

Draft guidance for registered medical practitioners

NOTE: There is a general presumption that the registered medical practitioner will, when notifying the relevant senior coroner, make full disclosure of all the circumstances known to him/her to the best of his/her information, knowledge and belief.

The notification requirement

1. A registered medical practitioner (R) means a person on the General Medical Council's list of Registered Medical Practitioners and is anticipated that in practice, the following would be responsible for referring a death to the senior coroner:
 - a. The registered medical practitioner, including a hospital consultant, who attends the deceased shortly after the time of death.
 - b. The medical examiner.
 - c. The attending practitioner, including a hospital consultant, who would otherwise complete the medical certificate of cause of death (MCCD) practitioner i.e. if you attended the deceased during his/her last illness before his or her death – you are expected to prepare an MCCD stating the cause of death to the best of your knowledge and belief based upon a conscientious appraisal of the deceased's medical history and any other information available. As with a clinical diagnosis, this means a reasonable tolerance of uncertainty is acceptable.
2. It should be noted that regulations made under section 20(1)(a)(ii) require an attending practitioner to notify the senior coroner where they have been unable to complete the MCCD because the cause of death is unknown. In order to ensure there is no duplication of statutory duty, this requirement is not referred to in the Notification of Deaths Regulations.
3. If you have questions about the cause of death, or about completing the MCCD, you should discuss these with a medical examiner.

Circumstances in which a notification should be made under regulation 3

A death must be reported to the relevant senior coroner where:

The death occurred as a result of poisoning, the use of a controlled drug, medicinal product or toxic chemical

4. This applies to deaths caused by the deliberate or accidental intake of poison, including:
 - Illicit drugs.
 - Medical drugs (e.g. a self administered overdose or an excessive dose given in error or deliberately).

- Toxic chemicals.
- Prescribed or non-prescribed medication or prescription only medication taken by someone for whom it was not prescribed

The death occurred as a result of trauma, violence or physical injury, whether inflicted intentionally or otherwise

5. A violent death involves some sort of trauma or physical injury. For example, if the deceased:
 - Died as the result of trauma or injuries inflicted by someone else or by him/herself.
 - Died as the result of trauma or injuries sustained in an accident, such as a fall or a road collision.
 - This category also extends to scenarios in which the deceased may have contracted a disease (e.g., Mesothelioma) probably contracted as a result of washing his/her partner's overalls which were covered in asbestos however long before the death this occurred.

A death should be notified however long after the delivery of the initial injury or trauma it occurs.

The death is related to any treatment or procedure of a medical or similar nature

6. This applies if the death may be related to surgical, diagnostic or therapeutic procedures and investigations, anaesthetics, nursing or any other kind of medical care. It includes scenarios such as:
 - Death that occurs unexpectedly given the clinical condition of the deceased prior to receiving medical care.
 - Mistake(s) made in the medical procedure or treatment e.g. the deceased was given an incorrect dosage of a drug.
 - The medical procedure or treatment may have either caused or contributed to death (as opposed to the injury/disease for which the deceased was being treated).
 - Death follows from a (known) complication of a procedure that has been given for an existing disease or condition.
 - Death that is clinically unexplained.
 - The original diagnosis of a disease or condition was delayed or erroneous, leading to the death.

It should be noted that a death that has occurred following medical or similar procedure may not necessarily be related to that treatment; the registered medical practitioner should consider whether there is a relationship.

The death occurred as a result of self harm, (including a failure by the deceased person to preserve their own life) whether intentional or otherwise

7. This may apply if it is reasonable to suspect that the deceased died as the result of poisoning, trauma or injuries inflicted by his/herself, as per categories (2) and (3) above.
8. Or the death may be a result of a failure by the deceased to preserve their own life. This may include, for example, a failure to:
 - Take adequate nourishment or liquid.
 - Obtain basic medical attention.
 - Obtain adequate shelter or warmth.
 - Take proper personal care.
9. It does not extend to deaths where the lifestyle choices of the deceased – for example, to smoke, drink or to eat excessively – may have resulted in their death.

