When to notify deaths to the Coroner: New legal framework from 1st October

Published 19 September 2019

It has been a long time coming, but doctors are finally about to have a clearer legal steer on when they should be reporting deaths to the Coroner.

'*The Notification of Deaths Regulations 2019*' have existed in draft form for several years, but will at last see the light of day when they come into force from **1st October 2019**.

These new Regulations set out the range of circumstances in which deaths must be notified to the Coroner, with further practical detail provided in the recently published accompanying guidance document.

We look at what the new Regulations say and their possible impact.

Up to now…

Until now, there have been no statutory criteria for reporting deaths to the Coroner. In the words of the Chief Coroner in his 2017/18 annual report, this has created '*uncertainty and inconsistency*'.

Whilst there are some pointers for doctors on this within existing guidance on completing Medical Certificates of Cause of Death (MCCDs), this is broadly drawn and has no legal force.

There have accordingly been calls for a clearer, more binding set of criteria for some time.

What do the new Regulations say?

When to notify?

The new Regulations place a duty on registered medical practitioners to notify the relevant Senior Coroner of a death if one or more of the circumstances set out in Regulation 3(1) applies. These need to be read alongside the accompanying guidance document which gives a practical steer on the situations which might fall within each category.

The list of circumstances requiring notification include where the medical practitioner 'suspects' (likely to be interpreted as a low hurdle) that the person's death was due to (i.e. more than minimally/trivially caused or contributed to by) any of the following:

- ***Poisoning*** - whether deliberate or accidental, including substances which would normally be benign but can be harmful at certain levels (e.g. salt).
- ***Exposure to toxic substances*** - including radioactive material.
- ***Medicinal products, controlled drugs or psychoactive substances*** - e.g. deliberate or accidental intake of recreational drugs, 'legal highs' or medications, whether prescribed or unprescribed.
- ***Violence/trauma/injury*** - e.g. inflicted by someone else or themselves or sustained in an accident such as a fall or RTA.
- ***Self-harm*** - e.g. if reasonable to suspect the person died as a result of poisoning, trauma or injuries inflicted by him/herself.
- ***Neglect, including self-neglect*** - the guidance accompanying the regulations goes into some detail about this category, explaining that 'neglect' applies if the deceased was in a dependent position (e.g. a minor, elderly or with a disability or serious illness) and it is reasonable to suspect that there was a failure to provide for certain basic requirements such as adequate food/drink, shelter/warmth or adequate medical assessment, care or treatment. The guidance goes on to explain that: *"This also includes a death, albeit from natural causes, where it is reasonable to suspect that the death results from some human failure, including any acts/omissions"*. In the context of deaths potentially linked to problems in the person's care, this is possibly the most 'thorny' of the new notification categories, because consideration of whether care and treatment failings were sufficient to justify a Coroner concluding that the

death was contributed to by 'neglect' would usually take place in light of the evidence during the course of the inquest itself, rather than being a view reached by a medical practitioner at the point of notification.

- ***Due to undergoing any treatment or procedure of a medical or similar nature*** (e.g. encompassing surgical, nursing, diagnostic or therapeutic procedures) where the medical practitioner has considered and believes there to be some relationship between the treatment/care and the death. The accompanying guidance gives quite a few practical examples of when this category might apply, including: where the death was unexpected given the deceased's clinical condition prior to receiving medical care; where there were treatment errors such as incorrect drug dosage; where there was a recognised complication or where diagnosis of a disease/condition was incorrect or delayed, leading to death or accelerating death.

- ***Disease/injury attributable to the person's employment*** - e.g. miner dies of pneumoconiosis.

- ***Other unnatural death*** - essentially a catch-all for any deaths which were not due to natural causes but do not fall into any of the above categories. An example given is where someone contracts mesothelioma from washing their partner's overalls.

In addition, the Regulations stipulate that a death must be notified to the Coroner where:

- ***Cause of death unknown*** - where the attending medical practitioner is unable to determine the cause of death despite suitable consultation with colleagues or a medical examiner.

