



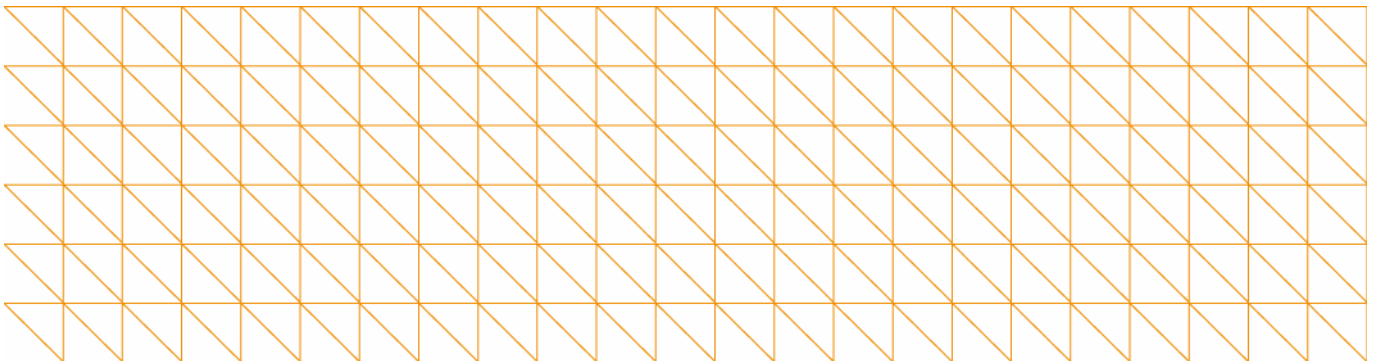
Ministry of
JUSTICE

Statutory Duty for Doctors and other Public Service Personnel to Report Deaths to the Coroner

Response to Consultation

CP(R) 12/07

21 May 2008





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JUSTICE

Statutory Duty for Doctors and other Public Service Personnel to Report Deaths to the Coroner

Response to consultation carried out by the Ministry of Justice.

**This information is also available on the Ministry of Justice website:
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Statutory Duty for Doctors and other Public Service Personnel to Report Deaths to the Coroner
Summary of responses

Introduction

This document is the post-consultation report for the consultation paper, Statutory Duty for Doctors and other Public Service Personnel to Report Deaths to the Coroner.

It will cover:

- the background to the report;
- a summary of the responses to the report;
- a detailed response to the specific questions raised in the report; and
- the next steps following this consultation.

Further copies of this report and the consultation paper can be obtained by contacting the **Coroners Unit** at the address below:

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This report is also available on the Ministry's website: www.justice.gov.uk.

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Background

The consultation paper 'Statutory Duty for Doctors and other Public Service Personnel to Report Deaths to the Coroner' was published on 26 July 2007. It invited comments on proposals on whom the duty to report deaths should rest, the circumstances and categories of deaths that should be reported to the coroner, and possible sanctions that may apply if there is a failure to report a relevant death to the coroner.

Coroners have a vital task, giving certainty and re-assurance to bereaved people, and meeting the public interest by determining the facts of deaths which are reported to them. These deaths may be violent, or unnatural, or of unknown cause. The coroner, supported by his or her staff, will investigate these cases and may conclude with a formal inquest. The inquest will give an official finding of the facts, and can identify lessons for preventing future deaths.

In order to carry out their duties, coroners must have deaths referred to them. The majority of deaths are referred by doctors yet there is no current statutory requirement for them to make referrals and neither is there a nationally recognised list of the particular types of death they should refer. Although many coroners issue guidance to medical professionals in their areas, there is no standard practice, and a case which may be referred to a coroner in one area is not necessarily referred in another area. In practice, this means that coroners have deaths referred to them which should not have been and, to a lesser extent but more worryingly, vice versa.

We sought views on proposals relating to the introduction of a statutory duty to report deaths to the coroner into the Coroners Bill as we wanted to ensure that appropriate deaths are reported so that the bereaved are guaranteed an opportunity to learn the facts about the death of a loved one. This will also ensure that the coroner's public protection role – where lessons to be learned are communicated to the appropriate authority or organisation to prevent further deaths – can be discharged.

The consultation period closed on 7 September 2007 and this report summarises the responses, including how the consultation process influenced the final shape of the policy on the duty to report and other proposals consulted upon. It remains the intention to bring the Coroners Bill before Parliament at the earliest opportunity.

The paper also refers to and takes account of a related public consultation undertaken by the Department of Health (DH) in 2007 about their proposals to

reform death certification. The response to that consultation was published alongside this paper.

A list of respondents is at Annex A.

Summary of responses

1. A total of 74 responses to the consultation paper were received. Of these, 27 responses came from the medical profession in the field of general practice, hospital work and representative bodies, 11 from individual registrars or those involved in local authority registration services, 9 from voluntary groups working for the bereaved, 4 responses from coroners and coroner's officers. Some of the consultees covered all the questions asked in the consultation paper whilst others addressed particular points.
2. The responses received were analysed for views on which public service personnel should have a statutory duty to report deaths to the coroner. The responses were also analysed for any potential impact on those services of placing such a duty on their personnel and the coroner system.
3. The responses were also analysed for the appropriateness of the categories of cases suggested that should be referred to the coroner, and how this would potentially impact on referral rates.
4. The responses to the possible options put forward as sanctions for those who fail in the duty to report deaths to the coroner were analysed for the potential impact on professionals' behaviour and the consequential impact on referral rates to the coroner.
5. The majority of the responses to the consultation supported the introduction of a statutory duty to report. There were different views as to the public service personnel who should have that duty, and some felt that others e.g. funeral directors should also have such a duty to report deaths to the coroner.
6. Those who responded to the consultation were evenly split as to who the right set of public service personnel were. Some favoured a comprehensive list of personnel including nurses, fire service, paramedics, and ambulance crew. However, many highlighted the risks associated with this approach. This included possible over reporting if several agencies reported the same death to the local coroner, but equally the risk that a death never got reported as agencies left it to each other to make the referral.
7. Several respondents made the point that it was a funeral director who had eventually alerted the relevant authorities to irregularities in the paperwork provided by Harold Shipman, and that this therefore made the case for funeral directors in general to have a statutory reporting duty. However, that idea was not suggested by the National Association of Funeral Directors. In practice any funeral director could report any concerns to the

police or the coroner under the current common law duty which will not be affected by these proposals.

8. There was a consensus that in the future this list should be amended to include the role of the medical examiner in relation to scrutiny of death certificates proposed by DH, which was subject to concurrent consultation.
9. Some put forward the view that in many instances even when the deceased had been in the care of, for example, a nursing home, a doctor will have attended to certify the cause of death so that the duty was best placed solely with medical practitioners. The Health proposals on independent scrutiny of death certificates would deal with the situation where doctors are closely associated with the administration or particular nursing homes. This was further supported by those who highlighted the practical issues arising from a multi agency duty and the risk of over and under reporting to the coroner in those circumstances.
10. The responses received provided detailed comments on the categories of deaths listed in the consultation paper as those suitable for referral to the coroner. For example, areas requiring clarification were highlighted, like the category “self-harm and neglect”, and whether circumstances such as substance abuse or suicide, and causes such as an elderly person starving themselves, alcoholism, smoking and obesity would be included in this category.
11. The responses received which dealt with the issue of sanctions were evenly split between support for the introduction of a criminal offence for a deliberate or wilful failure to discharge the duty to report deaths to the coroner and support for sanctions through a disciplinary route. A number of those who responded felt that there should be some criminal sanction for a deliberate and wilful failure to discharge the duty to report a death to the coroner.
12. However, many accepted that there was a significant difference between deliberately covering up events, perhaps for personal gain, and being inexperienced, lacking suitable guidance and training. Consequently, there was a suggestion that an investigation through the appropriate professional regulator was effective in the first instance as it could identify cases where possible criminal activity had taken place which could be reported to the police. The existing range of criminal charges and sanctions could then be applied as appropriate, rather than creating a separate criminal offence of failure to report to the coroner.
13. We are grateful to all those who took the time to participate in the consultation process and responded in writing.

Responses to specific questions

1. Are these the right types of public service personnel who should be given a statutory requirement to report a death to a coroner? If not, who else should be placed under this duty and why? Are there authorities on this list who do not need to be?

60 responses were received to these questions. 37 agreed and 23 disagreed and suggested an alternative group of public service personnel to have a duty to report deaths to the coroner.

The consultation paper asked whether personnel such as mental health facility managers, immigration removal centre managers, care home managers and owners, and ambulance personnel, as well as medical practitioners, should have a duty to report deaths to the coroner in specified circumstances.

The **Royal College of Physicians** and the **Faculty of Forensic Medicine** questioned whether the creation of a statutory duty to report was necessary to deal with the current systemic failings of the coroners' service. They felt that any failings in the current system, where there is a common law duty on everyone to report deaths to coroners, are borne out of ignorance, and better addressed through education and clarification of existing requirements rather than by putting good practice onto a statutory footing. A major drawback of introducing a statutory framework for reporting deaths is the inevitable delay that will occur when amendments need to be made. Amending guidance is a much swifter and more flexible process that would be best left to the proposed Chief Coroner and his National Medical Adviser. If a statutory duty to report deaths to the coroner is to be introduced they consider this should be limited to doctors, the police and the proposed new medical examiner, who will scrutinise the cause of all deaths not initially reported to the coroner. There is an inherent danger that by spreading the obligation too widely deaths will go unreported because each agency may think the other has done so.

Ceredigion and Mid Wales NHS Trust believed that the proposals in the consultation paper involved far too many people potentially in reporting cases to the coroner. Confusion will be created by the same case being reported several times leading to extra work for the staff dealing with case referrals. Conversely, a case which should be reported may not actually be reported because several people each think someone else has dealt with the formal reporting to the coroner. The Trust felt that the statutory duty to report to the coroner should fall to the doctor in charge of the patient (GP

in the community, hospital consultant in hospital deaths), therefore giving a clear line of accountability.

Dr Stephen Rowlands, a general practitioner also believed that widening the group who have a statutory duty to report was unnecessary and potentially confusing. He suggested that the groups listed should be able and encouraged to report a death when they perceive uncertainty or suspicious circumstance, and in that case should make the report personally. In that instance, the option that one person discharges the responsibility of all leaves open a possibility of an inadvertent, or advertent missed report whereas duplication would do no harm.

Dr Medwyn Williams of the Anglesey Local Health Board submitted that he believed it would be unwise to broaden the types and numbers of personnel who should be given a statutory requirement to report a death to those groups of personnel who currently do not either report to the coroner or sign death certificates. This would increase bureaucracy and greatly slow down the process. **Dr John O'Malley, GP** agreed and stated that the statutory duty should lie with doctors only as it would be an additional burden on other public services.

The **Muslim Burial Council of Leicestershire (MCBOL)** favoured the model used in New Zealand where police and prison governors had a statutory duty to report deaths to the coroner.

Dr Ian Hussein, Cemetery and Crematorium Director submitted that the funeral industry should have a statutory duty to report deaths to the coroner as family members are more likely to mention any concerns they have to the professionals they come across whilst making the funeral arrangements.

A consultant from **Royal Liverpool Children's NHS Trust** submitted that any person professionally involved in the care of someone who dies should have a responsibility to highlight any concerns about the circumstances of the death, including anybody involved in the detention of the deceased. The family of the deceased should also have this opportunity. The report should be to the medical examiner in the first instance to ensure most effective use of the coroners' service.

The **Royal College of Pathologists** submitted that the list of individuals who might have a duty to report to the Coroner was too lengthy and complex, leading to uncertainty about who has the responsibility to report a death when several individuals on the list are involved in a particular case. As there will be a need for a doctor to confirm that death has occurred in almost all deaths, they suggested that the primary duty to refer a case to the coroner should fall on the doctor who confirms that death has

occurred. A doctor would then have a duty either to certify the death, to confirm that another medical practitioner has agreed to certify the death, or to refer the case to the coroner. They also considered the relationship between doctors, the coroner and the medical examiner role proposed in the DH consultation paper, "Improving the Process of death certification". In "borderline" cases, a doctor who has a duty either to refer a case to the coroner or to sign a death certificate should seek the advice of a medical examiner. If done formally, this might transfer the duty to refer the case to the coroner over to the medical examiner. The medical examiner should be able to decide either to refer to the coroner or to insist on a death certificate being produced by the original doctor, if this has not been completed as part of the referral. This mechanism would place the decision on referral in difficult cases in the hands of the medical examiner, who will be better trained than other doctors in this respect, whilst minimising inappropriate or 'defensive' referrals to the coroner.

