Browne Jacobson

# New statutory duty to report deaths – are you complying with the new law?

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09 December 2019

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## Introduction

The law on certifying death and notifying deaths to the Coroner has remained largely unchanged for over 50 years but is currently being completely overhauled. It is important that all registered medical practitioners understand their new statutory duties and that organisations update their policies, processes and training to ensure compliance with the Notification of Deaths Regulations 2019.

## Background

Historically, doctors have reported deaths to the Coroner voluntarily in accordance with usual custom and practice. This has led to an inconsistent approach to death reporting. To remedy this, the Notification of Deaths Regulations 2019 came into force in England and Wales on 1 October 2019 and impose new statutory duties on doctors to notify deaths to the Coroner.

## When does the Statutory Duty to Notify Arise?

The Notification of Deaths Regulations 2019 require that a medical practitioner (who is registered with the GMC and has a licence to practice) MUST notify the Coroner where there is reasonable cause to suspect that the death was due to i.e. more than minimally, negligibly or trivially caused or contributed to by:

- Poisoning, including acute alcohol intoxication;
- Exposure to a toxic substance;
- The use of a medicinal product, controlled drug or psychoactive substances (which will include drug errors);
- Violence, trauma or injury;
- Self-Harm;
- Neglect, including self-neglect. This will apply where there is reason to suspect that the death resulted from some human failure, including the acts/omissions of the clinicians involved in treating the deceased before he died;
- Medical treatment or a procedure, which includes surgical, diagnostic or therapeutic procedures and investigations, nursing or any other kind of medical care and treatment that may have caused or contributed to the death. Deaths from a recognised complication of a procedure must be reported. Guidance accompanying the regulations also specifies that if a delayed diagnosis leads to an acceleration of death this must be reported to the Coroner;
- An injury or disease attributable to any employment held by the person during their lifetime.

The statutory duty to notify also arises where a doctor suspects that the death was unnatural, the cause of death is unknown, the patient died whilst in custody or state detention (which includes detention under Mental Health legislation) or when the doctor is unable to identify the deceased despite taking “reasonable steps” to do so.

Finally, it remains the case that the Coroner must be notified of a death unless a registered medical practitioner attended the deceased in their last illness AND has either seen the deceased in the 14 days prior to death or viewed the body after death.

# What information should be provided to the Coroner and when?

The Regulations require that the Coroner must be notified "as soon as is reasonably practicable". Where the statutory duty to notify arises the Coroner should always be notified, regardless of how much time has passed since the death. So for example if a medical practitioner becomes aware of shortcomings in care weeks or months after the death has occurred and has reasonable cause to suspect that these more than minimally, negligibly or trivially contributed to the death then he or she would have a statutory legal duty to notify the Coroner as soon as reasonably practicable.

Notification must generally be in writing. The Regulations stipulate that the following information (if known) must be provided to the Coroner at the time of notification:

1. The reporting doctor's full name, postal and email address and telephone number;

2. The deceased's full name, date of birth, sex, address and occupation;

3. The name and address of the deceased's next of kin or where there is no next of kin the person responsible for the body of the deceased or the Local Authority who will be responsible for disposal of the body;

4. The reason why it is deemed that the death should be notified to the Coroner. It is expected that the notifying doctor will provide a detailed explanation of the likely cause of death, including the proposed medical cause of death and an explanation of any technical terms used;

5. The place of death;

6. The date and time of death;

7. Where the deceased is a child, the name and address of the parent or other person who had parental responsibility for them;

8. The name of any Consultant who attended the deceased in the 14 days prior to death;

9. Any further information that the registered medical practitioner considers to be relevant. The Guidance accompanying the regulations recommends that this should include the reporting doctor's GMC number.

# The Medical Examiner System

These Regulations form part of the introduction of the medical examiner system, which will provide independent scrutiny of all deaths that are not notified to the Coroner. By 31 March 2020, all acute Trusts are required to have established medical examiner offices to scrutinise non-Coronial deaths that occur in their own hospitals. The service will be rolled out to include deaths in the community in 2020/21. The Chief Coroner has issued useful Guidance on Death Referrals and Medical Examiners as has NHSI. Evidence from the DHSC impact assessment and pilot schemes suggest that the involvement of Medical Examiners will result in a significant increase in the number of inquests into deaths that would previously have gone unreported.

# Commentary

For the first time, doctors now have statutory duties to notify the Coroner of deaths in clearly defined circumstances and to provide the Coroner with written information prescribed by Regulations. It is crucial that organisations update their policies, procedures and training on death reporting to ensure compliance with the Regulations. In addition, Acute Trusts have just 4 months to set up and embed the medical examiner service, which in turn is likely to lead to a significant increase in the number of Coroner's inquests with some Coroners anticipating an increase as high as 25%.

Browne Jacobson can advise Trusts on amending their Reporting Deaths policies and procedures and help to prepare for the medical examiner system and the anticipated increase in Coroner's inquests that this will bring – please get in touch if we can help your organisation to comply with these new legal duties.

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