- ***Person died in custody or otherwise in 'state detention'*** - the guidance explains that this includes any case where the person was detained under the Mental Health Act when they died and also includes any person who would ordinarily have been in state detention but had been temporarily released (e.g. for medical treatment) or had absconded from detention. Importantly, the guidance also makes clear that the fact someone died whilst subject to a Deprivation of Liberty Authorisation does not require notification under this category (although notification may still be required if the death falls within any of the other categories).

- ***No attending medical practitioner to sign MCCD (or not within reasonable period).***

- ***Identity of deceased unknown*** - in which case, the guidance recommends reporting the death to the police as well as to the Coroner.

Who should notify and when?

The guidance anticipates that, in practice, the person who notifies the death to the Coroner will generally be one of the attending medical practitioners who is qualified to complete the MCCD.

In terms of timing, the Coroner should be notified of the death via his/her office 'as soon as reasonably practicable' after the medical practitioner decides that the death falls within any of the circumstances requiring notification. The guidance further highlights that the notification should be made regardless of how much time has passed since the death.

A notification should still be made even if someone other than a medical practitioner (e.g. family member or the police) have already reported the death to the Coroner, because they may not have provided the full medical picture.

How to notify?

The Regulations list the information which needs to be provided by the medical practitioner when making the notification, which should include the reason why he/she believes the death should be notified - e.g. by reference to the relevant circumstances as set out in the Regulations. As part of this, the guidance suggests, Coroners will expect to be provided with a detailed explanation of the likely cause of death in narrative form, including the proposed medical cause of death where possible.

Importantly, the Regulations also specify that the notification to the Coroner must be in writing (which includes by e-mail or other electronic means such as web-portal) unless there are exceptional circumstances which justify notifying orally - e.g. by phone - in the first instance (to be followed up in writing as soon as reasonably practicable). The guidance suggests that 'exceptional circumstances' might include, for example, if IT systems are not available at the time. This provision essentially formalises what should already be happening in practice given most coroner jurisdictions now have written notification systems in place.

Practical Impact?

The hope is that these new Regulations will in practice mean more clarity and more consistency in terms of when deaths are notified to Coroners.

Given that the extent of the Coroner's duty to investigate deaths will remain unchanged (i.e. if he/she has reason to suspect

that a death was violent, unnatural, in state detention or cause of death unknown), these new Regulations should not in principle have a significant impact on inquest numbers. It is, however, quite possible that - particularly whilst the new Regulations 'bed down' - we may see a spike in numbers of deaths being reported to Coroners, especially as this is the first time there has been a legal duty to notify. It will be interesting to see if this is borne out in the next set of annual coroners statistics.

It will be particularly important for medical practitioners to familiarise themselves with the new Regulations ahead of these provisions coming into effect on 1st October, as failure to notify a death as required could potentially lead to a referral to their professional body and/or possible disciplinary action by their employer. Any intentional failure to report a death in line with these requirements could also amount to an offence under coronial law.

Healthcare providers also need to be alert to the new provisions and ensure these are reflected in local protocols on reporting and learning from deaths, as well as ensuring they are covered in staff education and training programmes - e.g. as part of junior doctor induction and as part of training for nursing and other clinical staff who need to understand the circumstances in which deaths should be reported to the Coroner even though they are not actually doing the notifying themselves. Consideration will also need to be given to how the Regulations will tie in with the new local Medical Examiner systems which are in the process of being set up via NHS Trusts across the country.

How we can help

Our national team of healthcare regulatory lawyers has extensive experience of advising on a wide range of matters relating to patient deaths and inquests, and the support we can provide includes advice and training on the application of these new notification of deaths requirements.

Authors

Peter Merchant
Leeds
pmerchant@dacbeachcroft.com

Louise Wiltshire
Bristol
lwiltshire@dacbeachcroft.com

Elizabeth Stokes
Newcastle
estokes@dacbeachcroft.com

DAC BEACHCROFT