Action against Medical Accidents (AvMA) felt it important that the statutory duty should apply to other medical staff as well as hospital doctors and general practitioners, as listed, and should include nursing staff, midwives, locum doctors, dentists, psychiatrists and the designated paediatrician with responsibility for informing relevant professionals of unexpected deaths in childhood. They also agreed that the proposed statutory duty should be extended to mental health facility managers, immigration removal centre managers, care home managers and owners and ambulance service personnel and that if one person reports a death to a coroner it should discharge the duty of all.

AvMA noted that the proposals did not include funeral directors in the list of those with a duty to report deaths to the coroner. AvMA suggested that either the funeral industry should be added to the list of those who should report cases to the coroner or the coroner should be given power to act on such concerns from either the funeral industry or others without the death otherwise being reported. This was also supported by the responses from the **British Medical Association (BMA), Support After Murder and Manslaughter (SAMM), Bath Registration Service and Gipping and Hartismere Registration Service.**

AvMA felt that it is difficult to train medical practitioners to recognise the types of deaths to be reported. However, the new proposals will not remove this problem completely and they remain of the view that it would be far more effective if all deaths were reported to the Coroner. The Coroner could identify the deaths which warranted further investigation rather than attempting to train all such potential personnel.

Blaenau Gwent Registration Service felt that there were too many on the proposed list. The police, primary care doctors and medical examiners,

as proposed by the DH, should be the main personnel with a statutory duty to report. Some should have a statutory duty – others should be given a duty of care to report as part of a Charter governing their working practices. As there are too many on the list already, no others should be added. Other **Registration Services** had other views.

Devizes and Marlborough Registration Service submitted that within the health care environment there are procedures in place for medical and care staff to report deaths where any explained sudden death is automatically reported to the deceased's GP and Police/Coroner. They believed that all emergency services including those in the voluntary sector, i.e. Mountain Rescue and RNLI, should be included in the legislation, albeit police involvement would follow, as it reaffirms and reassures the general public of a system concerned for the deceased. It is far better to have a substantial public protection policy encompassing many agencies. They suggested that another consideration would be to extend it to public and private refuges and establishments such as drug rehabilitation units, which have a responsibility for the residential care of persons, and also senior members of the armed forces who are responsible for the personnel under their command (field exercises and camps).

Bath Registration Service submitted that if there were a new statutory duty created, these are the right types of public service personnel to be given a statutory duty to report deaths to coroners. However, given that there is a common law duty to report deaths now, it is not clear what value further legislation will add beyond what would be achieved by publicising the common law duty to those involved. They cautioned that care needs to be taken in framing any new legislation that we do not create a situation where multiple and overlapping reports overload the coroners service and generate confusion and error.

Sandwell Registration Service suggested that the DH's proposed medical examiner should be added to the list of personnel who have a duty to report as they will have access to all medical notes for the deceased putting them in the best position to decide whether the coroner should be involved.

Peterborough Registration Service believed that the wider the list of personnel, the greater the chance that a problem is picked up. The list should include hospital bereavement officers who often co-ordinate the issue of Medical Certificates of Cause of Death (MCCDs). It may be more helpful to include the care home manager rather than the owner as the latter often have a business or financial interest only. The nursing staff should be included as they are often aware of the personal circumstances of the patient, which may be relevant for deaths occurring as a result of

industrial disease, for instance. There is a danger of multiple reporting, but this is preferable to no reporting at all.

Sunderland Registration Service submitted that the public service personnel who should have a duty to report should include Fire Personnel, midwives, nurses.

Gipping and Hartismere Registration Service submitted that the list of personnel is more far reaching than the current position which is desirable. They felt that the clergy should be encouraged to bring any concerns they had to the attention of the coroner as well as funeral directors.

Swansea and Plymouth Registration Services agreed with the list of personnel proposed in the consultation paper.

The Local Authorities Co-ordinators of Regulatory Services (LACORS) agreed with the list of public service personnel but would include bereavement officers, care home managers and nursing staff.

The **Health and Safety Executive (HSE)** noted that they are not listed as one of the types of public service personnel to which this proposed duty should apply. They agree strongly that this is as it should be, as it would be inappropriate and unnecessary for the HSE to be included. It may be appropriate to include bodies such as the Fire service, rescue services (for example, coastguard, air sea rescue and mountain rescue services), as well as ambulance services.

The **Ministry of Defence (MOD)** welcomed in principle the proposal to give a statutory duty to report deaths to clinical providers. Consideration would need to be given to how this might be managed, to ensure that appropriate guidance is put in place reflecting the specific nature of Service chain of command responsibilities. The Defence Fire Risk Management Organisation is made up of the Defence Fire and Rescue Service (civilian staff), RAF Fire Service (military personnel), Royal Navy (Aircraft Handlers) and a number of Agency and contract fire services. The key issue would be to establish an effective primacy in reporting to avoid duplication.

Dr Jonathan Howes, consultant in Anaesthesia and Intensive Care at Yeovil General Hospital submitted that other health service staff should have a duty to report deaths to the coroner. It needs to be clearer who is actually, or ultimately, responsible for doing so, particularly if sanctions are imposed for a failure to report. Often a very large team is involved in patient care with nurses, doctors and consultants working together. Issues may also arise with 'perceived' differences of opinion and personalities. Staff within hospitals may have concerns about some clinicians, often only

based on anecdotal evidence. By opening up this channel of communication it may provide a route by which staff can voice these concerns.

Christopher Dorries, HM Coroner for Sheffield, believed it is important that the wider NHS community including senior nurses and managers are put under a responsibility to ensure that reporting has taken place. Ambulance personnel should be encouraged to refer when necessary but placing them under a statutory duty possibly means that every case they deal with will be referred automatically, which is inappropriate. This view was supported by **Andre Rebello, HM Coroner for Liverpool**.

Roger Atkinson, HM Coroner for Lincolnshire, submitted that the list of public service personnel who had a duty to report deaths to the coroner should be as wide as possible.

The **Coroners Officers Association (COA)** felt that the list is too extensive and there is a danger that if someone is not on the list they will not report; or there would be multiple reports for the same death. They feel it is better to have a broad generalisation that includes virtually everyone without specifying exactly who they are. Their suggested list included: police officers; Registrars of Births, Deaths and Marriages; and any person who verifies the fact of death.

The **National Assembly for Wales** had no reservations on the categories of people who could be added to the list but questioned the need for this additional change if a clear statutory duty is to be introduced for doctors. A consequence might be that all concerned assume that someone else has reported the death – or more than one report is made for the same death. There would need to be a clear system of communication (and monitoring) and the value of this is therefore questionable.

The **Bereavement Services Managers Association** broadly agreed with the list of personnel proposed in the consultation paper. They agreed that no useful purpose would be served by including funeral industry staff on the statutory list. The Association also suggested that the statutory duty should apply to medical referees and deputy medical referees at crematoria in circumstances where they are not satisfied that the fact and cause of death have been definitely ascertained.

The **Association of Personnel Injury Lawyers (APIL)** supported the proposal to introduce a statutory duty on public service personnel to report deaths to the coroner. APIL agreed the statutory duty should apply to the public service personnel mentioned in the consultation paper. APIL commented on the statement in the consultation paper that 'if one person reports the death to a coroner it will discharge the duty of all'. APIL

believes that this may have implications where a death is reported by a member of the medical profession. It is the experience of APIL members that a junior doctor will be charged with filling out the report to the coroner. Their inexperience means the report is not always completed to the requisite standard or level of detail. APIL believes that in the case of medical practitioners, the report should be completed by the most senior available medical practitioner. The force and rationale for allowing one person to complete the report and thereby discharge the legal liability of all is undermined if that person does not perform the task adequately.

The **Royal Liverpool Children's NHS Trust** agreed with the proposed list of public service personnel except for ambulance service personnel who would likely be in transit to a place where someone will have a duty to report the death. They also pointed out issues around the risk of many agencies reporting to the coroner independently; communication that the death has been reported may prove difficult or complicated, creating vulnerability among groups who unintentionally do not report due to different interpretation or assumptions that others have already reported.

The **National Association of Funeral Directors** agreed with the list of public service personnel proposed. They also pointed out that where there are multi agencies involved it would help if a lead agency could be identified to ensure that there was no confusion as to who reports; for example, the agency that has care of the deceased at the time of death.

The **Bereavement Advice Centre** agreed that public service personnel such as doctors, midwives and nurses should have a statutory duty to report deaths to the coroner together with police, ambulance, fire and coastguard services. It should also include custodial staff of any kind and social services staff (who may be aware of relevant home circumstances of someone who dies in hospital for example). This duty should also extend to any personnel in private facilities who exercise equivalent responsibilities of care or control over other people, especially vulnerable groups such as the elderly, children or people with disabilities.

Cruse Bereavement Care broadly welcomed the proposals to bring the current statutory requirements on Prison Governors and registrars into one place. They would support the measure recommended in the Luce Report that fire service personnel should be included. As a package, the measures should increase the probability of appropriate deaths being reported to the coroner. The new office of medical examiner proposed by the Department for Health should be included on the list. Because doctors have traditionally been involved in reporting deaths to the coroner, it appears reasonable to place a statutory duty upon them. Even for doctors however, there will be training needs and a requirement for appropriate, consistent, criteria against which professional judgement may be

exercised. Cruse believed that no other service or profession should be added to the list without appropriate protocols being in place.

Mrs Lewy of Deaths after Medical Negligence (DAMN) supported the inclusion of the emergency services – police, fire services, ambulance – so that wherever a premature and unnecessary death occurs it is reported.

National Concern for Healthcare Infections (NCHI) believed the types of public service personnel who should be given statutory responsibility appears to be fairly comprehensive. The only addition they suggested was the Coastguard. It is particularly important that Care Home Managers in both the public and private sectors are included and that the registration of such premises is dependant on compliance.

Tom Luce strongly supported the creation of a statutory power to define through subordinate legislation the types of deaths which should be reported to the coroner, and the types of people with the duty to report. This would help to create more uniformity of practice and also provide a mechanism to make adjustments over time. The personnel to be covered should obviously include doctors and the police since one or the other, and sometimes both, will be involved after the large majority of deaths. It might be better not to scatter the duty around overlapping groups of personnel – doctors, nurses and other health personnel, for example – because there may be confusion as to where the primary responsibility lies. He did feel that there was a link between the process for verifying deaths and the occupational groups which should have status and responsibilities in that process, and this had not been addressed so far in the Government's proposals on either coroner or death certification reform.

The National Patient Safety Agency (NPSA) believes a statutory duty to report deaths should improve the consistency of reporting, and the opportunities for learning from inquests, in order to reduce deaths in the future. NPSA also suggested that in establishing a duty to report deaths, the Government needed to consider how this might affect reporting of incidents through other routes, and how to ensure there are links between reporting to coroners and reporting to the NPSA.

The **Foundation for the Study of Infant Deaths (FSID)** supported the proposal that registered medical practitioners and other relevant public service personnel such as police and ambulance workers should have a statutory duty to report deaths.

The **BMA** supported the proposal to apply the duty of reporting a death to the coroner to more individuals and organisations as it provides a greater safety net for picking up deaths that need investigation. The BMA supported the inclusion of doctors, police, Registrars, funeral directors,

Prison Governors, and any members of the public as those who should have a duty to report deaths to the coroner. Additional groups suggested were nurses, midwives, ambulance personnel and the Fire Service because, especially when working in the community, they may be the first professional at the scene of death. The BMA also highlighted difficulties that may arise including:

- duplication of communication with coroners and a higher risk of increasing the number of post mortems and delays to families if there are conflicting views; and
- coroners' officers have little medical knowledge and many unnecessary post mortems will take place if many people get involved.

The **General Medical Council (GMC)** submitted that if the duty were extended to public service personnel other than doctors, then clear guidelines will be needed to ensure that there is effective communication between the multiple agencies involved to make sure that no one forgets to report a death or several agencies report the same death. In respect of doctors, it is not necessary to break down the areas of medical practice which would be subject to the statutory duty to report. The duty should apply equally to all registered medical practitioners.