The death occurred as a result of an injury or disease received during, or attributable to, the course of the deceased person's work

10. This includes injuries sustained in the course of work (including employment), for example if the death was due to a fall from scaffolding, or being crushed in machinery.
11. It also includes deaths that may be due to diseases received in the course of employment or work even if the employment/work has long ceased. For example, if the deceased was:
 - A current or former coal miner who died of pneumoconiosis.
 - A current or former furniture worker who died of cancer of the nasal sinuses.
 - A current or former construction worker who died of asbestos-related lung-disease e.g. asbestosis or mesothelioma.
12. See above where the deceased may have contracted a disease (e.g. mesothelioma) probably contracted as a result of washing his/her partner's overalls which were covered in asbestos.

The death occurred as a result of a notifiable accident, poisoning or disease(1)

Please note this is not the same as being a “notifiable disease” under the Public Health Acts.

13. Section 7(4) of the Coroners and Justice Act 2009 defines that an accident, poisoning or disease is “notifiable” *“if notice of it is required under any Act to be given— (a) to a government department, (b) to an inspector or other officer of a government department, or (c) to an inspector appointed under section 19 of the*

(1) “Notifiable accident, poisoning or disease” has the meaning given in section 7(4) of the Coroners and Justice Act 2009.

Health and Safety at Work etc. Act 1974 (c. 37).” If in doubt then the relevant senior coroner and/or the local medical examiner should be consulted.

The death occurred as a result of neglect or failure of care by another person

14. This applies if the deceased was in a dependent or vulnerable position (e.g. a minor, an elderly person, a person with a registered disability) and it is reasonable to suspect that there was a failure to provide him/her with – or to procure for him/her – certain basic requirements. This would include, for example, a failure to provide:

- Adequate nourishment or liquid.
- Adequate shelter or warmth.
- Proper medical assessment and care.

15. It also includes a death, albeit from natural causes, where it is reasonable to suspect that the death results from some culpable human failure.

The death was otherwise unnatural

16. A death is considered to be unnatural if it has not resulted entirely and solely from a naturally occurring disease process running its full course.

The death occurred in prison, police custody or other state detention

17. This is relevant where the person was compulsorily detained by a public authority regardless of the cause of the death. This applies whether the custody or state detention was in England and Wales or elsewhere and includes:

- Prisons (including privately run prisons).
- Young Offender Institutions.
- Secure accommodation for young offenders.
- Any form of police custody e.g. the deceased was under arrest (anywhere) or detained in police cells.
- Immigration detention centres.
- Hospitals, where the deceased was detained under mental health legislation (including instances when the deceased is on a period of formal leave).
- Court cells.
- Cells at a tribunal hearing centre.
- Military detention.

- Bail hostel.
- When the deceased was a detainee who was being transported between two institutions.
- When the deceased was subject to a Deprivation of Liberty Order.
- Any death which would have been in state detention but that the deceased was temporarily elsewhere, non exclusive examples of which are medical treatment, attending a funeral, temporary compassionate leave.

There was no attending registered medical practitioner

18. Only an attending registered medical practitioner – a registered medical practitioner who attended the deceased during his/her last illness before his or her death – can complete an MCCD, without reference to a senior coroner.
19. “Attending registered medical practitioner” is generally accepted to mean a doctor who has cared for the patient during the illness that led to death and so is familiar with and has knowledge of the patient’s medical history, investigations and treatment. He or she should also have access to relevant medical records and the results of investigations.
20. In hospitals there may be several doctors in a team caring for the patient. It is ultimately the responsibility of the consultant in charge of the patient’s care to ensure that the death is properly certified. In general practice, more than one GP may have been involved in the patient’s care and so be able to certify the death.
21. If there is no attending registered medical practitioner then the death must be referred to a senior coroner. You will need to provide the senior coroner with the relevant medical and supporting information.
22. Similarly, if the attending registered medical practitioner(s) is unavailable on either the day the person died (or the day the body was discovered) or the following working day then the death must be referred to a senior coroner. Again, you will need to provide the senior coroner with the relevant medical and supporting information.

