Ministry of Justice

Guidance for registered medical practitioners on the Notification of Deaths Regulations

September 2024

Contents

Introduction

1. This guidance is for **registered medical practitioners and Medical Examiners (MEs)** and sets out **how they notify the coroner[1] of a death** if one or more prescribed circumstances apply.

2. References to 'the regulations' in this documents relate to the Notification of Deaths Regulations 2019 as amended by the Cremation, Coroners and Notification of Deaths (England and Wales) (Amendment) Regulations 2024 which are available at this link; https://www.gov.uk/government/publications/notification-of-deaths-regulations-2019-guidance.

3. This guidance has been updated in the light of the new statutory death certification process and attendant changes which came into effect on 9 September 2024.

[1] Statutory provisions typically refer to 'senior coroner'. However there is also statutory provision for area and assistant coroners to exercise the powers and undertake the duties of a senior coroner. Therefore, for ease of reference, the generic term 'coroner' is used throughout this guidance.

Death Certification Reform and the Medical Examiner System

Death Certification Reform: a summary of the changes

4. The reforms to the death certification process which came into effect on 9 September 2024 require all deaths in England and Wales to be independently scrutinised, either by a coroner or by a Medical Examiner (ME). MEs are senior medical doctors who provide independent scrutiny of all non-coronial deaths.

5. **One of the key changes relates to the eligibility for completing the Medical Certificate of Cause of Death (MCCD)**. Under the new system, in cases **not** involving a coroner, stillbirth, body parts or anatomical research, **a registered medical practitioner will be eligible to be an attending practitioner and complete an MCCD, if they have attended the deceased in their lifetime.** The attending practitioner will propose a cause of death, where they have been able to establish it to the best of their knowledge and belief. This change represents a simplification of the previous attendance criteria. This is reflected in the Medical Certificate of Cause of Death Regulations 2024 and a minor amendment has been made to the Notification of Deaths Regulations 2019 to reflect this.

6. **Another change relates to information about implantable medical devices:** The existence of **implantable medical devices** is now recorded on the MCCD by the attending practitioner.

7. **The final key change relates to the role of the ME.** Under the new system, an ME **provides independent scrutiny of the cause of death proposed by the attending practitioner.** MEs are supported by Medical Examiner Officers (MEOs), and their independent scrutiny includes a proportionate review of medical records, an interaction with the attending practitioner completing the MCCD, and offering representatives of the deceased person the opportunity to ask questions and raise any concerns.

Changes to documentation:

8. Many of the existing regulations governing cremations are unaffected by the recent death certification reform. However, it is important to note that:

9. The requirement for a **medical certificate (form Cremation 4)** has been permanently removed for cases in England and Wales, and a **confirmatory medical certificate (form Cremation 5) has been permanently removed**.
   - **The right of the applicant to inspect the medical certificate (form Cremation 4)** before the **Medical Referee (MR) authorises the cremation has been removed as this form will no longer exist**. However, MEs will offer representatives of the deceased person the opportunity to ask questions and raise concerns about the cause of death at an earlier stage.

10. **Fields on the presence of implantable medical devices have been added** to form Cremation 6.
    - **For deaths in the rest of the British Isles (excluding England and Wales) the 2008 Regulations as they stood prior to the 2024 amendments will continue to apply, and the forms issued in 2018 are to be used. A version of the 2008 Regulations without the 2024 amendments are available at this link:** https://www.gov.uk/government/collections/cremation-forms-and-guidance**.**

The requirements under the Notification of Deaths Regulations 2019

11. For the purpose of the regulations, a registered medical practitioner means a person on the General Medical Council's list of Registered Medical Practitioners who has a licence to practice.

12. The following pages in this guidance set out the circumstances where notification should be made to the coroner. If, however, you have questions about the cause of death, or about completing the MCCD, you should discuss these with an ME.

13. It is anticipated that in practice, where available, it will be a registered medical practitioner who is also an attending practitioner who will make the notification to the coroner.

14. A death may have already been reported to the coroner by a person other than a registered medical practitioner, such as a friend or family member of the deceased person, or the police. Such reports will not always include the information required at regulations 4(3) and 4(4) and may not provide the coroner with the full medical picture. Therefore, even if a registered medical practitioner is aware that someone has already reported a death to the coroner, they should still make a notification under the regulations.