SAMM believes it was reasonable that Fire Service Personnel should have a duty to report deaths to the coroner. Nursing staff, midwives and care home managers should also be added to the list. In the case of care home managers, if there was a statutory duty to report deaths then this might help to safeguard vulnerable elderly people.

Victims Voice submitted that the public service personnel listed should be required to report a death to the coroner and the list should include all of the front-line personnel who get involved in dealing with sudden deaths. Funeral staff should be included. There may be confusion about who is to report the death and a protocol needed e.g. the listed person first attending a death should be responsible for reporting it as soon as possible, naming all other persons responding to the notification of the sudden death. This would assist coroners' officers (and proposed medical examiners) to follow-up for information. This would discharge the general duty, but should not exonerate anyone from keeping a record of any concerns and information they have. Making the reporting of a death a duty of an executive or other person removed from the front-line will delay contact with bereaved relatives. Victims Voice suggested that head teachers of primary and secondary schools and principals and vice-chancellors of further education establishments should be required to report a death on premises for which they are responsible.

INQUEST agreed with the personnel suggested in the consultation paper and suggested that Secure Training Centres should be included under this duty to report deaths of individuals in their care.

Dr Paul Attwood, GP, Dr John Gannon, Mr John Calvert, Medical Director, Swansea NHS Trust, and Dr Caroline Lorenz, GP agreed that the list of public service personnel proposed in the consultation paper was right.

Professor Sebastian Lucas, of the Department for Histopathology at Kings College London School of Medicine agreed that the list of non-medically qualified personnel is comprehensive and appropriate. He suggested that care home managers will surely be reporting deaths to the responsible GP first, so they may not need to be part of the group of personnel who have a duty to report.

The **Medical Defence Union (MDU)** agreed that people should be expected to report the deaths of individuals in their care in specific circumstances. They do not know if this would include those who are not what the document describes as 'public service personnel', but if it does, they expect they would need to be under the same duty as anyone else in such a position of authority. However, if each of those involved has an individual statutory duty, the fact that if one person reports the death to a coroner it will discharge the duty of all, is unlikely to prevent multiple reports of the same death. There are likely to be circumstances in which an individual may consider it easier to report a death to the coroner, rather than to establish who else was involved and whether or not they may have reported the death. Given the limited resources available to the coroner, this may not be desirable.

The **Royal College of General Practitioners** submitted that the professionals on the list are sensible, but the procedures for reporting need to be clearly applied. The professional issuing the death certificate should be under a statutory obligation to inform the coroner when circumstances necessitate. If care home managers and other professionals in similar positions are concerned about the care given to a patient then they should initially contact the Primary Care Trust (PCT) and not the coroner.

The **National Public Health Service for Wales** submitted that the public service personnel to have a statutory duty to report a death to the coroner as proposed in the consultation paper are correct. However, the requirement would be on doctors as a professional group (i.e. those registered with the GMC) and there is no reason for a distinction being made between this professional group and locum doctors, psychiatrists and designated paediatricians.

In a joint response, **Lady Justice Smith and Mrs Justice Swift** supported the introduction of a statutory duty to report deaths to the coroner, where the duty should rest on qualified or responsible personnel other than doctors. This would include doctors, nurses, hospital managers, and nursing and care home managers and owners, paramedics, police officers, funeral directors, embalmers and mortuary technicians. They did not consider it would be reasonable to expect that all the categories of personnel to have in mind all the various categories of death which should be reported by doctors. They suggested that in their case the duty could be made simpler by being confined to a single circumstance:

“To report as soon as practicable any information relating to a death believed by that person to be true and which, if true, might amount to evidence of crime, malpractice or neglect.”

2. Do you believe the proposed list of reportable deaths to the coroner is workable, effective and proportionate?

59 responses were received which addressed this question. 51 agreed with the list of circumstances suggested in the consultation paper when a death should be reported to the coroner and 8 disagreed and suggested additional circumstances where a death should be reported.

APIL, the National Association of Funeral Directors, NCHI, Sunderland Registration Service, LACORS, Gipping and Hartismere Registration Service, Dr Paul Attwood GP, Dr Caroline Lorenz GP, Dr Calvert of Swansea NHS Trust, Devizes and Marlborough Registration Services, Blaenau Gwent Registration Services, Peterborough Registration Services, MOD, Dr Ian Hussein, Dr Medwyn Williams, and INQUEST agreed with the proposed list of reportable deaths.

Lady Justice Smith and Mrs Justice Swift submitted that the proposed list of reportable deaths was workable, effective and proportionate. They made some comments on the categories “deaths of a child” and “deaths associated with child birth or pregnancy”. They suggested that the circumstances in which the death of a child should be reported should be defined with greater clarity. The category should also be extended to include those who, at the time of their death are:

- being cared for by or on behalf of a social services authority;
- on the at risk register;

- living with a family where another child is being cared for by or on behalf of a social services authority or is on the at risk register;
- being fostered in the community; as well as
- children who die while in secure accommodation.

They agreed that the category of “deaths associated with child birth or pregnancy” should be included, but suggested an alternative draft so that the category is not drawn too widely, which reads:

“A death of a woman is reportable where the death occurred

During pregnancy; or

Subsequent to ectopic pregnancy, miscarriage, delivery or termination of pregnancy, in circumstances where there is reason to suspect that the event may have caused or contributed to the death.”

John O’Malley, general practitioner, felt that the list was not workable. He suggested that more patients should be referred especially in cases of the elderly where imprecise reasons for death are often given. **Roger Atkinson, HM Coroner for Lincolnshire** suggested that the deaths of all children under the age of 5 should be reported. He believed that all deaths should be reported to the coroner anyway, accepting that this would have resource implications. If this does not happen, however good the list of reportable deaths is, there will inevitably be failures to report deaths.

Dr John Gannon submitted that the list as drawn up may result in many unnecessary referrals where ‘infections’ are an associated risk of treatment (e.g. chemotherapy treatment) and many ‘treatments’ have attended risks which need to be balanced against the overall benefits.

Dr Stephen Rowlands GP questioned the need to always report deaths associated with alcohol or tobacco use as self-harmful.

Prof Sebastian Lucas submitted that the list of reportable deaths must be matched and synchronised with improvements to the MCCD. He suggested that some of the categories be tightened up to prevent unnecessary referrals:

- Death following detention. As the peak period of mortality after detention in prison is in the first week he suggested specifying a time period of within 7 days of release;

- Deaths related to employment will need to be reviewed periodically and asbestos exposure and known or suspected asbestos-related disease must be specified as it is still forgotten by doctors at death;
- Death relating to lack of care, treatment etc. Hospital-acquired infections will need to be defined carefully, e.g. proven MRSA bacteraemia is probably 'in', whilst screen-detected skin MRSA infection without relation to death is not. Patients dying rapidly, e.g. whilst undergoing surgery, from known fatal disease could be excluded, even though the actual procedure must have shortened life a little;
- Death of a child. All categories of death are covered in other sections, so not persuaded that a separate category is necessary;
- Where death has not been certified, which needs coordinating with MCCD improvement. Many persons dying in care homes have no determined specific diagnosis; but as long as no suspicious circumstances exist (e.g. neglect) then it is debatable why 'old age' is not sufficient, for example, 'Dementia NOS (not otherwise specified) +/- old age' is not a necessarily a cause of death to report to a coroner;
- Specific diseases. Other diseases that should be reported are mesothelioma and suspected asbestos-related lung disease; deaths in psychiatric units; deaths from suspected cardiac disease in persons less than 35 years to catch the potentially familial heart disease cases;
- Maternal deaths should be included as it is the single biggest cause of suicide in the UK, so deaths of all women in pregnancy and up to one year post-delivery will better capture these sad cases.

A consultant from the Royal Liverpool Children's NHS Trust made the following suggestions to the contents of the list of reportable deaths:

- Death from self harm and neglect. This is vague and could be interpreted to include use of legal drugs such as tobacco and alcohol or failure of compliance with prescribed treatments;
- For the treatment of some conditions there is a recognised risk of death related to the underlying condition and/or the treatment, highlighting the importance that any units involved in such care establish governance arrangements and reporting mechanisms to review their own practice.

Dr Ian Back, Palliative Care Physician in the Pontypridd and Rhondda NHS Trust believed the problem was that referring a death to the coroner can lead automatically to a lengthy, and distressing, interview with a coroner's officer, and a post-mortem examination – depending very much on the sensitivities of the coroner and their officer. In several places where he worked a custom of “informing” the coroner of the sort of deaths listed in the consultation paper (especially categories 9 and 11) had developed. The coroner's officer was told that the doctor was happy to issue a death certificate, but wished to inform the coroner for purposes of transparency. This alerted coroners to any pattern of suspicious deaths, but prevented subjecting families to an inappropriate investigation.

The **Royal College of Pathologists** felt the overall tone and intent of the list was appropriate. They suggested that the list should be reduced and simplified as it was too complex, and despite its complexity there are many areas where the definitions are vague. They suggested that there should be a simple statement that referral to the coroner is necessary where death has been hastened or caused in full or in part by factors which do not represent a natural disease process. It should then be explicitly left to the Chief Coroner and the National Medical Advisor to draw up guidance on the interpretation of that requirement. This would facilitate future flexibility, and this guidance would then become a necessary part of the training of the medical examiners proposed by the DH.

BUPA Care Homes were concerned about the clarity and consistency of the guidelines. It is important to strike a balance between recognising that the majority of deaths in care homes will occur naturally, whilst not allowing any suspicious deaths to fall through the net.

Ann Wadey, Bereavement Advice Centre felt a defined list to ensure national consistency of training and practice is most welcome. She did have concerns that some categories are not workable as currently worded and offered detailed comments.

- Self harm and neglect has proved extremely difficult to use particularly where there has been self neglect over a period of time e.g. chronic malnutrition and unkemptness leading to a final illness, as opposed to a single event such as an accidental overdose of any kind. Clearer guidance would need to be given.
- Neglect by others is also difficult in practice, mostly where there has been concern about possible neglect by an individual e.g. failure of care by an adult child of an older relative.
- Shortly after release from detention needs clarification to prevent different interpretations of “shortly”. She suggested that while

reporting of all deaths in any form of custody should be mandatory, the Coroner should thereafter have some discretion rather than the mandatory inquest as at present. Where medical history and reported events with or without a post mortem examination to confirm the diagnosis result in a cause of death that is natural and this is not contested by the next of kin, it should not be necessary for there to be an inquest.

- Deaths related to medical treatment – this category is far too broad to work in its present wording. This is especially the case now that the medical examiner role is not to be integrated into the Coroner's office. Many medical treatments are undertaken after an assessment of the balance of risk against potential benefit with the involvement and consent of the patient and often the next of kin.
- It is good that flexibility of response to changing circumstances is included within the rights of the Chief Coroner. The high quality of the medical advice available to the Coroner is critical for this.

The **Bereavement Services Managers Association** agreed that the proposed list of reportable deaths is workable, effective and proportionate. However, they believe that "any registrar" should be added to the list of persons having unresolved concerns or suspicions. The reference to deaths occurring "subsequent to delivery, termination of pregnancy, ectopic pregnancy or miscarriage" should be clarified by the definition of a maximum period (12 months) from the date of the event.

The **Royal Liverpool Children's NHS Trust** agreed the list of reportable deaths was workable but emphasised the need for clarity to avoid misinterpretation by different groups. Most child deaths would need reporting to the coroner. This would have implications for the relationship with specialist children's hospitals with critical care services. High quality liaison would be essential in these circumstances.

The **NPSA** welcomed the proposal that there should be an explicit list of reportable deaths, and believes this will lead to a more consistent approach to reporting and investigating deaths. The NPSA also welcomed the inclusion of deaths which may be related to patient safety issues. They would recommend that the wording is amended to be consistent with deaths which would be reported to the NPSA as patient safety incidents (and suggested "any unintended or unexpected incident during the provision of healthcare which may have led to the death of a patient"). The focus is currently on cases where a death can be related to care provided by an individual practitioner. However, in practice, when patient safety incidents occur there are likely to be a combination of factors. A focus on deaths linked to individual action is less likely to result in learning than an

approach taking account of the system in which care is provided, as well as individual roles. By quoting specific examples, there is the risk that staff will only report these examples. In the case of infection control deaths, it should be noted that the resource implications of reporting every death to the coroner would be enormous; infection control deaths are already being reported via the Health Protection Agency and DH; most clinicians would not know at the time of death whether or not the infection was hospital acquired or present on admission.

