquiries phase.

21. As a result of the 2024 reforms, there is now a clear delineation between the coronial and medical sides of the death certification system, with coroners only determining the cause of death if they have commenced an investigation. This makes coroners' certification responsibilities clear, but it has created a complication where a post-mortem examination is conducted as part of the coroner's preliminary enquiries and the coroner then decides that their duty to investigate is not engaged. In such cases, the coroner must pass the pathologist's report to the attending practitioner and/or medical examiner to certify the cause of death, which means duplication of effort, could lead to

disagreement between medical practitioners and pathologists, and is likely to mean that the bereaved family have to be involved in additional processes (e.g. a discussion with the attending practitioner about the post-mortem examination report, having already discussed it with the coroner's officer).

22. To avoid the need for additional processes, my advice is that when a coroner is requesting a post-mortem examination, they should usually commence an investigation on the basis that they have reason to suspect the cause of death is unknown. I cannot direct coroners, so it is ultimately each coroner's decision as to how to proceed. However, one of the reasons the office of Chief Coroner was created was to promote consistency, and I consider that this is one area where consistency is important to assist with the smooth operation of the death certification system.

Relocation of the body

23. As has long been the case, moving the body before an investigation has been commenced can impact on which coroner has jurisdiction for dealing with a death referral.

Relocation of the body before an initial report to a coroner

24. Where a person dies in a coroner area, but their body is moved outside that area before the death is reported, s1 CJA 2009 requires that the report is made to the coroner area in which the body lies. A coroner who receives a report of death relating to a body that at the time of the report is outside their area should either ask the person who made the referral to make a fresh referral to the correct coroner area, or should notify the correct coroner area of the death directly.

25. If before a report of death is made, the deceased person's body is moved to a coroner area that has no connection with the circumstances of the death (for example because it is transported to a regional cremation site), the death must still be reported to the coroner area where the body lies. However, the principles within Chief Coroner Guidance No. 24 on Transfers will apply. If, for example, the coroner where the body lies decides that a post-mortem examination is needed and so follows my guidance above and commences an investigation, there will be an investigation capable of transfer. In my view, the coroner area with the connection to the death should agree to accept a transfer under s2 CJA 2009 (including arranging and funding a post-mortem examination, if they consider one is needed). Coroners should note that under s1 CJA 2009, it is the coroner with jurisdiction who decides whether or not an investigation is commenced, and no-one can interfere with that independent judicial decision. A transfer can therefore proceed even if the coroner area with the connection to the death does not agree that an investigation is warranted. If coroners cannot agree about a potential transfer, an application can be made to me under s3 CJA 2009 in the usual way.

Relocation of the body between the initial referral and a re-referral

26. If a coroner who has issued a Form CN1A or CN1B has the death re-referred to them after the deceased person's body has been moved out of their area (or cremated), that coroner retains jurisdiction to deal with the re-referral[11]. If the

[11] See paragraphs 41-48 of Chief Coroner's Guidance No. 33 on Suspension, Adjournment and Resumption of Investigations and Inquests, for more information.

coroner decides that s1 CJA 2009 is triggered, the investigation will be conducted within that coroner's area in the usual way.

Cremation

27. On 9 September 2024, the Cremation (England and Wales) Regulations 2008 (the Cremation Regulations) were amended so that a coroner's certificate (Form Cremation 6) is now only required to enable cremation where a coroner has commenced an investigation. The only exception to this is where the death of the deceased person occurred outside the British Islands and the body is repatriated for cremation. In such cases, the coroner may determine that no investigation is necessary, but a certificate from the coroner will still be required before cremation can take place.

28. When a body is repatriated from Scotland, Northern Ireland, the Channel Islands or the Isle of Man, there are provisions in the Cremation Regulations that allow forms from those jurisdictions to be used to enable cremation. As those jurisdictions do not have medical examiner scrutiny, the regulations as they stood prior to the 2024 amendments continue to apply. More information is available at this link: https://www.gov.uk/government/collections/cremation-forms-and-guidance.