15. Whilst COVID-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010, the fact that a death was caused by COVID-19 is not on its own a reason to notify the coroner. COVID-19 is a recognised and acceptable direct or underlying natural cause of death.

Circumstances in which a notification should be made under regulation 3

16. A person's death should always be notified to the coroner where there is reasonable cause to suspect that the death was due to (i.e. more than minimally, negligibly, or trivially caused by or contributed to by) any of the following:
    - poisoning including by an otherwise benign substance;
    - exposure to, or contact with a toxic substance;
    - use of a medicinal product, the use of a controlled drug or psychoactive substance;
    - violence, trauma or injury;
    - self-harm;
    - neglect, including self-neglect.
    - the person undergoing any treatment or procedure of a medical or similar nature;
    - an injury or disease attributable to any employment held by the person during the person's lifetime.

17. In addition, a person's death should always be notified to the coroner where:
    - the registered medical practitioner suspects that the person's death was unnatural, but does not fall within any of the above circumstances;
    - the cause of death is unknown;
    - the registered medical practitioner suspects that the person died while in custody or otherwise in state detention;
    - there is no attending practitioner, or an attending practitioner is not available within a reasonable time to sign a MCCD in relation to the deceased person; or
    - the identity of the deceased person is unknown.

18. The length of time that has passed since the person died does not impact on the duty to notify a coroner of the death once relevant circumstances come to light.

Where a death was due to poisoning, including by an otherwise benign substance

19. This applies to deaths due to the deliberate or accidental intake of poison, including any substance that would otherwise be benign, beneficial or tolerable but at certain levels is injurious to health, such as sodium chloride (salt).

20. Regarding alcohol or smoking related deaths, only those caused by acute poisoning should be notified to the coroner. Deaths due to natural chronic/long-lasting conditions (caused by alcohol or cigarette consumption) should not be notified to the coroner.

Where a death was due to exposure to, or contact with, a toxic substance

21. This applies to any case where death was due to exposure to, or contact with, a toxic substance. Examples of this include, but are not limited to, deaths due to:
    1) Toxic material, including toxic solids, liquids and gases.
    2) Radioactive material.

Where a death was due to the use of a medicinal product, controlled drug or psychoactive substance

22. This applies to deaths due to either the deliberate or accidental intake or administration of medicinal products or any other drugs, or any complications arising from this. Examples of this include, but are not limited to, deaths due to:
    1) Illicit, or recreational drugs.
    2) Medical drugs, including but not limited to prescribed or non-prescribed medication (e.g. a self-administered overdose or an excessive dose given either in error or deliberately).

23. Any circumstance where the death may be due to a psychoactive substance should be notified to the coroner. A psychoactive substance includes any substance which is capable of producing a psychoactive effect in a person if, by stimulating or depressing the person's central nervous system, it affects the person's mental functioning or emotional state. Examples of this include, but are not limited to:
    1) New psychoactive substances, also known as 'legal highs' or 'designer drugs'.
    2) Herbal highs, such as salvia.

Where a death was due to violence, trauma or injury

24. A death may be considered 'due to violence, trauma or physical injury' where, for example, the deceased person:
    1) Died as the result of violence, trauma or injuries inflicted by someone else or by themselves.

2) Died as the result of violence, trauma or injuries sustained in an accident, such as a fall or a road traffic collision.

Where a death was due to self-harm

25. This applies where it is reasonable to suspect that the deceased person died as the result of poisoning, trauma or injuries inflicted by themselves or their actions.

Where a death was due to neglect, including self-neglect

26. Neglect applies if the deceased person was in a dependent position (e.g. a minor, an elderly person, a person with a disability or serious illness) and it is reasonable to suspect that there was a failure to provide them with – or to procure for them – certain basic and obvious requirements.

27. This would include, for example, a failure, omission or delay by any person to provide or procure:

    1) Adequate nourishment or liquid.

    2) Adequate shelter or warmth.

    3) Adequate medical assessment, care, or treatment.

28. This also includes a death, albeit from natural causes, where it is reasonable to suspect that the death resulted from some human failure, including any acts/omissions.