Swansea Registration Services believed that the list was workable with the exception of “a death which is the subject of significant concern or suspicion” because the ‘unresolved concern’ of any family member and/or any member of the public is far too subjective and open to interpretation. They felt there must be a clear definition of reportable deaths, in order for the system to be workable.

The **MDU** agreed that the proposed list covered broadly the types of deaths that are currently reported. It should be clear that the list is not exhaustive and facilities will need to be available to discuss with the coroner (or possibly a medical examiner) borderline cases or those where there is uncertainty.

The National Public Health Service for Wales agreed that the production of a clearly defined list of the types of death that should be reported would result in a reduction in unnecessary reporting. It cautioned that such a list should be reviewed and if needed revised on a pre-determined regular basis. This is particularly appropriate to the category “a death which may have been caused or contributed to by a specific disease or condition”. However, this should not preclude urgent amendments to respond to a particular need when necessary. In relation to “deaths relating to employment”, a caveat should be added to protect against future exercises taking place with the benefit of hindsight such as “...where this is known to the reporter at the time of reporting”. Under the category, “deaths resulting from lack of care or appropriate treatment, defective treatment and adverse reactions to prescribed medicine”, as currently worded, there is undue inference of cause and contribution attributed to health professionals generally and doctors specifically.

The **MBCOL** suggested that the circumstances when deaths should be reported to the coroner should include any deaths resulting from defective treatment or adverse reaction to prescribed medicine and also including deaths related to employment.

Victims Voice believed that the proposed list does clarify some of the circumstances when a death should be reported to the coroner, but the following suggestions are made in relation the following categories:

- Death was due to suspected violence or poisoning, or to a traumatic event (road death, fire, disasters – natural or otherwise)
- Sudden deaths caused by unexpected events (fall, drowning)

They made the point that “road crash, collision or incident” should be used in the drafting as the word “accident” is judgemental, implying that the death could not have been caused by any person or criminal act.

Dr Alan Fraser, Counsellor, European Society of Cardiology Reader and consultant cardiologist had comments on the category where there are suspicions that the deceased may have contributed to his or her own death. He felt that the section needed amending to exclude a patient who has been a life-long heavy smoker and who develops lung cancer, or the overweight poorly adherent and controlled diabetic who has died of cardiovascular complications, or the alcoholic who dies from hepatic cirrhosis.

Cruse Bereavement Care broadly supported the types of reportable deaths. The provision for death of a child to be reported should be elaborated; there should be a clear differentiation between the expected death of a child (i.e. death in the terminal stage of illness) and unexpected death. This makes the 24 hour provision less relevant, particularly when child protection considerations come into play. These should be integrated into the criteria for all reporting, and the death of a child on the Child Protection Register should trigger an investigation. It is important that deaths should be reportable by Registrars, and by family members or members of the public who have concerns. Cruse also supported including specified diseases or conditions.

FSID suggested the list of reportable deaths should include where the certified cause of death means that the cause is unknown, i.e. Sudden Infant Death Syndrome, as well as “where the death has not been certified”.

The **BMA** were broadly content with the list of reportable deaths. However, they did suggest additional clarity for circumstances where the cause of death is unknown. They suggested using the phrases “not been certified clearly indicating the cause of death and that the registered medical practitioner believes that no further enquiries are required” or “where the cause of death cannot be ascertained to the required degree of certainty by the attending registered medical practitioner after consultation with the medical examiner” – assuming that medical examiners are introduced as proposed under the current death certification proposals.

The **Royal College of GPs** agreed that for the most part the categories suggested were workable. They suggested that more detail could be given under the category “self-harm and neglect.” This seems to only include substance abuse or suicide; causes such as an elderly person starving themselves may be overlooked. It is also unclear whether alcoholism, smoking and obesity would be included in this category.

Sandwell Registration Services believe the majority of the list entries are workable, effective and proportionate. However, they felt that category 10 as drafted could open the door to a range of accusations by grieving relatives who are often feeling guilty, upset and angry and seek to direct these natural emotions against third parties.

3. Are there any additional circumstances not mentioned in the proposed list where you believe there should be a statutory duty to report a death to the coroner?

54 responses were received which addressed these questions. 32 supported the list of circumstances put forward in the consultation paper and 22 disagreed and suggested further circumstances when a death should be reported to the coroner.

The Royal Liverpool Children’s NHS Trust (Alder Hey), Oldham Primary Trust, Dr Caroline Lorenz, GP, LACORS, Medical Defence Union, BMA, MOD, Dr Ian Hussein, Dr Medwyn Williams, Ceredigion and Mid Wales NHS Trust, SAMM, Lady Justice Smith and Mrs Justice Swift all endorsed the proposed list of reportable deaths in the consultation paper, and had no additional circumstances to add.

Cruse Bereavement Care submitted that it was important to pay attention to the detail given to compiling the list of circumstances, and it should be supported by a clear drive towards national standards, binding upon all local services.

The **NPSA** submitted that the new list of circumstances might affect reporting of incidents via other routes, and there was a need to ensure there are links between reporting to Coroners and reporting to the NPSA. The statutory duty as currently set out, without clear linkages with reporting by organisations, has the potential to result in duplication and under-reporting.

The **Deputy Chief Medical Officer for Wales** believed that in the absence of a clear framework on what should be reported to a coroner it seems a large step forward to a legislative solution. He submitted that if there was a

publicly declared framework, concerned relatives would be enabled to make representations to the coroner, if needed.

APIL submitted that a death resulting from delay in medical treatment should be added. This situation could arise, for instance, where there was a delay in the ambulance arriving to treat the person and this resulted in, or was a contributory factor to, that person's death.

The **Bereavement Services Managers Association** suggested that children on the at risk register should be included in the category of deaths of children in category 7 whose death should be reported. It is important that a doctor should have seen the deceased after death. In cases where the body has not been seen, the death should be reported to the coroner. All cases in which the deceased cannot be identified should also be referred.

The **Bereavement Advice Centre** suggested that the death of any child on an at risk register or in care of any kind including fostering be added to the category of child deaths to be reported.

The **NCHI** suggested that in the event that a relative has reported suspicions to the police concerning the circumstances of a death then the case should be referred to the coroner.

Tom Luce felt the categories of reportable deaths were broadly right but suggested the following amendments:

- a clearer definition of reportable work deaths as there would be no reason why heart attack deaths in the work-place should be reported if there was no link to occupational risk;
- the reference to infectious diseases is too wide, as it could include deaths from pneumonia in patients with immune system compromise following oncology or AIDS treatment and there seems no reason to report such deaths, which are properly handled through the certification process. However under "Hospital-acquired infections" – those that are not a known or accepted risk of the treatment are a different matter and may need to be reported;
- on category 12 (specified conditions etc) - the coroner service should not replicate the work done through public health networks. There may be exceptions – e.g. where a clear medical diagnosis is hard to reach, or there are particularly complex or controversial features in the circumstances of infection; and

- category 7 (children) should include death of any looked after child or privately fostered child.

The **HSE** submitted that the criteria need to include all deaths of members of the public that might arise from work activities (which would potentially be reportable under other statutory regimes). For example, a member of the public who contracts legionnaire's disease when walking past the work premises, or a visitor to work premises who is killed as a result of those work activities. Some of these might be picked up by category 9, or ultimately by category 10. They are however specifically work-related, yet not picked up by category 5. The specifics of the circumstances under which such deaths might be reportable may well be picked up in any later statutory instrument, but it might be better to have them explicitly included in the table in the consultation paper.

The **Royal College of General Practitioners** believes that all deaths of children on the child protection register as well as those that are "looked after" should be reported, as well as deaths of adults on the at risk register.

Dr Calvert, Swansea NHS Trust submitted that there is a lack of clarity about whether deaths of very premature babies should be reported, and this could be clarified.

The **National Public Health Service for Wales** submitted that the death of an adult within 24 hours of admission to hospital where that death was not anticipated as a distinct possibility should be added to the list of reportable deaths.

Pembrokeshire and Derwen NHS Trust submitted the list of reportable deaths should include those whilst being detained in hospital or liable to be detained in hospital or in the future on a community treatment order or guardianship order, and also supervision related to domestic violence, and protection of vulnerable adults and children.

Whilst some involved in the registration service felt the proposed list of circumstances when a death should be reported to the coroner was sufficient (**Plymouth, Gipping and Hartismere, Devizes and Marlborough, Blaenau Gwent, Bath**), some (**Sunderland, Swansea, and Northumberland**) suggested additional circumstances which included:

- hospital related infections;
- local agreements, for example, in Sunderland deaths of underground mine workers are reported;

- when any person or body with a professional duty of care is involved; and
- when there is reason to doubt the information presented or suspect that there may be important omissions.

HM Coroners for Liverpool and Sheffield also suggested additional circumstances to be included. These included the following:

- any death that may be related to a crime – e.g. a confidence trickster preying upon the elderly is not a violent crime but the coroner would certainly want to know of a death that followed shortly thereafter; and
- limit deaths at work to any death which may be related to current or previous employment or an industrial disease.

Their responses highlighted the potential resource implications for the service if all deaths from a hospital acquired infection should be referred, as these are for the most part not dealt with by coroners.

Roger Atkinson, HM Coroner for Lincolnshire stated that his own personal view was that all deaths should be reported to the Coroner, but accepted the resource implications for the service.

The **COA** suggested that the category “Death resulting from self-harm and neglect” should specifically include alcohol and also an additional circumstance of ‘Still-Birth contributed to by traumatic event on mother or baby’. The **COA** felt that it was important that still-births arising because of care issues are reported. Many are not reportable now as they fall within the definition of a still-birth.

Dr John O’Malley, GP submitted that cases of poor self care such as alcohol disease should also be referred to the coroner.

A consultant from Royal Liverpool Children’s NHS Trust suggested circumstances where the death may be linked to the availability of a treatment due to local resource management, e.g. in the absence of NICE approval, might constitute grounds for making a referral to the coroner.

The **Faculty of Forensic and Legal Medicine** and the **Royal College of Physicians** submitted that deaths that have occurred during or shortly after a period of detention should include deaths occurring under common law powers of detention as well as the statutory forms of detention.

Dr Stephen Rowlands, GP questioned whether there was a need to always report deaths associated with alcohol or tobacco use as self-harmful.

Dr Stephen Leadbeatter submitted that the Coroner should be informed of any death where a body is unidentified (or there is doubt as to its identity), where no MCCD acceptable to the medical examiner is available, where there is insufficient evidence to demonstrate that a death is not violent, unnatural, of unknown cause, or “subject of significant unresolved concern”; or where the death is of any person who has been “deprived of liberty” or is wholly dependent upon the care of another and there is reason to believe that that care has been suboptimal. He felt that any attempt to move from broad categorisation to specific sets of circumstances would increase confusion.

The **Royal College of Pathologists** submitted that when the identity of the deceased is not known, the matter should be referred to the coroner.

Victims’ Voice submitted that a death should be reported to the coroner if the same circumstances could cause or contribute to further deaths, and where a sudden medical death could have hereditary or genetic implications for relatives.

INQUEST suggested that Secure Training Centres should be added to the list of custodial institutions where deaths should be reported to the coroner.

4. Are there any circumstances where deaths are reported to the coroner unnecessarily? If yes, please specify. (Please do not mention deaths occurring outside of England and Wales in this section.)

49 respondents answered this question. Of these, 30 respondents, including some Registration Services, medical practitioners and voluntary organisations, were of the view that there were circumstances where deaths were reported to the coroner unnecessarily.

Cruse Bereavement Care noted that the 45% reporting rate (2005) in the Constitutional Affairs Select Committee report would appear to indicate unnecessary reporting. **Tom Luce** commented that reporting rates are far in excess of those found elsewhere, and seemed still to be rising if measured as a proportion of total deaths. He suggested that restraining, and preferably reducing, referral rates were an important and legitimate objective.

Some respondents commented that unnecessary reporting added a burden to the coroner system, prolonged the burial/cremation process and caused additional and avoidable distress for bereaved families (**Bereavement Advice Centre, APIL, Gipping & Hartismere Registration Service, Royal College of GPs**).

For the most part, respondents felt that unnecessary reporting was the result of doctors and/or registrars being over-cautious, fearful of criticism or uncertain of the circumstances where reporting was required (**Bereavement Services Managers Association, Cruse Bereavement Care, Sunderland Registration Service, Dr Medwyn Williams**). **Dr John Gannon** noted that criteria provide by his local coroner was too broad.