Visiting Forces cases

29. Before the 9 September 2024 reforms, coroners would use Form Rev 99 to inform the registrar when there was an adjournment of an inquest into the death of someone to whom the Visiting Forces Act 1952 applied. Now, Form 90 is the only form coroners need to use when notifying the registrar about decisions made in connection with a death of a member of the visiting forces when no inquest is completed, including any adjournment.

Deaths abroad

30. Where a person dies abroad and a coroner is informed that their body has been repatriated to the coroner's area, the coroner's duty to investigate under s1 CJA 2009 may or may not be triggered.

31. If s1 CJA 2009 is not triggered, the coroner does not need to notify a medical practitioner or medical examiner using form CN1A or CN1B, as the MCCD Regulations do not apply. The coroner should simply issue a Cremation Form 6 or Order for Burial and advise the family to seek from the registrar a Certificate of No Liability to Register. It would also be helpful for the coroner to inform the registrar of the steps the coroner has taken, to avoid duplication. An example of an email to the registrar is provided at Annex 4.

32. If s1 CJA 2009 is triggered and the coroner commences an investigation, the coroner will go through the usual investigation process and either discontinue the investigation following further enquiries or hold an inquest. The coroner should complete a Notice of Discontinuance or Record of Inquest (as appropriate) but does not need to issue a Form CN2 or a Rev 99, as the registrar will not register the death. Instead, when the coroner issues the Cremation Form 6 or Order for Burial, the coroner should advise the family to seek from the registrar a certificate of no liability to register. It would also be helpful for the coroner to inform the

registrar of the steps the coroner has taken, to avoid duplication. An example of an email to the registrar is provided at Annex 4.

Additional information on forms

33. To align with information gathered in other parts of the death certification system, new fields have been added to some of the forms used by coroners. These new fields include:

    i) a field '(d)' in the medical cause of death;
    ii) a field for capturing ethnicity information;
    iii) fields relating to pregnancy to capture information regarding maternal death;
    iv) fields capturing information regarding medical devices.

34. Coroners only need to complete the answers to the ethnicity, pregnancy and medical devices questions if the information is known to the coroner without additional inquiry.

35. Coroners should also bear the following information in mind when completing these fields:

    a) Ethnicity

    This information will be provided on any MCCD if it was available in the deceased person's patient record. The intention is that ethnicity information will be the information that was declared by the deceased person during their lifetime. Coroners do not need to determine a deceased person's ethnicity. If the information is not provided from the person's patient record, the information is not known for the purposes of the relevant coronial forms.

    b) Pregnancy

    The answers to the pregnancy field questions are multiple choice. 'Not applicable' is for use where the deceased person was incapable of being pregnant. 'Not pregnant' and 'unknown' are for use where the deceased person was capable of being pregnant, but was either not pregnant at the time of death, or the coroner does not have that information.

    When disclosing documents including the pregnancy fields, coroners should remember that pregnancy information can be sensitive. If pregnancy was not relevant to the cause of death, there may be cases where despite open justice considerations it is appropriate to redact the fact of pregnancy when disclosing copies of the forms.

    c) Medical devices

    The purpose of the medical devices fields is to inform crematoria and burial authorities of any relevant information for safety and environmental reasons. Coroners will have this information if it was provided on an MCCD. They may also have it if it was included in a pathologist's report following a post-mortem examination (assuming the report is in the coroner's possession at the time the form is completed), or if they have received it from the deceased person's family. If coroners do not have medical devices information, they are not expected to

make additional enquiries to obtain it and should use the ‘Don’t know’ option on the form.

Transitional arrangements

36. The MCCD Regulations and related amendments to Ministry of Justice and General Register Office legislation came into force on 9 September 2024. All deaths on or after 9 September 2024 should therefore be managed under the new framework.

37. The transitional arrangements in the MCCD Regulations mean that some deaths occurring before 9 September 2024 will also be subject to the new arrangements. If prior to 9 September the following factors applied to a case, the new framework applies:

    i) the death had not been registered;
    ii) a registered medical practitioner had not signed an MCCD;
    iii) a coroner is not under a duty to hold an inquest into the death under section 6 of the Coroners and Justice Act 2009.