29. Self-neglect applies if the death is a result of the deceased person intentionally or unintentionally not preserving their own life. However, this does not include circumstances where there has been a documented, reasonable and informed decision by the deceased person not to act in a way that would have preserved their own life. This may include a decision not to take a certain course of treatment.

30. There may be cases where people fail to take adequate nourishment or proper personal care due to the natural progression of an underlying illness, such as dementia. Although this may hasten their death, this death should not be notified to the coroner unless there was neglect by others.

31. It does not extend to deaths where the lifestyle choices of the deceased person – for example, to smoke, to eat excessively, or addiction to the consumption of alcoholic drink – may have resulted in their death.

Where a death was due to a person undergoing any treatment or procedure of a medical or similar nature

32. This applies if the death was related to surgical, diagnostic or therapeutic procedures or investigations, anaesthetics, nursing or any other kind of medical care. It includes scenarios such as:

    1) Death that occurs unexpectedly given the clinical condition of the deceased person prior to receiving medical care.

    2) Errors made in the medical procedure or treatment e.g. where the deceased person was given an incorrect dosage of a drug.

    3) The medical procedure or treatment may have either caused or contributed to death (as opposed to the injury/disease for which the deceased person was being treated).

    4) Death follows from a recognised complication of a procedure that has been given for an existing disease or condition.

    5) The original diagnosis of a disease or condition was delayed or erroneous, leading to either the death or the acceleration of the death.

33. It should be noted that a death that has occurred following a medical or similar procedure may not necessarily be due to that treatment; the registered medical practitioner should consider whether there is a relationship. It is only in circumstances where the registered medical practitioner believes that the death was due to this procedure that the death should be notified.

Where a death was due to an injury or disease attributable to any employment held by the person during the person's lifetime

34. This includes injuries sustained in the course of employment (including self-employment, unpaid work, work experience or contracted services), for example if the death was due to a fall from scaffolding or being crushed in machinery. It also includes deaths that may be due to diseases contracted in the course of employment, even if the employment has long ceased.

35. Examples of diseases contracted in the course of employment include, but are not limited to:

    a. A current or former coal miner who died of pneumoconiosis.

    b. A current or former furniture worker who died of cancer of the nasal sinuses.

c. A current or former construction worker who died of asbestos-related lung-disease e.g. asbestosis or mesothelioma.

d. A current or former rubber or paint worker who died of bladder cancer.

Where a person's death was unnatural but does not fall within any of the above circumstances

36. A death is typically considered to be unnatural if it has not resulted entirely from a naturally occurring disease process running its natural course and where nothing else is implicated. For example, this category includes scenarios in which the deceased person may have contracted a disease (e.g. mesothelioma) as a result of washing their partner's overalls which were covered in asbestos, however long before the death occurred.

Where a cause of death is unknown

37. The duty to notify the coroner where the cause of death is unknown applies to an attending practitioner who is unable to determine the cause of death to the best of their knowledge and belief, based upon a conscientious appraisal of the known facts, including after suitable consultation with an ME.

Where a registered medical practitioner suspects that the person died while in custody or otherwise in state detention

38. 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:

1) Hospitals, where the deceased person was detained under mental health legislation (including instances when the deceased person was on a period of formal leave).

2) Prisons (including privately run prisons).

3) Young Offender Institutions.

4) Secure accommodation for young offenders.

5) Secure accommodation under section 25 of the Children Act 1989.

6) Any form of police custody e.g. the deceased person was under arrest (anywhere) or detained in police cells.

7) Immigration detention centres.
8) Court cells.
9) Cells at a tribunal hearing centre.
10) Military detention.
11) Bail hostels.
12) When the deceased person was a detainee who was being transported between two institutions.
13) Any death in which the person would ordinarily have been in state detention but had been temporarily released (for example for medical treatment) or had absconded from detention.

39. This does not include circumstances where the death occurred while the deceased person was subject to a Deprivation of Liberty Order, unless the person was additionally subject to custody or detention as described above.

Where there was no attending practitioner, or an attending practitioner is not available within a reasonable time to sign an MCCD in relation to the deceased person

40. A registered medical practitioner will be eligible to complete the MCCD if they attended the deceased person during their lifetime. The introduction of MEs will see routine independent scrutiny of the cause of death proposed by the attending practitioner.

41. In hospitals, there may be several registered medical practitioners in a team caring for a 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 general practitioner may have been involved in the patient's care and so will be able to certify the death.