The identity of the deceased person is unknown

23. If the identity of the deceased is not known, then it follows that there will be no attending medical practitioner and/or the deceased’s medical history is unknown, precluding the completion of an MCCD. In this scenario the death must be referred to the senior coroner.

Information to be provided to the senior coroner

24. Regulation 4(1) requires the notification to the senior coroner to be made as soon as reasonably practicable after the registered medical practitioner has determined that the death should be notified. While the regulations do not prescribe a time limit for notifications, an example would be that where the registered medical practitioner is working in a shift pattern, the notification this should take place within the shift that he/she becomes aware of the death and if

the death arises from an event or occurrence that may be suspicious then the police should be notified without delay.

25. It is important to note that advice may be sought from the medical examiner on the possible cause of death before notifying the coroner. It is expected that this would be sought where a death has occurred under the in the circumstances set out in Regulation 3, however where the death is clearly unnatural it may be more appropriate for a notification to be made directly to the senior coroner.
26. Regulation 4(2) prescribes the information that a registered medical practitioner must, in so far as it is known to him/her, provide to a senior coroner when making a notification.
27. Regulation 4(3) allows information to be provided orally or in writing but where the notification was made orally, it must be recorded in writing by the senior coroner and its accuracy confirmed by the registered medical practitioner.
28. Oral notifications may include notification by telephone. However where it is not appropriate or possible to notify a coroner orally within a reasonable period of time it would be more appropriate to make the notification in writing. For example if the death has occurred outside of the coroner's working hours and the registered medical practitioner is due to finish the shift before the senior coroner returns, then it would be more appropriate to complete the notification in writing and send across to the senior coroner.
29. Notifications in writing include submission of documents by secure post, courier or electronically (including email, facsimile or other scanning methods). The Department of Health has issued a series of exemplar forms to **[Local Authorities/NHS Trusts/PCTs – awaiting DH confirmation]** which may be used by registered medical practitioners to provide the relevant information regarding a death. The ME-1 and Final Entry in Clinical Record Following a Death forms contain all information required under the Notification of Deaths Regulations and the registered medical practitioner would satisfy the requirements of the draft Regulations by providing copies of these to the senior coroner.
30. Regulation 4(2)(j) requires that the registered medical practitioner indicate the paragraph or paragraphs of regulation 3 which he/she considers relevant, i.e. the reason why it was deemed that the death should be notified. The Regulations do not specify how this notification should be made and in certain circumstances it may be sufficient to refer simply to the paragraph number. However, it is expected that in most cases, the registered medical practitioner would have provided a more detailed explanation of the likely cause of death, so it is likely that a narrative of the likely cause be provided.
31. Regulation 3(6) states that the duty to notify the senior coroner does not apply where the registered medical practitioner reasonably believes that the relevant senior coroner has already been notified of the death. This is to prevent duplication of notification to the coroner which may occur for example where the coroner has already been notified of a death by the police or another registered medical practitioner who may have attended the deceased as part of a team in a surgical environment. The registered medical practitioner will need to consider carefully whether there should be police involvement, and if so, how the death should be notified accordingly.

32. It is anticipated that in an event where there are a number of registered medical practitioners in attendance, that agreement would be reached amongst them as to who should make the notification. However, where this has not occurred, a registered medical practitioner should make reasonable attempts to identify whether a notification has been made before determining whether he/she is under a duty to notify the senior coroner.
33. A coroner investigation may not be necessary in all these cases. If the senior coroner is satisfied that he/she does not need to open an investigation then he/she will refer the case to a medical examiner, who, after carrying out an appropriate scrutiny, can issue a medical certificate of cause of death. For example, this might happen if the deceased was receiving palliative care at home, and this was well documented in the GP notes, but the GP is unavailable.