38. This means coroners will have 3 types of cases:

    i) Cases where the deceased person died on or after 9 September. Those cases will be managed under the new framework;
    ii) Cases where the deceased person died before 9 September, but where the position before 9 September 2024 was that there was no MCCD and the coroner was only undertaking preliminary enquiries. Those cases will be managed under the new framework;
    iii) Cases where the deceased person died before 9 September and where the position before 9 September 2024 was that an MCCD had been signed, and/or the coroner had commenced an investigation. Those cases will be managed under the old framework.

39. There are two exceptions to these transitional arrangements:

    i) Because of an error in the drafting of The Cremation, Coroners and Notification of Deaths (England and Wales) (Amendment) Regulations 2024 (the MoJ Regulations), the changes to the Cremation Regulations and to the text of the NOD Regulations do not perfectly align with the transitional arrangements within the MCCD Regulations; and
    ii) The transitional arrangements in the MoJ Regulations do not apply to the amended Order for Burial and Notice of Discontinuance. The new versions of those two forms have their own coming into force arrangements and should simply be used in all cases where the forms are being completed on or after 9 September 2024.

40. The error in the MoJ Regulations should not impact on death referrals, as the changes to the text of the NOD Regulations are minor and the Order for Burial and Notice of Discontinuance are not affected. However, the position in relation to the Cremation Regulations is more complex because the changes to those regulations are more substantive. The position from 9 September is that where the deceased person died on or after 9 September 2024, the new legislative framework applies. If, however, the person died before 9 September 2024, the position is as follows:

i) If before 9 September 2024 there was an MCCD and/or the death had been registered, the old cremation framework applies.
ii) If before 9 September 2024 there was no MCCD and the death had not been registered, the new cremation framework applies.

41. From the coroner's perspective, this means:

i) **In cases where there was an MCCD before 9 September 2024** – Where applicable, coroners will issue:
- an old-style Cremation Form 6 in the circumstances set out in the previous iteration of the Cremation Regulations (i.e. where a post-mortem examination was undertaken as part of preliminary enquiries, an investigation is underway, an investigation has been discontinued, or the death of the deceased person occurred outside the British Islands and no post-mortem examination or investigation is necessary).
- the new style Order for Burial and Notice of Discontinuance.

ii) **In cases where there was no MCCD before 9 September** – Where applicable, coroners will issue:
- a new-style Cremation 6 Form in the circumstances set out in the current version of the Cremation Regulations (i.e. in cases where the s1 duty to investigate is triggered, or where there is no duty to investigate but the death occurred outside the British Islands);
- the new style Order for Burial and Notice of Discontinuance.

42. This should not create any operational difficulties, as the only scenario where there is a mismatch between the MCCD Regulations and Cremation Regulations as to the use of the old and new framework is where before 9 September 2024 there was no MCCD, but the coroner had commenced an investigation. In that scenario, coroners should proceed as they would have before the MCCD Regulations took effect (e.g. using Form 100B if the coroner discontinues an investigation following a post-mortem examination). However, the coroner should use the new style Cremation Form 6, Order for Burial and Notice of Discontinuance where those forms are needed, omitting any information that is not available to the coroner (e.g. in relation to ethnicity).

Coroner certificate in the absence of a qualified informant

43. There is a new provision in the Births and Deaths Registration Act 1953 that took effect on 9 September 2024[12] allowing registrars to ask a coroner to provide a certificate to enable registration where the death would otherwise remain unregistered. The circumstances in which this provision applies are where the coroner previously discontinued an investigation and authorised the disposal of the body, but a qualified informant is unable or unwilling to provide and verify the necessary particulars to enable registration.

44. In this type of case, the registrar will write to the coroner requesting a certificate and providing a pre-populated form for the coroner's response that incorporates the information the coroner provided on form CN2. The coroner can amend the

[12] Section 43A

details if needed and should then complete the certificate to enable the death to be registered.

HHJ Alexia Durran
The Chief Coroner

9 September 2024