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## **Draft Guidance for registered medical practitioners on the Notification of Deaths Regulations 2019**

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**Date:** 2 August 2019

### **Submission from the Royal College of Pathologists**

This document covers comment and feedback from members of the Royal College of Pathologists' (RCPATH) Death Investigation Group and the Toxicology Specialty Advisory Committee (SAC). Comments and additions are added under relevant paragraphs below.

### **The notification requirement**

1. A registered medical practitioner means a person on the General Medical Council's list of Registered Medical Practitioners.
2. It is anticipated that in practice, the following would be responsible for referring a death to the senior coroner:
  - The registered medical practitioner, including a hospital consultant, who attends the deceased either previously to, or shortly after the time of death.
  - Any attending practitioner, including a hospital consultant, who would otherwise complete the medical certificate of cause of death (MCCD).
  - A medical examiner - **RCPATH comment:** Need to be clear here whether this can or cannot be the medical examiner officer (MEO), as some pilot sites have delegated this activity to the MEO instead.

### **RCPATH comment:**

The guidance should specify that the doctor reporting the death should be the most senior in the team, to move away from reporting by junior doctors who may not have the necessary experience.

3. If you have questions about the cause of death, or about completing the MCCD, you should discuss these with a medical examiner where one is available.
4. A registered medical practitioner who reasonably believes that the relevant senior coroner has already been notified of a death has no duty to notify that death under these regulations.
5. 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.

### **RCPATH comment**

We agree that this guidance is sufficient.

6. A medical practitioner who only **suspects** that the senior coroner **may have been notified** of a death should confirm with the senior coroner or his/her officials whether a notification

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has been made to determine if they have a duty to make a notification under these regulations.

7. A death may be reported to the coroner by any person such as a friend or family member of the deceased, or the police. The Registrar of Births and Deaths has a duty to report a death to the coroner in certain circumstances. Where such a report has been made to the coroner, a registered medical practitioner should still make a notification under the Regulations. This will ensure the coroner has the information required to be provided at regulation 4(3) and (4).

## **Circumstances in which a notification should be made under regulation 3**

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

**RCPATH comment:** State the relevant legal standard to report a death here.

### ***The death was due to poisoning including by an otherwise benign substance***

8. 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 are injurious to health, such as sodium (salt) or alcohol.

### ***The death was due to exposure to, or contact with a toxic substance***

9. This applies to any cases where death was due to the exposure to a toxic substance. Examples of this include, but are not limited to deaths due to:
  - Toxic chemicals.
  - Toxic gases (i.e. carbon monoxide).
  - Toxic plants, fungi and other poisonous non-synthesised chemicals.
  - Radioactive material.

### **RCPATH comment**

The distinction should be made that coroners would only want to be informed about acute events not chronic/long lasting alcohol problems which are viewed as natural deaths as are deaths from smoking.

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

10. This applies to deaths due to either the deliberate or accidental intake of medicinal products or any other drugs. Examples of this include, but are not limited to:
  - Illicit drugs.
  - Medical drugs (e.g. a self-administered overdose or an excessive dose given in error or deliberately).
  - Prescribed or non-prescribed medication or prescription only medication taken by someone for whom it was not prescribed.

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**RCPATH comment:** Why are illicit drugs not covered below in section 11? Also would classical/established recreational drug be a better term?

11. Any circumstance where the death was due to a psychoactive substance should be reported 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:

- New psychoactive substances, or 'legal highs' - **RCPATH comment** also add "also known as designer drugs".
- Nitrous oxide
- Salvia
- Dimethocaine

### ***The death was due to violence, trauma or injury***

12. 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.

13. This category also extends to scenarios in which the deceased may have contracted a disease from inadvertent exposure to a toxic material through another person (e.g., Mesothelioma contracted as a result of washing his/her partner's overalls which were covered in asbestos however long before the death this occurred).

**RCPATH comment – Consider moving paragraph 13 to paragraph 24.**

14. A death under these circumstances should always be notified, regardless of how much time has passed since the delivery of the initial injury or trauma that occurred.

### ***The death was due to self-harm***

15. 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 or his/her actions. This will include any deaths that have occurred by suicide.

### ***The death was due to neglect, including self-neglect***

16. Neglect 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 - **RCPATH Addition "and obvious" requirements.** This would include, for example, a failure to provide:

- Adequate nourishment or liquid.
- Adequate shelter or warmth.

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- Proper medical assessment and care. **RCPATH addition** “and treatment.”
17. This also includes a death, albeit from natural causes, where it is reasonable to suspect that the death results from some culpable human failure **RCPATH addition**. “**Including any acts/omissions.**”
18. Self-neglect applies if 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. **RCPATH addition** “Unless the cause of self-neglect is due to underlying illness such as dementia.”
19. 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.

**RCPATH comment:** This appears to contradict Section 8 above where excess alcohol is listed as a reason for referral.

## ***The death was due to a person undergoing any treatment or procedure of a medical or similar nature***

20. 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) **RCP Comment. Would “errors” be preferable to “mistakes”?** 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) **RCP Comment. Would “recognised” be preferable to “known”?** complication of a procedure that has been given for an existing disease or condition.
  - Death that is clinically unexplained.
- RCPATH comment:** It should be made clear that the burden of proof is “balance of probability” i.e providing the clinician can state the cause of death on the balance of probability then a MCCD can be filled out and the death does not need to be referred to the coroner unless one of the other requirements for referral means it should be.
- The original diagnosis of a disease or condition was delayed or erroneous, leading to the death.

