



Ministry of  
**JUSTICE**

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

**Consultation Paper**

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**JUSTICE**

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

**A consultation produced by the Ministry of Justice. This information is  
also available on the Ministry of Justice website at [www.justice.gov.uk](http://www.justice.gov.uk)**



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

## Executive summary

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 conclude with a formal inquest. That 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 doctors to make referrals and neither is there a 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 deaths which should have been referred left uninvestigated. One of the aims of the coroner reform programme – being taken forward initially in the Coroners Bill - is to establish a broad consistency and transparency of approach between areas at all significant stages of a coroner's work, while leaving scope for detailed local arrangements to be negotiated.

The consultation paper makes proposals in relation to three aspects of the policy:

- the public service personnel on whom the duty to report deaths should rest (page 12);
- the specific circumstances and categories of death that should be reported to the coroner (page 13); and
- the sanctions that may apply if there is a failure to report a relevant death to the coroner ( page 16).

In the main, this is a preliminary consultation. We need to establish now on whom the duty to report to the coroner should fall, but there will be further opportunity after the enactment of the Coroners Bill to discuss the precise nature of cases to be referred, and the mechanisms for doing so.

We need to ensure that appropriate deaths are reported to the coroner so that the bereaved are guaranteed an opportunity to learn the true 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.

If there was a statutory framework which clearly defined the types of death which doctors should report, they would be more likely to make accurate referrals, and

reduce unnecessary referrals to the coroner. We propose a list of the types of deaths where doctors and other public service personnel have a statutory duty to report the case to the coroner, while at the same time recognising that there will need to be continued informal contact between coroners and doctors to discuss cases which don't fall precisely into a particular category.

The Government's proposed new medical examiners, (see page 17, on the proposed improvements to the process of death certification), based in Primary Care or NHS or NHS Foundation Trusts, would also be a potential source of advice to both doctors and coroners. Taken together - the creation of that post, the general reform of the coroner service, and the new statutory duty to report deaths to the coroner - the system for regulating deaths is being thoroughly overhauled, with new and better safeguards being introduced.

Our proposals, which were prompted by a recommendation from the Constitutional Affairs Select Committee in its 2006 report<sup>1</sup> aim to bring clarity for the medical profession so that cases are referred to the coroner in the most appropriate circumstances. At the same time, we are seeking views on whether a similar statutory requirement should be placed on other public service personnel to report cases to coroners, when specified circumstances apply – these circumstances are likely to be defined in secondary legislation. In the case of Prison Governors and Registrars, this will also provide an opportunity to bring their current statutory requirements into one place. In line with the recommendations in the Luce Report, we are also seeking views on whether the police, relevant inspectorates covering social care functions, and fire service personnel should be added to the list of those required to report.

We also propose that this statutory duty applies to other medical staff as well as hospital doctors and general practitioners such as nursing staff, midwives, locum doctors working in out of hours services, dentists, and psychiatrists. Mental health facility managers, immigration removal centre managers, care home managers and owners and ambulance service personnel should also report deaths in specific circumstances of individuals in their care. Several agencies may be involved in an incident involve sudden or unnatural death, so we propose that the Coroners' Bill will make clear that if one person reports the death to a coroner it will discharge the duty of all.

In relation to sanctions for a failure to report, there is a difficult balance to achieve between wanting to provide a sufficient deterrent so that all appropriate deaths are reported, but also safeguarding against over-reporting by individuals who wish to protect their professional reputation. We do not wish to see every death reported to

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<sup>1</sup> *Reform of the Coroners' System and Death Certification – Government Response to the Constitutional Affairs Select Committee's Report Cm 6943*

the coroner as that does not use the resources of the coroners' service to best effect and can only cause delay and distress for the bereaved. The consultation paper looks at possible sanctions for clear breaches of referral regulations – from possible criminal penalties in the worst cases to the application of existing disciplinary codes in less serious instances.

