EXPLANATORY MEMORANDUM TO

THE NOTIFICATION OF DEATHS REGULATIONS 2019

2019 No. 1112

1. Introduction

1.1 This explanatory memorandum has been prepared by the Ministry of Justice and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instrument

2.1 This instrument requires a registered medical practitioner to notify a relevant senior coroner of a death if one or more of a set of prescribed circumstances apply. The "relevant senior coroner" to be notified is the senior coroner appointed for the coroner area in which the body of the deceased person lies. It additionally sets out the information that a medical registered practitioner must provide as part of their notification to the relevant senior coroner, and the applicable procedure.

3. Matters of special interest to Parliament

Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None.

Matters relevant to Standing Orders Nos. 83P and 83T of the Standing Orders of the House of Commons relating to Public Business (English Votes for English Laws)

3.2 As the instrument is subject to negative resolution procedure there are no matters relevant to Standing Orders Nos. 83P and 83T of the Standing Orders of the House of Commons relating to Public Business at this stage.

4. Extent and Territorial Application

4.1 The extent of this instrument is England and Wales.

4.2 The territorial application of this instrument is England and Wales.

5. European Convention on Human Rights

5.1 As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

6. Legislative Context

6.1 In her third report on the Shipman Inquiry, *Death Certification and the Investigation of Deaths by Coroners*, published in 2003, Dame Janet Smith identified how Harold Shipman had been able to exploit weaknesses in the death certification system. In light of the conclusions of the report, the Government introduced reforms to death certification and coroner investigations through the Coroners and Justice Act 2009 ("CJA 2009").

6.2 The provisions relating to coroners in the CJA 2009 were substantially implemented in July 2013, including the statutory duty on coroners (in section 1) to conduct an investigation into deaths reported to them where the deceased has died a violent or

unnatural death, the cause of death is unknown, or the deceased has died while in custody or otherwise in state detention.

6.3 Provisions for reforming the death certification process were not, however, commenced, at that time. These provisions include the introduction of medical examiners who would scrutinise and confirm the medical certificate of cause of death issued by the deceased's medical practitioner and confirm when they judge the death to be from natural causes, or refer the case to a senior coroner.

6.4 The provisions relating to the introduction of medical examiners and reforms of the death certification process were subject to a Department of Health consultation, *Introduction of Medical Examiners and Reforms to Death Certification in England and Wales* in 2016. On 11 June 2018 the Government published its response which announced that NHS England would begin implementing a non-statutory medical examiner system from April 2019, and would implement a statutory scheme in due course. The response also stated that the Government would proceed with introducing this instrument (which is not dependent on statutory medical examiners operating a reformed death certification process).

6.5 Under section 22 of the Births and Deaths Registration Act 1953, any registered medical practitioner who attended the deceased during their last illness has a statutory duty to sign and provide the registrar with a medical certificate stating the cause of death. Regulation 41 of the Registration of Births and Deaths Regulations 1987 imposes a duty on registrars to report a death to the coroner where the deceased was not attended by a medical practitioner either during their last illness, within 14 days before death or after death. The 1987 Regulations also provide that the registrar must report a death where the cause of death is unknown, unnatural or attended by suspicious circumstances or is due to: an operation or the effect of anaesthetic, an industrial disease, industrial poisoning, violence, neglect or an abortion.

7. Policy background

What is being done and why?

7.1 This instrument requires a registered medical practitioner to notify the relevant senior coroner of a death if one or more prescribed circumstances apply.

7.2 Broadly speaking, under the Regulations, medical practitioners must report a death if: they suspect the cause of death was unnatural; the cause of death is unknown; the deceased died in custody or otherwise in state detention; they suspect that no medical practitioner is required to sign a medical certificate cause of death for the deceased person; another medical practitioner is required to sign a death certificate for the deceased person but is not available to do so within a reasonable time; or the identity of the deceased cannot be ascertained. The instrument provides a detailed list of examples of unnatural deaths which must be reported to the coroner.

7.3 The circumstances set out in the Regulations, in which a death must be reported, cover both those circumstances in which coroners have a duty to investigate and those circumstances in which registrars currently have a duty to report deaths to coroners (following receipt of a medical certificate from the medical practitioner). Although some reportable categories overlap with each other, we have retained these categories to ensure that the coroner is aware of the full circumstances under which a death should be reported and in these circumstances, the medical practitioner should specify all the applicable circumstances in their report to the coroner

7.4 The majority of medical practitioners already routinely report deaths in the circumstances set out in these Regulations to coroners, but this instrument clarifies those circumstances in which a death must be reported, and when and how this should be done. This should reduce the risk of medical practitioners either unnecessarily reporting a death, or failing to report a death that the coroner has a statutory duty to investigate.