The **Swansea Registration Service** considered that many deaths reported to the coroner by the registration service were due to MCCDs being completed incorrectly by certifying doctors and suggested “a re-designed form with clearer instructions and better preliminary training for doctors”. The **Sunderland Registration Service** also suggested that training for doctors in this area would be useful.

LACORS suggested that being given a definitive list would go some way to addressing unnecessary reporting. **Cruse Bereavement Care** submitted that the ideal situation was one where the profile of deaths reported to the coroner fits reasonable criteria for professional concern and public confidence.

The **Royal College of GPs** noted that there are cases where dying patients have agreed with the doctor that no further investigations should be carried out, but relatives arrive at a later stage and demand further investigation.

Some respondents noted that the proposed new medical examiner post could have an effect on reducing the number of deaths reported to the coroner unnecessarily. Doctors could consult with the medical examiner regarding the cause of death rather than referring the death to the coroner (**Tom Luce, Sandwell Registration Service, and Royal College of Pathologists**).

Examples given by stakeholders of circumstances where deaths were reported unnecessarily included:

- Deaths that had occurred through a long and protracted illness and old age where time limits were arbitrary (**MBCOL**).
- Where a patient who was believed to have died from natural causes after a lengthy illness, but may not have been seen by a medical practitioner in the previous 14 days. This applies particularly in the

cases of elderly people who have suffered from an illness for a considerable period of time. The doctor knows why the person died but was forced to report the death because of the 14 day rule (**APIL**).

- Where the death was a recognised consequence of the disease process or treatment (**Consultant, Royal Liverpool Children's NHS Trust**).
- Deaths of persons over 75 years of age where no single cause can be readily identified by the medical practitioner but where comprehensive records exist of underlying conditions that have been treated over a number of years but with no very recent visits (**National Association of Funeral Directors**).
- The '24 hour' rule – the practice in some areas where deaths that occurred within 24 hours after admission to hospital were reported. Stakeholders noted that the cause of death was often known (e.g. where the patient had been referred by a GP) and there was sufficient information for a doctor to sign a MCCD without referring the death to the coroner (**Bereavement Advice Centre, Deaths after Medical Negligence, Devizes and Marlborough Registration Service, Dr Stephen Rowlands**).
- Where a doctor was unable to issue a death certificate because they did not attend the deceased either in the period of fourteen days prior to death or after death (**Gipping & Hartismere Registration Service, Bath Registration Service**).
- Where a death occurs while the person's usual doctor was not available (**COA**). Current practice where a death occurred outside normal working hours and the doctor was not contactable was that the death was reported to the coroner (even where the death was expected and due to natural causes), which caused bereaved families unnecessary distress. The doctor was normally able to issue the certificate when contacted by the coroner's office (**Oldham Primary Care Trust**).

We received a drafting comment from a respondent who noted that the specific circumstances and categories of death that should be reported to the coroner include circumstances where it was suspected that the individual may have contributed to his/her own death. **Dr Alan Fraser** suggested that the section be reconsidered as the current wording did not exclude, for example, the patient who has been a life-long heavy smoker and who develops lung cancer, or the overweight poorly adherent and controlled diabetic who has died of cardiovascular complications, or the alcoholic who dies from hepatic cirrhosis.

Nineteen of those who responded to this question did not consider that deaths were reported to the coroner unnecessarily. For the most part these respondents were medical practitioners or representative organisations, although some voluntary organisations and Registration Services also took this view (including **the MDU, Faculty of Forensic and Legal Medicine, Royal Liverpool Children's NHS Trust, NPSA, Caroline Lorenz GP, Peterborough Registration Service, SAMM, NCHI, HM Coroner for Lincolnshire**).

Victims Voice considered that it would be preferable to have all deaths reported to coroners. The **Pembrokeshire & Derwen NHS Trust** submitted that where the cause of death was clearly stated by a practitioner and has been predicted or expected the death will be certified by the practitioner. Otherwise it was for the coroner to determine the cause(s) of death.

The **BMA** expressed the view that it was better to over report than under report and that doctors should discuss deaths with the coroner if they had any uncertainty. The **Ceredigion and Mid Wales NHS Trust** shared the view regarding under-reporting stating that with the benefit of hindsight it can be seen that a particular referral to the coroner served no useful purpose, but it was better to have an excess of referrals to ensure that all those deaths which need to be referred were actually referred.

The **BMA** and the **Pembrokeshire & Derwen NHS Trust** also noted that doctors would be able to discuss deaths with the medical examiner in the future.

5. Do you agree that the 14 day rule is arbitrary and unnecessary? If not, what length of time limit would you suggest?

56 respondents answered this question. Their views were reasonably evenly divided regarding the 14 day rule, which requires a death to be reported to the coroner if the certifying doctor has not seen the deceased after death or within 14 days before their death.

Support for the 14 day rule (or an alternative period)

Of the 51 respondents who stated a preference, slightly more than half (27 respondents) considered the 14 day rule (or an alternative period) was necessary. Respondents who supported the rule included coroners and the COA, a number of Registration Services, medical practitioners and their representative organisations and some voluntary groups.

Of these respondents who supported the rule, some agreed that the period was inevitably arbitrary and/or restrictive but nevertheless they supported the principle and did not want to see the rule abolished (including **Northumberland Registration Service, National Public Health Service for Wales, Faculty of Forensic and Legal Medicine**).

The **MDU** submitted that it was more important that the certifying doctor can state the cause of death with a high degree of certainty but on balance felt that the rule was necessary.

Reasons for supporting the rule (either the 14 day rule or an alternative period) included:

- it provided a benchmark which was simple and understandable (including **National Public Health Service Wales, Faculty of Forensic and Legal Medicine, Royal College of Physicians**);
- if left open ended, some doctors may be pressured by the family to certify even if they have not seen the patient for a long time. Chronic illnesses may not change for weeks, yet some conditions such as children's illnesses can develop very rapidly (**BMA**);
- it precluded the possibility of a supervening illness being unrecognised as a cause of death (**MDU**);
- the doctor could note down a long standing illness by assumption rather than establishing the fact (**Sandwell Registration Service**);
- a doctor who had not seen the deceased for some time would not be able to sign the MCCD with any confidence or accuracy (**Chippenham Registration service**); and
- there may have been events before death that would not be on the medical record, but should be taken into account (**Victims Voice**).

Of the 27 respondents who supported the rule, 8 did not state a preference for changing the 14 day time period (including **Paul Attwood GP, Faculty of Forensic and Legal Medicine, SMM**). The others stated a preference for extending the time period. The most common period to be suggested was 28 days (13 respondents including the **Royal College of GPs, BMA** and several **Registration Services**).

The **Ceredigion and Mid Wales NHS Trust** submitted that extending the period to 21 or 28 days “may be a better compromise between too many referrals and missing those cases which should be referred”.

The **MDU** suggested a limit of 28 days, with discretion reserved for the coroner to extend if satisfied as to the circumstances.

The **BMA's** preference was for a 28 day limit with provision for "someone else in the team or practice to sign if unavailable through shifts, annual leave etc to cater for certain religious groups' requirements". The BMA submitted that "if the doctor can justify to the coroner the most likely cause of death from the evidence available and the previous history, then they should be able to certify". This view was contingent upon the introduction of medical examiners under the current death certification proposals. The BMA submitted that if these proposals were introduced then "the doctor and the medical examiner would need to agree to the required degree of certainty and then the M CCD could be signed, whatever the circumstances unless one or other believed that the death was in a reportable category".

Suggestions from other respondents regarding the time period included 21 days, 4 – 6 weeks, one calendar month and 3 months (8 respondents including the **National Association of Funeral Directors, National Public Health Service for Wales** and several **Registration Services**).

Opposition to the 14 day rule

Of the 51 respondents who stated a preference, just under half (24 respondents) considered that the 14 day rule was arbitrary and unnecessary and did not think a time limit should be applied.

Reasons for opposing the 14 day rule included:

- what was important was not the date when the doctor had last seen the patient but the quality of the doctor's knowledge about the patient and the death (**Lady Justice Smith and Mrs Justice Swift, Royal College of Pathologists, Dr Medwyn Williams, Professor Sebastian Lucas, Dr Stephen Rowlands**);
- the fact that the doctor has seen the deceased within the last 28 days (or any other period) of his life may or may not assist him in certifying a cause of death. There are many circumstances where a doctor may have seen a deceased person within the last 28 days of life yet will have no idea what the cause of death might be. The consultation with the patient may have been about a condition wholly unrelated to the death and may shed no light at all upon its cause (**Lady Justice Smith and Mrs Justice Swift**);
- it resulted in unnecessary post mortem examinations (**BMA**);
- it created much unnecessary work and distress to relatives (**Bath Registration Service**);

- it did not create any safeguards and there should be scope for discretion in each individual case (**MBCOL**);
- a report to the coroner should only be required if the relevant medical practitioner did not expect the death of the patient or was unable to issue the death certificate (**APIL**); and
- it was unnecessary especially when the patient has a terminal diagnosis or chronic condition that could lead to death at any time but care was led mainly by nurses (**Bereavement Advice Centre**).

Some respondents commented on the practical difficulties created by having a time limit. For example, it did not accommodate for doctors being away on holidays (**Dr Anthony Evans**). **Lady Justice Smith and Mrs Justice Swift** noted that the requirement has been the subject of confusion/disagreement in the past – “was it the certifying doctor who had to have seen the deceased? Or was it sufficient if the certifying doctor has information from a colleague who has seen the deceased within the requisite period?” They noted that GP practices operated different systems where the doctor who had seen the deceased was unavailable for some reason.

Some of the respondents who opposed the rule commented that if there was to be a time limit, a more appropriate limit would be 28 days (**Bath Registration Service**), or something in the region of three months (**Bereavement Advice Centre**).

Others considered that guidance might be more appropriate than a statutory time limit. For example, the **Royal College of Pathologists** noted that appropriate time limits for different circumstances may be provided in guidance from the Chief Coroner/National Medical Advisor.

Some respondents suggested another alternative to a statutory time limit – the date the deceased was last seen by a doctor could be included on the MCCD. It would then be up to the proposed medical examiner to follow up on cases where a patient had not been seen for a long time. The time frame could be decided within that service and take into account the specific features of the case (**Dr Stephen Rowlands, Dr Jonathan Howes**).

The **Bereavement Services Managers Association** also believed that “careful scrutiny of the medical history will reveal the date of the last consultation with the doctor and that this will be taken into account in determining the reliability of the diagnosis.”

Other comments

Cruse Bereavement Care commented that it was important that training was improved to support any changes to the 14 day rule and to improve confidence generally. Cruse noted that distress was caused to relatives when, through the use of deputising services or because of hospital shift systems, the relevant doctor was not available, even though the cause of death might be clear.

The **Peterborough Registration Service** supported the removal of the 14 day rule, but only if the proposed changes to death certification meant that two doctors (or a doctor and a medical examiner) were obliged to sign a MCCD. If there was only one doctor to sign, the Service felt that there should be an alternative safeguard to the 14 day rule.

Some respondents commented on the requirement for a doctor to have viewed a body after death. The **Faculty of Forensic and Legal Medicine** expressed concern about any removal of this requirement as a combined effect of the DH 'Consultation on Improving the Process of Death Certification' and the MoJ consultation paper. The Faculty considered that a proper examination of the body after death could be an important safeguard against undetected secret homicide. This view was endorsed by the **Royal College of Physicians**. The **Bereavement Services Managers Association** also considered that it was important for a doctor to have viewed the body after death to confirm the absence or otherwise of any obvious signs of abuse, neglect or unlawful acts.

Lady Justice Smith and Mrs Justice Swift submitted that "the viewing of a body after death is (apart from in the most obvious case of unlawful injury) valueless unless performed by a trained pathologist carrying out a full external examination of the naked body. The post-death 'view' by a doctor usually consists of the doctor looking cursorily at the deceased's face for the purposes of identification. Consequently, the fact that a deceased person has or has not been seen by a doctor after death should be irrelevant for the purposes of the duty to report."