## Introduction

This paper sets out proposals for the circumstances where medical practitioners or other public service personnel will have a duty to refer deaths to coroners when specific circumstances prevail. The draft Coroners' Bill will be amended to introduce this statutory provision, and is likely to make provision for regulations to set out circumstances in which a death should be reported to the coroner. The Coroners' Bill will be introduced to Parliament as soon as time allows. The consultation is aimed at those who work in, fund, interact with, or have an interest in the Coroner Service in England and Wales.

Although in the main this consultation follows the Code of Practice on Consultation issued by the Cabinet Office, Bridget Prentice, Parliamentary under Secretary of State for Justice, has decided that this consultation exercise will run for a limited period of 6 weeks. A full 12 week public consultation has already taken place on the draft Coroners' Bill. To ensure that consultation is as effective as possible, this paper will be published on the Ministry of Justice web site, so that anyone wishing to submit their view will be able to do so. Wider consultation will take place on particular implementation issues flowing from the Coroners' Bill after it receives Royal Assent.

An initial regulatory impact assessment indicates that coroners, coroners' officers, doctors and other public service personnel with a duty to report, users of the coroner service, voluntary groups dealing with issues related to bereavement are likely to be particularly affected. The proposals are unlikely to significantly affect businesses, charities or the voluntary sector, or the public sector. A Partial Regulatory Impact Assessment is attached at page 32. Comments on this Regulatory Impact Assessment are also welcome. If you disagree with its conclusions you are invited to send your reasons as part of your overall response to this paper.

Copies of the consultation paper are being sent to:

The Coroners' Society of England and Wales

The Coroners' Officers Association

The Right Honourable Lady Justice Smith DBE

Tom Luce

The Honourable Mrs Justice Swift DBE

The British Medical Association (E&W)

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

The General Medical Council

Royal College of Physicians

Royal College of Pathologists

Royal College of General Practitioners

Medical Defence Union

The Department for Health (E&W)

The Chief Medical Officer (E&W)

The National Patient Safety Agency

The Department for Communities and Local Government

The Local Government Association (E&W)

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

The Association of Chief Police Officers

The Welsh Assembly Government

The General Register Office

Action against Medical Accidents (AvMA)

Adverse Psychiatric Reactions Information Link (APRIL)

Asbestos Support Group Forum

Association of Directors of Children's Services (ADSS)

Association of Personal Injuries Lawyers

Cardiac Risk in the Young (CRY)

Centre for Corporate Accountability

Child Bereavement Trust (CBT)

Confidential Enquiries into Maternal and Child health (CEMACH)

Epilepsy Bereaved

Foundation for the Study of Sudden Infant Deaths

JUSTICE

Coroners' Courts Support Service (CCSS)

Crematorium Medical Referees (E&W)

CRUSE Bereavement Care

Deaths After Medical Negligence

Families against Corporate Killing

Fire Service

Forum for Preventing Deaths in Custody

Funeral Industry reps

Home Office

INQUEST

Independent Police Complaints Commission

Justice for Victims

Liberty

Marchioness Action Group (MAG)

Merseyside Asbestos Victim Support Group

Ministry of Defence

Ministry of Defence Surgeon General's Office

National Bereavement Partnership

National Society for the Prevention of Cruelty to Children (NSPCC)

Police Federation

Prison Governors Association

Prison Service

Refuge

Rethink

RoadPeace

Sudden Adult Death Trust

Support after Murder and Manslaughter

Support after Murder and Manslaughter Abroad

Survivors of Bereavement by Suicide (SOBS)

The Childhood Bereavement Network (CBN)

The Compassionate Friends

Victim Support

Victims' Voice

Churches Together in England

The Inter Faith Network for the UK

The Zoroastrian Trust Funds of Europe

The British Sikh Consultative Forum

The Network of Sikh Organisations

The Catholic Bishops' Conference of England and Wales

The Board of Deputies of British Jews

The Muslim Council of Great Britain

The Hindu Forum of Britain

The Jain Samaj Europe

The British Humanist Association

However, this list is not meant to be exhaustive or exclusive and responses are welcomed from anyone with an interest in or views on the subject covered by this paper.