7.5 There is no evidence that registered medical practitioners are systematically failing to report deaths to coroners. However, medical examiner pilot schemes that have been in operation since 2008 show that medical examiners identify and report a small number of deaths that would not otherwise be reported by the certifying doctor. Overall, fewer deaths have been referred to the coroner in pilot areas as medical examiners have identified deaths which do not need to be reported to the coroner, but where the medical practitioner completing the medical certificate cause of death believed that the death did require reporting. This demonstrates that there is some confusion about which deaths medical practitioners should report to the coroner.

7.6 In the absence of regulations, medical practitioners have entered into local agreements with their Senior Coroner as to which deaths should be reported, which has led to variation across coroner areas. To promote greater consistency, the Chief Coroner has provided non-statutory guidance to medical practitioners on when they should report deaths. However, in order to deliver consistency and provide clarity in what medical practitioners should do following a death, regulations are required that place a duty on medical practitioners to report deaths under prescribed circumstances to the coroner.

8. European Union (Withdrawal) Act/Withdrawal of the United Kingdom from the European Union

8.1 This instrument does not relate to withdrawal from the European Union / trigger the statement requirements under the European Union (Withdrawal) Act.

9. Consolidation

9.1 No consolidation is being done in relation to this instrument.

10. Consultation outcome

10.1 A draft of this instrument and accompanying draft guidance document were consulted on as part of the Department of Health consultation which ran from March to June 2016.

10.2 The consultation invited views on the draft regulations, and where they could be improved. We received responses from healthcare professionals, coroners and local government workers amongst others. In its June 2018 response the government committed to amending the draft regulations in light of the responses received and the decision to proceed with a non-statutory (rather than statutory) medical examiner service at this time. This statutory instrument incorporates those changes.

10.3 Section 18(2) of the Coroners and Justice Act 2009 also requires the Lord Chancellor to consult with the Secretary of State for the Department for Health and Social Care and the Chief Coroner prior to the making of these Regulations. This consultation has taken place and the Secretary of State for the Department of Health and Social Care and the Chief Coroner have confirmed they are satisfied with the Regulations.

11. Guidance

11.1 In the 2016 consultation, *Introduction of Medical Examiners and Reforms to Death Certification in England and Wales,* the government also consulted on a draft guidance document to accompany the Regulations. This can be found at the following link: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/506784/Draft_guidance_-_notification_of_deaths_regulations_A.pdf,.

11.2 We will be making changes to this draft guidance document in light of responses to the 2016 consultation. Once the Regulations have been published, we will be consulting with stakeholders (through the Notification of Deaths Regulations Working Group) to develop this guidance. This guidance will be finalised and published before the Regulations come into force on 1 October 2019.

12. Impact

12.1 The impact on business, charities or voluntary bodies is minimal. Although it is unlikely, as there is a low risk that the introduction of this instrument could increase the number of referrals made to the coroner, it could lead to an increase in workload amongst medical practitioners, potentially incurring costs for private hospitals. However, the majority of medical practitioners already routinely report these deaths to the coroner, and any burdens upon medical practitioners' workloads are likely to be negligible, with costs absorbed by the individual hospitals or medical practitioners concerned.

12.2 Again, in the public sector the majority of medical practitioners already routinely report these deaths to the coroner, and any potential costs will be absorbed by the individual NHS hospital trust or medical practitioners concerned.

12.3 An Impact Assessment has not been prepared for this instrument because any financial burdens this instrument may create would fall below the £5m threshold. This instrument will not change existing behaviours significantly and will bring greater clarity to reporting procedures.

13. Regulating small business

13.1 The legislation does not apply to activities that are undertaken by small businesses.

14. Monitoring & review

14.1 The government has committed to run a full post-implementation review 18 months after the implementation of the statutory medical examiner system, to assess any impacts it has had on coroner workload and any net costs associated with the changes. Any impacts that this instrument has will be absorbed within the wider context of the death certification reforms, and will be examined in this review.

15. Contact

15.1 Glenn Palmer at the Ministry of Justice Telephone: 07889414862 or email: glenn.palmer@justice.gov.uk can be contacted with any queries regarding the instrument.

15.2 Dominic Lake, Deputy Director for Administrative Justice, Coroners, Burials, Cremations and Inquiries, at the Ministry of Justice can confirm that this Explanatory Memorandum meets the required standard.

15.3 Minister Edward Argar can confirm that this Explanatory Memorandum meets the required standard.