Tom Luce submitted that the question of whether the 14 day rule could be abolished or extended needed to be looked at against the standards of accuracy and confidence as to cause of death required in the certification procedure. His view that the 14 day rule be extended to 28 days was based on the assumption that new procedures for verifying that death had occurred were introduced (as recommended by the Shipman Inquiry and his own fundamental review). He considered that the changes proposed in the separate DH consultation on death certification reform were relevant, and that the time period could be extended if "there were a clear, documented and reasonably robust and uniform professional process for

confirming death at the scene and documenting the death and the circumstances in which it was reported and verified”.

6. Do you believe that a deliberate or wilful failure to discharge this duty on the part of a doctor or other public service professional should be dealt with as a criminal offence as described? We would be interested to hear any reasons behind your views.

We received 59 responses to this question. Respondents were divided over whether or not there should be a criminal offence as described in the consultation document (i.e. some kind of criminal sanction for a deliberate or wilful failure to report a relevant death to the coroner). Some respondents noted that they could not provide their final views without knowing which public service personnel the statutory duty would apply to.

Over half of the respondents (32 out of 59) supported some kind of criminal sanction for a deliberate or wilful failure to report a relevant death; although they expressed a broad range of views regarding the circumstances in which a criminal investigation would be appropriate. These respondents included voluntary organisations, Registration services, coroners, medical practitioners and their representative organisations.

Some respondents, including the **COA, HM Coroners for Sheffield and Liverpool, INQUEST** and **Lady Justice Smith and Mrs Justice Swift**, favoured the creation of a new criminal offence for the deliberate or wilful failure to report a relevant death. The reasons for this included:

- not all those in the potential list to have a duty to report (e.g. fire-fighters, care home workers) have appropriate professional regulators (**Cruse Bereavement Care**);
- the public needed to have trust that the whole process was transparent and correctly operated – this was especially so when wilful or deliberate negligence was involved (**National Association of Funeral Directors**);
- the lack of sanctions reduced the force and importance of the coronial system (**Bereavement Advice Centre**);
- there needed to be recognition that the offence was very serious (**Victims Voice**);

- such a sanction underlined the importance of reporting for families and society as a whole, and the requirement for unnatural deaths to be properly investigated (**HM Coroner for Sheffield**);
- a failure to report a death to the coroner may in some circumstances be an attempt to disguise a cause of death and deny relatives and the State the true reasons for a death. It also denied the opportunity to learn lessons from a death and protect others (**NCHI**); and
- a criminal sanction for a deliberate or wilful failure to discharge that duty would emphasise its importance and encourage a change of attitude (**Lady Justice Smith and Mrs Justice Swift**).

Many respondents noted the difference between ‘deliberate and wilful’ as opposed to unintentional failure to report. Some of those who favoured a new criminal offence for the deliberate or wilful failure to report a relevant death considered that many failures to report would not necessarily be deliberate or wilful and in this event should be dealt with through the relevant professional regulatory framework (including **Plymouth Registration Service, Dr Stephen Leadbeatter, Royal College of GPs**).

APIL submitted that the relevant regulatory body should investigate the case first and then refer the matter to the Chief Coroner before ultimately criminal sanctions could be incurred.

Some respondents, such as the **Royal College of Pathologists** and the **MDU**, considered it was important that the circumstances of each case were considered. The **National Public Health Service for Wales** submitted that there should be a range of sanctions depending on the circumstances, including further training, referral to the relevant professional regulator, and criminal proceedings.

This view was shared by **Cruse Bereavement Care**, which submitted that “consideration should be given as to whether mistakes arise from lack of knowledge, from inexperience or from inadvertent oversight.” There needed to be a spectrum of sanctions, ranging from further training to ultimately the application of criminal sanctions.

The **Royal College of GPs** submitted that care needed to be taken that a criminal sanction was “appropriately applied and that the unique situation of each case, such as mitigating circumstances, were considered. Cases explained by poor practice, which will be the majority, should be dealt with as usual by the professional regulatory body and not as a criminal offence.”

Dr Jonathan Howes submitted that in some circumstances criminal proceedings may be the way to go, although he favoured more scrutiny by medical examiners rather than drastic sanctions.

Slightly less than half of the respondents (25 out of 59) did not consider that a new criminal offence was necessary (including Registration Services, medical practitioners and their representative organisations).

Some respondents were of the view that professional disciplinary action was adequate (including **MDU, BUPA Care Services, and FSID**).

The **Faculty of Forensic and Legal Medicine** submitted that coroners already have considerable powers to 'name and shame' doctors appearing before them at inquests which can be reported in the media. In addition to 'naming and shaming', doctors who wilfully or deliberately fail to discharge their duties were liable to disciplinary action from the GMC. The Faculty believed that this was more than sufficient to ensure that doctors comply with their obligations. Their view was endorsed by the **Royal College of Physicians**.

The **Bereavement Services Managers Association** submitted it had no evidence that the creation of a criminal offence for the deliberate or wilful failure to report a death to the coroner would result in a greater deterrence effect than the threat of internal disciplinary action.

Other respondents did not consider that a new criminal offence was necessary because existing criminal offences could be applied where required (including **BMA, Dr Stephen Rowlands, Peterborough Registration Service, and Sandwell Registration Service**).

The **BMA** submitted that where a person deliberately or wilfully failed to report a death "there may be some other criminal activity going on, which would bring the non-reporter to the attention of the police. Then the lack of reporting would just be part of the whole picture and it would add little to make it a criminal offence in its own right". The BMA considered that action for non-reporting would be entirely dependent on circumstance and could vary from GMC action to criminal proceedings if the cause warranted it; for example, wilfully covering up someone else's actions. They submitted that "there may be a need to undertake criminal action under different legislation if there is, for example, a conspiracy to defraud or otherwise misbehave".

Tom Luce agreed that professional or employer procedures would be appropriate unless there were wilful intent to cover up malpractice which should be a criminal matter.

This view was shared by **Dr Anthony Evans** who felt that the better solution would be that the doctor should be reported to the GMC, which could then go forward and involve the doctor in a criminal report to the police if they deemed it necessary.

Professor Sebastian Lucas supported some form of professional compulsion to report a relevant death, but not a criminal sanction. He noted the DH proposals for medical examiners to screen MCCDs; “Since medical examiners are going to be inquiring into deaths, in many cases as a first screen prior to reporting a death to the coroner, presumably not going first to a coroner but via a medical examiner is not going to be a sanctionable act. And what if the medical examiner wrongly advised that such reporting was not needed in a particular case?”

A number of respondents submitted that a criminal offence for non-reporting would lead to a significant increase in the number of deaths reported (including **MDU, BMA, and NPSA**). **LACORS** noted that this would be especially so if the duty extended to the public service professionals specified in the consultation paper, some of whom may become over cautious and report cases that are inappropriate to avoid the potential of criminal proceedings.

Some respondents noted that a deliberate or wilful failure to discharge the duty would be very difficult to prove (including **BMA, HM Coroner Lincolnshire, and BUPA Care Services**). **Dr Caroline Lorenz** submitted that any sanction would be unworkable if there was a large diffusion of responsibility – “it would be impossible to prove deliberate or wilful failure in any one individual if, for example, ten professionals all fail to discharge this duty in one case.”

7. Do you agree that the most appropriate sanction is through the employer’s code of conduct and the relevant professional regulatory body? Again, we would be interested to hear any reasons behind your views.

We received 54 responses to this question. Some respondents noted that they could not provide their final views without knowing which public service personnel the statutory duty to report a death would apply to. For example, a number of respondents (including **Cruse Bereavement Care, Faculty of Forensic and Legal Medicine, MDU, Medical Protection Society**) pointed out that not all of the public service personnel to whom the proposals might apply have a relevant professional regulatory body. In addition, the **BMA** noted that the employer’s code of conduct will not

always be relevant; for example, “many GPs are effectively independent practitioners and do not have an employer.”

The vast majority of respondents (45 out of 54) agreed that there should be some sort of role for professional regulatory bodies. Views on the nature and extent of that role varied considerably.

Twenty-six respondents agreed that sanctions for the failure to report a relevant death through the employer’s code of conduct and the relevant professional regulatory body were appropriate, and did not support introducing criminal sanctions. The reasons for this included:

- professional regulatory bodies will certainly be effective, since breach of one’s professional duties can result in removal from the register, a very grave sanction (**BMA**);
- the GMC has power to apply sanctions proportionate to the offence (**Dr Stephen Rowlands**);
- compared to a criminal offence, this would not lead to the same level of over-reporting (**MDU**); and
- the deterrent effect would be the same as criminal sanctions (**Bereavement Services Managers Association**).

The other 19 respondents who agreed that there should be some sort of role for professional regulatory bodies considered that it would be appropriate for the regulatory body to investigate in the first instance and then, if necessary, refer the matter to the police (including **Royal College of GPs, MOD, APIL, Sandwell Registration Service, Blaenau Gwent Registration Service, Gipping and Hartismere Registration Service, Dr Stephen Leadbeatter**). The examples stakeholders gave of situations the should be referred to the police included in the event of a deliberate or wilful failure to report a relevant death, or where the intent of non-reporting was to cover up another criminal act.

The **National Public Health Service for Wales** noted that there needed to be a range of sanctions available to reflect degrees of severity, and should be dependant on circumstances. **Cruse Bereavement Care** submitted that “there must be a spectrum between such failings, which may give rise to the need for further training, and persistent neglect, carelessness or wilful concealing of the facts, to which of course, ultimately, the criminal law must apply in serious cases.”

The **COA** considered that the outcome of any disciplinary proceedings should be reported to the National Medical Advisor and the Chief Coroner.

Only a few respondents (5 out of 54) submitted that the failure to report a relevant death should be referred immediately to the police, with no initial role for the professional regulatory body (**MBCOL, Victims Voice, SAMM, DAMN** and **Bereavement Advice Centre**). Their reasons included the perception of impartiality if professional regulatory bodies are involved, and the need for the highest sanctions for deliberate failure to report or provide information about a death.

The **Bereavement Advice Centre** submitted that there might be a role for professional investigation into fitness to practice or other professional disciplinary issues “if an investigation by the police (or a small very specialised team within the office of the chief coroner) fails to determine adequately for prosecution whether a failure to report a death was deliberate or due to ignorance and no prosecution follows.”

8. Do you believe that these sanctions will fit with the Government’s White Paper, “Trust Assurance and Safety – The Regulation of Health Professionals in the 21st Century”? If not, please give your reasons.

We received 37 responses to this question. Almost all respondents believed that the sanctions in the consultation document (i.e. sanctions through the relevant professional regulatory body) would fit with the Government’s White Paper.

The **Bereavement Services Managers Association** submitted that in view of the proposals for strengthening the process of professional self regulation contained in the White Paper, the sanctions would be effective and consistent with the White Paper’s objectives.

The **National Association of Funeral Directors** noted that “there must be transparency and the average member of the public must feel that the action is reasonable”.

Some respondents believed the sanctions would fit with the White Paper provided that other certain things happened or certain conditions were met. For example:

- provided that there was recognition of criminal offences and a distinction between professional misconduct (dealt with by the appropriate professional body) and criminal intent (**Plymouth Registration Service**); and
- provided the Chief Coroner was provided with the statutory powers to review the sanction and, if warranted, refer the case to the courts (**APIL**).

A few respondents raised concerns. The **Bath Registration Service** considered that any criminal sanction appeared to be at odds with the White Paper's principle that regulation should not create unnecessary burdens and should be proportionate to the risk it addressed and that a common standard of proof based on civil court practice should apply to regulation of health professionals.

Dr Caroline Lorenz, GP suggested that sanctions would be unworkable if the statutory responsibility to report a death was diffused over doctors and a number of public service personnel.

The **BMA** submitted that "the key to the Governments overall proposals to reform this area is 'proportionality' and the system should not become a bureaucratic burden on the vast majority of hard working doctors".

HM Coroner for Lincolnshire submitted that the sanctions would fit with the White Paper "only if all deaths were reportable".

9. Do you foresee any practical difficulties arising from the introduction of a second scrutiny of death certificates and the list of reportable deaths?

The consultation paper sought views on any difficulties that might arise from the proposed introduction of a second scrutiny of deaths by the DH and the introduction of a list of reportable deaths.

56 respondents answered this question. 44 agreed that there would be issues to overcome to implement the second scrutiny of deaths proposed by the Department for Health and the list of reportable deaths proposed in the consultation paper, whilst 12 responses disagreed.