## The proposals

### The Current Position in England and Wales

In England and Wales, there is a common law duty to report a death to the coroner in circumstances where an investigation may be required to establish the full circumstances of the death. It applies to everyone and is not limited to professionals who are involved in dealing with death.

The Coroners Act 1988 only requires that coroners hold inquests into violent or unnatural deaths, sudden deaths of which the cause is unknown and into deaths in prison. The Act contains no statutory obligation for these deaths to be reported to the coroner. The sole reporting processes are derived from the Registration legislation, and various legislation governing prisons. The former prevents a registrar from registering a death which has been reported to the coroner and through Regulation 41 of the Births and Death Regulations 1987 defines the circumstances in which the registrar should report to the coroner.

Before the registration of a death and the disposal of the body can take place either:

- a medical certificate as to the cause of death must be issued by a doctor; or
- a certificate is issued by the coroner after appropriate investigations take place.

The duty on a Prison Governor to inform the coroner of the death of an inmate applies to all types of military and civil detention or imprisonment, and is underpinned by various statutes.

Registrars, doctors or the police will report deaths to the coroner in certain circumstances. Some examples are if a doctor cannot give a proper certificate of a cause of death; if the death occurred during an operation; if the death was due to industrial disease; or if the death was unnatural or due to violence or in other suspicious circumstances. These are set out in best practice and guidance<sup>2</sup>, and the information leaflet published by the Ministry of Justice<sup>3</sup>: The Luce Review also

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<sup>2</sup> For example, "Coroners' Courts – A Guide to Law and Practice" by Christopher Dorries

<sup>3</sup> "When Sudden Death occurs – Coroners and Inquests" published by the Ministry of Justice, formerly the Department for Constitutional Affairs

set out a proposed list of deaths which should always be reported to the coroner<sup>4</sup>. The majority of deaths are reported to the coroner by doctors.

The number of deaths reported to coroners in 2006 fell by 1.2% from the previous year which reflected the fall of 2% in the number of registered deaths in the same year. However, about half of the deaths reported to the coroner require neither post mortem nor inquest. These cases have been increasing in recent years. As a proportion of all coroners' cases, those where there was neither an inquest nor a post mortem examination have increased from 39% in 1995 to 51% in 2006. The number of cases in this category totalled 117,400 in 2006.

If there was a statutory framework which clearly defined the types of death which doctors or others should report, doctors would be less likely to report a death to the coroner unnecessarily, and other public service personnel would have greater awareness of the need to involve the coroner when the circumstances of the death demand. The intention is to put existing good practice on a statutory footing, and to ensure consistency of approach across England and Wales.

We need to ensure that appropriate deaths are reported to the coroner so that the bereaved are guaranteed an opportunity to learn the true facts about the death of a loved one. This will also support the coroner's public protection role where lessons learned are communicated to the appropriate authority or organisation to prevent further fatalities.

The new arrangements would be kept under review by the Chief Coroner, also enabled by the Bill, and his or her National Medical Advisor.

### **Other Jurisdictions**

Many other jurisdictions have a statutory framework where doctors and others have a duty to report deaths which meet specific criteria to the coroner. In developing our proposals, we looked at the position in Northern Ireland, Australia and New Zealand.

Whilst there is some variation across the individual jurisdictions, some common themes emerge. Deaths where:

- the person has not seen or been treated by a doctor within a certain timeframe ranging from 28 days to 3 months;

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<sup>4</sup> *Death Certification and Investigation in England, Wales and Northern Ireland - The Report of a Fundamental Review 2003 Cm 5831*

- the person was in prison, or where the individual has been detained under Mental Health legislation;
- it might be attributable to medical treatment or surgery received.

were common to most.