42. Where there is no attending practitioner, or where an attending practitioner is not available within a reasonable time, the death is referred to the coroner by a notifying registered medical practitioner. If the cause of death is known and the coroner decides not to investigate, the coroner will refer the case to the ME who will certify the death by completing a ME MCCD.

43. It is ultimately for a registered medical practitioner to determine what would be a 'reasonable time' based on the individual circumstances of the case.

44. Deaths will not be registered until the registrar receives certification of the cause of death from the ME. This certification will also trigger commencement of the five-day statutory timeframe to register a death.

Where the identity of the deceased person is unknown

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

46. Where the identity of the deceased person is unknown, it is recommended that the death is also reported to the police.

Information to be provided to the coroner

47. Regulation 4(1) requires the notification to the coroner to be made as soon as is reasonably practicable after the registered medical practitioner has determined that the death should be notified. While the regulations do not prescribe a specific timeframe for notifications, **this notification should be prioritised**. If the death arises from an event or occurrence that may be suspicious, the police should be informed immediately.

48. The registered medical practitioner should take reasonable steps to establish the cause of death before notifying the coroner. This may include seeking advice from another registered medical practitioner, such as an ME. However, where the death is clearly unnatural, it may be more appropriate for a notification to be made to the coroner straight away.

Written Notifications

49. The registered medical practitioner must notify the coroner in writing, and it is expected that they will use IT systems which will facilitate the electronic transfer of information and records to the coroner, which includes the scanning of paper records and documents or the creation and transfer of electronically stored records and documents. ‘Notifications in writing’ include submission of documents by courier or electronically (including email, web portal or other scanning methods).

Oral Notifications

50. Regulation 4(2) allows a notification to be provided orally in exceptional circumstances. There may be circumstances or occasions where the IT infrastructure or systems required to facilitate the transfer of information, records and documents is not available in order for a timely written notification to be made to the coroner. Where the notifying registered medical practitioner does not have access to the facilities required to make a notification in written form, they should inform the coroner of the reasons for this when making an oral notification.

51. Oral notifications may include notification by telephone.

52. Following an oral notification, the notifying registered medical practitioner must, as soon as is reasonably practicable, provide a written notification confirming the information given in the oral notification.

The Notification

53. Regulations 4(3) and 4(4) prescribe the information that a registered medical practitioner must, in so far as it is known to them, provide to a coroner when making a notification. If this information is not known to the registered medical practitioner, they do not have a duty to provide it as part of their notification.

54. Regulation 4(3)(c) requires the registered medical practitioner to provide the coroner with the name of the next of kin or, where there is none, the person responsible for the body of the deceased person. Where there is no known next of kin or identified person responsible for the body, the registered medical practitioner should provide the name of the Local Authority who will be responsible for the disposal of the body under s46 of the Public Health (Control of Disease) Act 1984.

55. Regulation 4(3)(d) requires that the registered medical practitioner indicates the reason why it is deemed that the death should be notified, with reference to the circumstances set out in regulation 3(1). The Regulations do not specify the details of how this notification should be made (see paragraphs 44–47 above for guidance on this), and in certain circumstances it may be sufficient to refer simply to the sub-paragraph number within Regulation 3(1). However, it is expected that in most cases, the notifying registered medical practitioner will provide a detailed explanation of the likely cause of death in narrative form. Where possible, this should include the proposed medical cause of death and an explanation of any technical terms used.

56. Regulation 4(4) requires the registered medical practitioner to provide the coroner with any further information that they consider to be relevant. It is recommended that the registered medical practitioner making the notification provides their GMC number. This provision allows for circumstances where a coroner requests that the registered medical practitioner includes information relevant to their investigation that is additional to that specifically listed within the regulations.

57. A coroner's investigation may not be necessary in all notifiable cases. If the coroner is satisfied that they do not need to open an investigation, then they will inform the attending practitioner or the ME, who can issue an MCCD in circumstances where they are able to determine the cause of death to the best of their knowledge and belief. For example, this might happen if the deceased person was receiving palliative care at home, and this was documented in the general practitioner's notes, but the general practitioner was unavailable at the time of notification.

Alternative format versions of this report are available on request from FuneralSectorBurialsandCremation@justice.gov.uk