21. It should be noted that a death that has occurred following medical or similar procedure may

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not necessarily be related to that treatment; the registered medical practitioner should consider whether there is a relationship. It is only in circumstances where the medical practitioner believes that there is a relationship that the death should be reported.

## ***The death was due to an injury or disease attributable to any employment held by the person during the person's lifetime***

22. 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.
23. It also includes deaths that may be due to diseases received in the course of employment even if the employment 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.
24. See paragraph 12, for guidance on reporting a death 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 person's death was unnatural but does not fall within any of the above circumstances***

25. A death is typically considered to be unnatural if it has not resulted entirely and solely from a naturally occurring disease process running its full course in an expected manner.

## ***The cause of death is unknown***

26. The duty to report unknown causes of death applies to an attending medical practitioner who is unable to determine the cause of death, including after suitable consultation with colleagues or a medical examiner.
27. A medical practitioner who was not the attending medical practitioner for the deceased does not have a duty to notify the coroner under regulation 3(c) simply because they know that the person has died and have insufficient knowledge of the deceased to determine the cause of death.
28. If such a doctor is concerned that there is no attending practitioner, see paragraphs 31-33.

## ***The registered medical practitioner suspects that the person died while in custody or otherwise in state detention***

29. 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.

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- Secure accommodation for young offenders. – **RCPATH addition and “Secure accommodation under S25 Children’s Act.”**
- 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.
- 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 or having absconded from detention.

30. This does not include circumstances where the death occurred while the deceased was subject to a Deprivation of Liberty Order unless the person was additionally subject to custody or detention as described at paragraph 29 above.

***There was no attending registered medical practitioner required to sign a medical certificate cause of death in relation to the deceased person***

31. 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.

**RCPATH Addition**

How long ago they attended the deceased should be specified to clarify when a clinician can complete a MCCD.

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.

32. 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.

***The attending medical practitioner is not available within a reasonable time of the person’s death to sign the certificate of cause of death;***

33. If there is an attending medical practitioner who is responsible for signing the MCCD **RCPATH suggested deletion - cause of death**, but this practitioner is unable to sign this

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certificate within a reasonable period, then the death must be reported to the coroner.

34. Although it is ultimately for the discretion of the medical practitioner to determine what would be a 'reasonable time', it is recommended that if the practitioner is unavailable on either the day the person died (or the day the body was discovered) or the following working day then the death should be referred to a senior coroner. Again, you will need to provide the senior coroner with the relevant medical and supporting information.

**RCPATH comment:** This seems a very short time-frame. There is no national guidance on the timeframe for completing the MCCD. There is concern that with hospital rotas/working time rules/shift pattern this will increase coronial referrals considerably.

## ***The identity of the deceased person is unknown***

35. 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 notified to the senior coroner.

## **Information to be provided to the senior coroner**

36. 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 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.

**RCPATH comment – Yes it does.**

**RCPATH comment:** Is there someone to take notifications out of hours/at weekends if that is when the doctor's next shift takes place?

37. 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 medical practitioner, such as a medical examiner, however where the death is clearly unnatural it may be more appropriate for a notification to be made directly to the senior coroner.

**RCPATH Comment -** Since most MCCD are completed by junior medical staff, consider adding 'discussion with the responsible consultant.'

## **Written Notifications**

38. Notifications in writing include submission of documents by secure post, courier or electronically (including email **RCPATH addition: "portal"**, facsimile or other scanning methods).

## **Oral Notifications**

39. Regulation 4(2) allows information to be provided orally in exceptional circumstances. It is expected that medical practitioners will operate with 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

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and documents.

40. However, 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 notification to be made to the coroner. Where the notifying medical practitioner does not have access to the facilities required to make a notification in written form you should inform the coroner of the reasons for this when making an oral notification.
41. Oral notifications may include notification by telephone. Following an oral notification, the reporting medical practitioner must, as soon as is reasonably practicable provide a written notification, confirming the information of the oral notification.

## The Notification

42. Regulation 4(3) and 4(4) 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.
43. Regulation 4(3)(c) requires the registered medical practitioner to provide to the coroner the name of the next of kin or where there is none, the person responsible for the body of deceased. Where there is no identifiable person who may be responsible for the body, the medical practitioner should provide the name of the Local Authority who will be responsible for the disposal of the body.
44. Regulation 4(3)(d) 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 will be provided.
45. Regulation 4(4) allows the medical practitioner to include any other information in their report to the coroner, and requires them to provide any other further information that they consider to be relevant for the coroner. This allows for circumstances where there may be local agreements between coroners and medical practitioners to include information as part of a report which is not specifically listed within these Regulations.
46. A coroner investigation may not be necessary in all notifiable cases. If the senior coroner is satisfied that he/she does not need to open an investigation then he/she may refer the case back to the registered medical practitioner, including a medical examiner, who 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 **RCPATH comment: delete well** documented in the GP notes, but the GP was unavailable at the time of notification.

### **RCPATH comment**

If this occurs, a clear record should be made in the notes by the clinician who referred the case to the coroner detailing the referral and subsequent re-referral back to the clinician by the coroner.