The majority of respondents from **registration services** felt that there would be practical difficulties arising from the introduction of a second scrutiny of death certificates and the list of reportable deaths. Some of the reasons included:

- the possibility of delay, which for certain groups would be very important for cultural and religious reasons;
- the lack of independence of the proposed medical examiners;
- the availability of the medical examiners;
- the training doctors would receive on their role in the process; and

- access to and availability of an individual's medical records for early consideration by the medical examiner.

Some of these concerns were echoed by other respondents. The **BMA** suggested that there would be immense practical difficulties in arranging for a second medical scrutiny of all death certificates, but probably not in the case of clearly reportable deaths. Doctors (and others) will continue to report deaths that are on the list of reportable deaths straight to the coroner, without any need to go through the medical examiner, though probably the medical examiner should be informed that it has happened.

The **Royal College of Physicians** and **Faculty of Forensic Medicine** highlighted the practical difficulties in terms of the cost and training of medical examiners and their ability to deal with deaths in a timely fashion. They submitted that it is essential for medical examiners to be independent, and to be seen to be independent, of the doctors certifying death. This will not be the case if they are part of the local PCT.

Christopher Dorries, HM Coroner for Sheffield submitted that a delay, either generally or in identifying suspicious cases that require police inquiry would be undesirable. Proposals for out of hours cover will be important so that religious minorities will not be disadvantaged. An additional burden on coroners will not be acceptable if they are expected to deal with the medical examiners work out of hours simply because there is no medical examiner available. It is difficult to see how an Out of England Order can be granted if the medical examiner has not had an opportunity to consider the case.

MBCOL believe that the practical difficulties of the introduction of a second scrutiny would be in terms of delay affecting early burial not only for Muslims but other faith groups.

Bereavement Services Managers Association shared a number of concerns voiced by Registrars. The potential for delay between the death and the funeral taking place was a significant concern as this may impact adversely upon certain religious and faith groups who prefer a minimal period between a death and the funeral. The proposals for the scrutiny of MCCDs by the medical examiner may impose additional delays in circumstances where the medical history of the deceased requires further investigation. Issues regarding data transfer and the protection of patient confidentiality may pose obstacles to effective and speedy recourse to patient records. These difficulties may be compounded where the medical examiner operates at some distance from the community in which the death occurred. If these proposals were to be implemented, it would be sensible for medical examiners to be included in the list of personnel having a statutory duty to report deaths to the coroner.

The **Bereavement Advice Centre** welcomed the principles both of a universal system regardless of manner of disposal of the body and that all certificates receive qualified medical scrutiny rather than by registrars who have no medical knowledge. However, the present proposals are adequate to avoid introducing significant delays into the process with consequent distress for many families and particularly those for whom an early funeral is required for reasons of faith or culture.

The **MDU** suggested that the practical difficulties would include:

- Recruitment and retention of appropriate medical examiners who have the necessary breadth of experience to ensure that second scrutiny is more than a box-ticking exercise; and
- Delays in authorising burial or cremation. The DH consultation paper on improving the process of death certification envisages that, as a matter of routine, the medical examiner will review the medical records, interview the relevant medical and nursing staff and, where appropriate, the family of the deceased. This may well involve considerable time taken to obtain the records and identify the relevant personnel.

Cruse Bereavement Care submitted that a second scrutiny is an important and necessary reform, but felt limited in how far it could comment given uncertainty about the following issues:

- What resources will be devoted to this, and what standards put in place, to ensure that delays are not caused? Delayed certification has the potential to cause distress to all families and to cause offence to some faith groups.
- How will medical examiners gain access to records?
- What procedures will be put in place to ensure the right balance between proper scrutiny and personal confidentiality?

Cruse welcomed the proposal that the medical examiner will be empowered to discuss the circumstances of the death with bereaved family members, but noted that training in bereavement awareness and appropriate communication skills will be essential for these professionals.

The **NPSA** recommended that important steps are taken alongside these proposals to address the delays and reduce the number of cases that are reported that in turn result in autopsies. The proposals to appoint a medical examiner attached to the clinical governance team in each PCT could be helpful but it remains to be seen in practice how this part-time role will be supported and if it will help tackle delays in the process. It is not

yet clear how the professional accountability of medical examiners will operate and if it will include some relationship with the new post of National Medical Adviser to the Chief Coroner (included in the consultation on improving the process of death certification). A stronger national medical advisory service, sitting alongside the coroner service and answerable to the National Medical Adviser and through that post to the Chief Coroner, could have access to greater specialist skills (e.g. statistics) that may not be available at a local level. Such an improved national medical advisory service could reduce also the need for many coroners' autopsies. The current high level being due, in part, to the lack of medical skills to deal confidently with deaths from natural causes.

The **COA** believed a second scrutiny of a death would lead to delay and distress to family where they expect death to be registered and then find it is reported to the coroner. They also predicted that there would be an increase in the number of deaths subject to an inquest that are currently not being reported due to inadequate scrutiny of notes. A proper medical scrutiny of deaths might result in a reduction in the number of post mortem examinations (resulting in a Form 100B). However, there is more workload in an inquest case than there is in a Form 100B case, so the overall workload for coroner's staff would increase. The current insufficient staffing levels and resources will be exacerbated and will need to increase within the coroner service.

Dr Stephen Rowlands, GP, believes the DH proposals are good and full access to medical records is the key. The difficulty will relate to the time necessary to complete all stages if burial or cremation needs to be done quickly, especially for any Muslim groups expecting burial on the day of death. Increasingly medical records are held electronically, which with proper safeguards may be transferred rapidly electronically. In rural areas, rapid transfer of paper records is more challenging. If more than one person may refer a death to the coroner there needs to be a time interval within which this must be done. It follows that there has to be a delay between the issue of a valid certificate by a doctor and the issue of a certificate for burial or cremation, to allow any such report to be received. This inevitably introduces another delay into the process, which may not be welcomed.

NCHI believed that there may be practical logistical difficulties arising from the introduction of a second scrutiny of death certificates and list of reportable deaths. However, NCHI added that the additional safeguards would far outweigh these difficulties.

Lady Justice Smith and Mrs Justice Swift believe it is essential that that the medical examiner has sufficient information about the deceased's past medical history, their condition before death, and the circumstances of the

death to enable them to make an informed and independent judgement about the likely accuracy of the stated cause of death and whether the death should have been reported to the coroner. They believe that the second scrutiny of death certificates will be completely ineffective unless the medical examiner has the information suggested and is able to cross check that information with recent entries in medical records and with the deceased's family.

Victims Voice believes that there are likely to be considerable difficulties with the introduction of second scrutiny of death certificates and the duty to report deaths. The proposals have become very confusing and will create even more fragmentation in the way the Coroner Service is expected to work. If the proposals are implemented, communication between coroners, coroners' officers, police and medical examiners will be particularly difficult and this will seriously affect communication with bereaved relatives. The medical examiner should be responsible to the coroner, not placed in a PCT where their independence is not apparent and will certainly be questioned, particularly in alleged clinical negligence cases. There also seems to be confusion about the different medical experience necessary for the proposed medical examiners, providers of additional medical advice and the expertise of a doctor providing advice about a medical specialty. Whereas a medical examiner will need wide general experience and could give a coroner additional advice about case management and what expert advice may be needed, a doctor giving expert advice should be an experienced consultant and an acknowledged expert in the recommended speciality. The MoJ and DH proposals should be reconsidered. It does not make sense to have two government departments making proposals which are closely related yet concern different functions: scrutiny of death certificates is a regulatory function, not a health issue. All deaths should be reported to the coroner. This would be a better use of resources and prevent bereaved people having to deal with different issues in different locations.

DAMN's view was that no practical difficulties would be posed if this proposed "second scrutiny of death certificates" is to be merely a paper exercise, whilst noting that a paper exercise would be of no benefit to the bereaved. An important consideration is that by the time a "second scrutiny of death certificates" is undertaken, the body will long since have been disposed of; a second more careful post mortem examination may prove difficult or even impossible to undertake.

Plymouth Registration Service, Dr John Gannon, Dr Caroline Lorenz, SAMM, Dr Calvert, and the Swansea NHS Trust did not see any practical issues arising with second scrutiny or in the list of reportable deaths. **Sunderland Registration Service** felt it was an improvement provided there are no delays for bereaved families.

LACORS did not see any practical issues arising with second scrutiny or in the list of reportable deaths. LACORS agrees that the second scrutiny is a good thing and that it should lessen the inappropriate responsibility on registration officers, but pointed out that if this scrutiny is purely a paper exercise and does not involve any examination of the body the potential for a second Dr Shipman is not eradicated.

Dr Ian Hussein believed that the DH proposals on improving the process of death certification provide the best way forward as the current system is ineffective, requiring a complete overhaul rather than minor changes or the addition of a second level of scrutiny.

The Royal College of Pathologists submitted that the DH proposals were a desirable development, and it would be essential that an appropriate number of high quality medical examiners are recruited and appropriately trained. They agree with the statement “the new medical examiner will not act as an intermediary between the medical profession and the coroner in the generality of cases” only if “the generality of cases” does not include a moderately large proportion where the medical examiner is used as a source of advice, so that referrals to the coroner are appropriate and well-informed.

The Royal College of GPs believed that the medical examiner would be able to gather much information about medical practice – both strengths and weaknesses, allowing practice to be refined with experience and there should be a mechanism to allow for changes to the formal rules. They warned that consideration would need to be given as to how this duty will be applied in circumstances where public professions’ capacities are severely stretched such as a flu pandemic. This duty may need to be relaxed in such an event and provision for this should be made.

Royal Liverpool Children’s NHS Trust believes that there would inevitably be some delay, for example if scrutiny of notes and other information is required as the location of notes and availability and location of clinicians could be difficult.

APIL supports the introduction of a second scrutiny of death certificates as long as this does not lead to unjustified delays. Most relatives will accept a delay if it is justified but any process which unnecessarily prolongs the painful and traumatic experience of the bereaved is to be avoided. **APIL** are also concerned about the role of the independent medical examiner. The consultation paper states that the examiner will be attached to the clinical governance team in a PCT. This means that the bereaved family may have to deal with a representative from a PCT which employed the doctor, who they mistrust, leading to a negative impact on public confidence.

National Association of Funeral Directors submitted that it already takes longer to organise a cremation than a burial because of the waiting time for the statutory documents to be prepared. There is a general lack of understanding by the majority of those responsible for the issuing or signing of these documents as to whose responsibility it is to drive this through on behalf of the bereaved. If bereaved families were to rely now on the letter of the law being fulfilled it is highly likely they would be waiting up to two weeks. It is recognised that goodwill on the part of funeral directors, coroners, doctors, and crematorium staff allows the process to work within the reasonable timescale.

Tom Luce believed it was important that coroner reform and death certification reform should be worked up closely together as past problems have been caused by their historic separation. The creation of a duty to report cases to the coroner would not of itself ensure compliance unless supported by effective monitoring and enforcement arrangements – the role of the medical examiner will obviously be crucial. He believed the impact on over-referral may be limited.

10. Do consultees agree with the principles which will inform a reporting system?

We received 46 responses to this question. In general, respondents welcomed these principles. There were no respondents who were outrightly opposed to them. Many respondents supported the principles as outlined, although others raised some concerns about certain aspects or made suggestions regarding additional principles.

The principles to guide the referral process were outlined in the consultation document as follows:

- bureaucracy to be kept to a minimum;
- no added delay for family members;
- process simple to use and understand; and
- discussions between coroners and referring authorities to continue to be dealt with by telephone or e-mail.

APIL was generally happy with the principles but noted that there were a significant number of complex cases. The Association hoped that “the desire for a reduction in bureaucracy does not lead to simplification of these cases and families not receiving the answers to which they are entitled.”

The **Bath Registration Service** submitted that many of the proposals would add to the bureaucracy and delay. Additional layers of administration such as the proposed independent medical examiners working on the basis proposed were likely to add significantly to delays.

Some respondents commented on the method by which deaths would be referred to the coroner. The **HM Coroner for Sheffield** was concerned that any paper based reporting system with more detailed discussion to be dealt with by phone or email would not work. This view was endorsed by **HM Coroner for Liverpool**. The **COA** felt that the use of an e-mail system was not adequate and that contact should be 'direct' and 'in person'. **Victims Voice** submitted that referrals should be made by fax or e-mail, not by telephone only.