A summary of the reportable deaths in other jurisdictions is included on page 20. Other jurisdictions also include a statutory duty for other professionals e.g. the police to report certain deaths to the coroner, as well as members of the public so that families with concerns could do the same.

### **Requirement for Doctors and other public service personnel to report cases to Coroners**

On occasions, other public service personnel are more likely than medical professionals to be the primary source of referral to a coroner. We are seeking views on whether a similar statutory requirement should be placed on these personnel to report cases to coroners, when specified circumstances apply – likely to be defined in secondary legislation. In the case of Prison Governors and Registrars, this will also provide an opportunity to bring their current statutory requirements into one place. In line with the recommendations in the Luce Report, we would also welcome views on whether fire service personnel should be added to the list of those required to report.

Additionally, we would welcome views on whether the statutory duty should apply to other medical staff as well as hospital doctors and general practitioners - such as nursing staff, midwives, locum doctors, dentists, psychiatrists, and the designated paediatrician with responsibility for informing relevant professionals of unexpected deaths in childhood. Mental health facility managers, immigration removal centre managers, care home managers and owners and ambulance service personnel might also be expected to report deaths in specific circumstances of individuals in their care.

We do not propose to add the funeral industry to the statutory list but they will be encouraged to bring any concerns they may have to the attention of the coroner as they do at present.

Several agencies may be involved in an incident involve sudden or unnatural death, so we propose that the Coroners' Bill will make clear that if one person reports the death to a coroner it will discharge the duty of all.

**Q1. 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?**

**Proposed List of Deaths which should be reportable to the Coroner**

Coroners have an important role to play in public protection, where their recommendations may help save future lives. A death should be reported where there is reason to suspect that it has been caused or contributed to by certain specified factors. This will provide a benchmark against which the conduct of the doctor (or other potential reporter) can be assessed.

The table below sets out are the circumstances where we believe deaths should be reported to the Coroner:

<p><b><i>1 Death resulting from self harm and neglect</i></b></p>
<p>A death is reportable where there is reason to suspect that the death may have been caused or contributed to by the actions of the deceased himself or herself.</p> <p>Examples would be a death where there is reason to suspect that the death may have been caused by the deceased's own hand or may have been caused or contributed to by drug or solvent abuse or by a self-administered drug overdose.</p>
<p><b><i>2 Death resulting from neglect or abuse where there is an established duty of care by a public authority, other organisations and individuals</i></b></p>
<p>A death is reportable where there is reason to suspect that the death may have been caused or contributed to by neglect or abuse on the part of:</p> <ul style="list-style-type: none"><li>(i) a public authority;</li><li>(ii) another organisation; and/or</li><li>(iii) an individual</li></ul> <p>who has responsibility for the deceased.</p> <p>Examples of relevant public authorities would be NHS trusts or NHS foundation trusts and local authorities; an example of a relevant organisation would be a private care home; examples of responsible individuals would be the parents of a child and the adult children of an elderly parent.</p>
<p><b><i>3 Death occurring during or shortly after a period of detention</i></b></p>
<p>A death is reportable where there is reason to suspect that the death, or the injury or illness which resulted in the death, occurred or developed during or shortly after a period of detention by the police, in prison custody, by the military authorities, under the Mental Health Act 1983 or by the Border and Immigration Agency.</p>