The **NPSA** suggested that "the links between deaths reported to coroners and deaths reported via other routes, including to the NPSA and trust local risk management systems, need further consideration. Without a supporting infrastructure, reporting is likely to continue to be "ad hoc", even with a statutory duty to report."

Other suggestions regarding possible additional principles included:

- some clarity would be welcome as to which matters may be dealt with by staff and which by the coroner in person (**Stephen Rowlands GP**);
- there has been no mention of time-scales; there should be an imperative on the person reporting to do so 'immediately' in order to preserve evidence (**COA**);
- a principle of reporting should be that this would enable learning from previous events, in order to avoid future deaths (**NPSA**);
- there are additional principles that should inform a reporting system, namely to fulfil an important public health function and to serve the interests of justice through the detection of secret homicide (**Faculty of Forensic and Legal Medicine**, endorsed by the **Royal College of Physicians**);
- we suggest an additional principle reflecting the need to ensure that the referral process is effective in identifying all deaths which the public interest requires should be investigated (**Lady Justice Smith and Mrs Justice Swift**); and
- it was imperative that full and effective communication was made especially for the bereaved relatives. Any delays exacerbate the stress and distress of relatives. Therefore transparent and effective

communication is paramount (**Devizes and Marlborough Registration Service**).

Some of the respondents who supported the principles expressed concerns about how they would work/be maintained in practice (**DAMN, Gipping and Hartismere Registration Service, National Association of Funeral Directors**). For example, the **Royal College of Pathologists** submitted that appropriate guidance and support would be crucial.

The **National Public Health Service for Wales** suggested that “any changes to current practice should be implemented only after practicalities of proposals have been piloted, and an appropriate “run-in” period. Any introduction should be accompanied by an awareness campaign to highlight the changes being made.”

The **BMA** also submitted that “there would need to be significant publicity to the profession, especially as there were significant numbers of EU and overseas doctors eligible to work in the UK many of whom do so for short periods.”

Some respondents commented on the principles and the referral process in general. The **Bereavement Advice Centre** submitted that it was imperative that there was a national system with consistency of implementation within the coronial system to have any continuing credibility with professionals and the public and for it to be able to function effectively.

The **Bath Registration Service** commented that the impact assessment contained “contradictory statements about the likely effectiveness of strong legislative pressures to report and there being no anticipated rise in the volume of reporting.” The Service’s view was that “emphasis should be on more training for doctors in death certification and improved communication between medical practitioners, the registration service and the coroners’ service. This would be likely to have much more impact on improving the system within the principles suggested.”

A consultant at the **Royal Liverpool Children’s NHS Trust** submitted that more direct involvement of the medical examiner in the process to advise the coroner would ensure a more effective service.

The **Sandwell Registration Service** noted that sometimes the cause of death as stated on the coroners form A (certificate allowing the registrar to register the death) differed from the MCCD and it was important to confirm that the medical examiner and/or coroner were in possession of all the facts before the registration takes place.

LACORS suggested that there should be formal arrangements for a reporting authority to insist that due consideration is given to a case, to avoid cases where arbitrary decisions are made by coroner officers following a report by registrars where it would appear that no proper consideration has been given to the circumstances.

HM Coroner for Lincolnshire considered that what was proposed was an improvement but did not go far enough and held the view that all deaths should be reported to the coroner.

Conclusions and next steps

1. The consultation asked which public service personnel should have a statutory duty to report deaths to the coroner. Some favoured a comprehensive list of personnel including nurses, fire service, paramedics, and ambulance crew. However, many highlighted the risks associated with this approach. This included possible over reporting if several agencies reported the same death to the local coroner, but equally the risk that a death never got reported as all agencies thought another would have reported it. We were also concerned that placing multiple agencies under such a duty would almost certainly impose further bureaucracy on those agencies, and lead to delays in funerals thereby causing distress to bereaved families.
2. Ministers decided that the Constitutional Affairs Select Committee recommendation, that the duty to report be placed on registered medical practitioners, is the most appropriate way forward and that, given they have responsibility for verifying and/or certifying every death, the duty should fall on registered medical practitioners only. In the future, when the DH proposals to reform the death certification process are implemented, the new medical examiner would pick up any irregularities or possible concerns during their automatic and independent scrutiny of the certificate, and would be able to refer a case to the coroner that a certifying doctor has overlooked. This will not prevent deaths being reported to the coroner as they are at present by, for example, police officers or prison governors, nor will it prevent bereaved relatives directly from asking the coroner to investigate a death if they have suspicions about its circumstances, and the certifying doctor or, under the new arrangements, the medical examiner has not made a referral.
3. A small majority of those who responded felt that there should be some criminal sanction for a deliberate and wilful failure to discharge the duty to report a death to the coroner. However, many accepted that there was a significant difference between deliberately covering up events, perhaps for personal gain, or from inexperience, or from lacking suitable guidance and training. Consequently, there was a suggestion that an investigation through the appropriate professional regulator was effective in the first instance as it could identify cases where possible criminal activity had taken place which could be reported to the police.

4. Given that the decision is for the statutory duty to be placed on all registered medical practitioners, the appropriate professional oversight is provided by the GMC. Ministers decided that the existing range of criminal sanctions could be applied as appropriate, and with no need to create a separate criminal offence of failure to report to the coroner.
5. The Coroners Bill has been amended therefore to place a duty on registered medical practitioners to report specific deaths to the coroner. The Bill now gives the Lord Chancellor the power to make regulations which set out the circumstances in which deaths must be referred to the coroner, in consultation with the Secretary of State for Health and the Chief Coroner (a post to be created by provisions in the Coroners Bill).
6. Coroners have a broad duty to investigate unnatural deaths, as well as all deaths which occur in custody or other state detention or during the course of police operations. There was a general consensus that the right categories of deaths were included in the consultation paper flowing from this general definition. Many helpful suggestions were put forward to help clarify the detail. Following the consultation process, we believe that the following categories of cases that should be referred to the coroner will provide the basis for further work and consultation:
 - death resulting from self harm and neglect (excluding deaths from alcohol or nicotine abuse where the death would not be investigated but for those reasons);
 - death resulting from neglect or abuse where there is an established duty of care by a public authority, other organisations and individuals;
 - death occurring during or shortly after a period of detention
 - death caused or contributed to by the conduct of the police or any other state authority or public organisation;
 - death relating to past or present employment;
 - death resulting from lack of care or appropriate treatment, defective treatment and adverse reaction to prescribed medicine;
 - death of a child where it is unexpected;
 - death where a violent crime is suspected;

- sudden and accidental death, and deaths resulting from traffic incidents;
 - where a death has not been certified as the doctor is unable to identify with any confidence the cause of death;
 - death where there is reason to believe it may have been caused or contributed by a disease or condition that has been specified as being reportable to the coroner because of regional social history, for example lung disease caused through working in the coal industry; and
 - death associated with pregnancy and childbirth.
7. The Coroners Bill has not been included in the legislative programme for the 2007-08 Parliamentary session. The Government is committed to reforming the coroner service for England and Wales and to making non legislative improvements ahead of a Coroners Bill. A Bill will be brought before Parliament as soon as time allows.
 8. In order to improve the coroner service for the bereaved ahead of legislation so that deaths are reported to the coroner appropriately, we will work across Government and with those who work in the coroners service to produce national guidance for England and Wales on the circumstances in which deaths should be reported to the coroner.
 9. Our aim is that coroners have referred to them the cases they should be investigating, but do not have to devote resources to cases which do not fall within their jurisdiction. The work on reform of death certification undertaken by the DH will help in this respect and we will be working closely with them as they develop parallel proposals on reform of the death certification system. These far-reaching reforms will include a single system of effective medical scrutiny, applicable to all deaths, ensuring a seamless and efficient service for bereaved families. There will be obvious benefits from these reforms, including better quality and accuracy in the certifying of deaths and improved local public health monitoring more generally.
 10. The national guidance developed now will form the basis of the list of reportable deaths in secondary legislation and associated guidance under the Coroners Bill when it is implemented.

Consultation Co-ordinator contact details

If you have any complaints or comments about the **consultation process** rather than about the topic covered by this paper, you should contact Gabrielle Kann, Ministry of Justice Assistant Consultation Co-ordinator, on 020 7210 1326 or email her at consultation@justice.gsi.gov.uk.

Alternatively, you may wish to write to the address below:

Gabrielle Kann
Assistant Consultation Co-ordinator
Ministry of Justice
5th Floor Selborne House
54-60 Victoria Street
London
SW1E 6QW

If your complaints or comments refer to the topic covered by this paper rather than the consultation process, please direct them to the contact given on page 3.

The consultation criteria

The six consultation criteria are as follows:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
2. Be clear about what your proposals are, who may be affected, what questions are being asked and the timescale for responses.
3. Ensure that your consultation is clear, concise and widely accessible.
4. Give feedback regarding the responses received and how the consultation process influenced the policy.
5. Monitor your department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.
6. Ensure your consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

These criteria must be reproduced within all consultation documents.

Annex A – List of respondents

Registration Services

Chippenham

Bath

Devizes and Marlborough

Northumberland

Blaenau Gwent, Tredegar

Peterborough

Sunderland

Sandwell, West Bromwich

Swansea

Plymouth

Gipping and Hartismere, Stowmarket

Bradford

Coroners Service

Andre Rebello, HM Coroner, Liverpool, Hon Secretary of the Coroners' Society of England and Wales

Christopher Dorries, HM Coroner for Sheffield

Roger Atkinson, HM Coroner, Lincolnshire

Coroners' Officers Association

Voluntary Groups

AB Welfare and Wildlife Trust

Bereavement Advice Centre

Deaths after Medical Negligence (DAMN)

Cruse Bereavement Care

Action Against Medical Accidents (AvMA)

Foundation for the Study of Infant Deaths (FSID)

Support after Murder and Manslaughter (SAMM)

Victims Voice

Medical Protection Society

INQUEST

Muslim Burial Council of Leicestershire (MBCOL)

National Concern for Healthcare Infections (NCHI)

Other Organisations

BUPA

Faculty of Forensic and Legal Medicine

Government Departments or Agencies

Health & Safety Executive (HSE)

Ministry of Defence (MOD)

National Assembly for Wales

National Patient Safety Agency (NPSA)

Safer Custody Group, HM Prison Service

National Public Health Service, Wales

The Local Authorities Co-ordinators of Regulatory Services (LACORS)

Deputy Chief Medical Officer for Wales

Northern Ireland Court Service

Professional Bodies

Bereavement Services Managers Association

Royal College of Physicians

Association of Personal Injury Lawyers (APIL)

National Association of Funeral Directors

General Dental Council

Medical Defence Union (MDU)

British Medical Association (BMA)

Royal College of Pathologists

Royal College of General Practitioners

General Medical Council (GMC)

Individuals

Tom Luce

Lady Justice Smith and Mrs Justice Swift

Dr Ian Hussein, Cemetery & Crematorium Director, City of London Cemetery and Crematorium

Professor Sebastian Lucas, King's College, London School of Medicine, St Thomas' Hospital, London

Dr Stephen Leadbeatter

Dr Jonathan Howes, Consultant in Anaesthesia & Intensive Care, Yeovil District Hospital

Dr John Gannon, Consultant in Anaesthesia and Intensive Care, Wirral University Teaching Hospital NHS Foundation Trust

Dr Medwyn Williams, Medical Director, Anglesey Local Health Board

Dr J.K.Murphy, Consultant Pathologist, Carmarthenshire NHS Trust, Wales

Dr Alan G Fraser, Consellor, European Society of Cardiology, Reader and Consultant Cardiologist, Wales College of Medicine, Cardiff

John G Williams, Consultant Physician, North Cheshire Hospitals NHS Trust

John Calvert, Medical Director, Swansea NHS Trust

Dr I Back, Pontypridd & Rhondda NHS Trust

Consultant, Royal Liverpool Children's NHS Trust (Alder Hey), Liverpool

Dr John O'Malley, General Practitioner

Dr Paul Attwood, General Practitioner

Dr Stephen Rowlands, General Practitioner

Dr A V Evans, General Practitioner

Dr Caroline Lorenz, General Practitioner

NHS Trusts

Royal Liverpool Children's NHS Trust (Alder Hey), Liverpool

Oldham Primary Care Trust

Velindre NHS Trust

Carmarthenshire NHS Trust

Ceredigion and Mid Wales NHS Trust

Pembrokeshire & Derwen NHS Trust

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