<b><i>4 Death caused or contributed to by the police's conduct</i></b>
A death is reportable where there is reason to suspect that the death may have been caused or contributed to by action or inaction by the police.
<b><i>5 Deaths relating to Employment</i></b>
A death is reportable where the death occurred at a time when the deceased was at work and/or there is reason to suspect that the death has been caused or contributed to by any injury, disease or medical condition resulting from the deceased's past or present employment.
<b><i>6 Death resulting from lack of care or appropriate treatment, defective treatment and adverse reaction to prescribed medicine</i></b>
A death is reportable where there is reason to suspect that the death may have been caused or contributed to by  (i) a lack of care, defective treatment and/or a failure appropriately to treat on the part of a doctor or other health professional;  (ii) an adverse reaction to prescribed medicine;  (iii) an infection acquired during the course of treatment; and/or  (iv) the effects of any medical or surgical treatment.
<b><i>7 Death of a child</i></b>
Where the death of that child was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that lead to that death, or where the child was provided with secure accommodation (under S25 Children Act 1989).
<b><i>8 Deaths where there a violent crime is suspected</i></b>
A death is reportable where there is reason to suspect that the death may have been caused or contributed to by an unlawful act or acts.
<b><i>9 Sudden and Accidental Death</i></b>
A death is reportable where there is reason to suspect that the death may have been caused or contributed to by a sudden and/or traumatic event or accident.  Examples would be deaths caused or contributed to by a road traffic incident, a fall, drowning, fire or poisoning including fume inhalation.

<p><b>10 A death which is the subject of significant concern or suspicion</b></p>
<p>A death is reportable where there is significant unresolved concern or suspicion as to its cause or circumstances on the part of</p> <ul style="list-style-type: none"><li>(i) any family member</li><li>(ii) any member of public</li><li>(iii) any healthcare or other professional with knowledge of the death</li></ul>
<p><b>11 Where the death has not been certified</b></p>
<p>A death is reportable where the cause of death has not been certified by a doctor.</p> <p>There will be circumstances where the doctor is unable to identify with any confidence (and therefore cannot properly certify) the cause of death. It may be that the only method of establishing the cause of death is by post mortem, and such a death must be reported to the coroner.</p>
<p><b>12 A death which may have been caused or contributed to by a specified disease or condition</b></p>
<p>A death is reportable where there is reason to suspect that it may have been caused or contributed to by a disease or condition that has been specified by the Chief Coroner as being reportable to the coroner.</p> <p>Examples of conditions that might be specified are well known hospital infections, food poisoning, severe acute respiratory syndrome (SARS), tuberculosis, deaths from deep vein thrombosis associated with air travel and deaths from avian flu. We envisage that these diseases and conditions specified will need to be kept under review and revised regularly. The Chief Coroner (to be appointed under the Bill) may consider it appropriate to specify certain diseases and conditions for different areas depending on its social history or demographic perhaps.</p>
<p><b>13 Deaths associated with childbirth or termination of pregnancy</b></p>
<p>Any death which occurs from any cause of a woman who is either pregnant, or subsequent to delivery, termination of pregnancy, ectopic pregnancy or miscarriage</p> <p>Regulation 41 of the Registration of Births and Deaths Regulations 1987 requires a registrar to report to the coroner any death that he has reason to believe has been caused by abortion.</p>

Under the present system, Regulation 41 of the Registration of Births and Deaths regulations 1987 requires a registrar to report a death to the coroner where it appears that the certifying doctor did not see the deceased after death or within 14 days.

Consideration was given by the Shipman Inquiry as to whether there should be a duty to report if the certifying doctor has not seen the deceased within a specified time before death. We agree with the conclusion that the most important consideration is the quality of the doctor's knowledge about the patient and the death. There are now many different ways of delivering health services, as well as a growth in the hospice movement which would make a time limit seem arbitrary. The time elapsed since a doctor had seen the deceased would in any event be a factor for them to take into account in deciding whether they had the necessary knowledge of the patient and the death.

For these reasons, we do not propose to include a time limit of this kind, and will work with the General Register Office to consolidate the statutory framework for these matters. For the same reason, the requirement for a doctor to have viewed the body after death also seems unnecessary as it has limited diagnostic value.

- Q2. Do you believe the proposed list of reportable deaths to the coroner is workable, effective and proportionate?**
- Q3. 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?**
- Q4. 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.)**
- Q5. Do you agree that the 14 day rule is arbitrary and unnecessary? If not, what length of time limit would you suggest?**

**Sanctions against Doctors and other public service personnel who fail to discharge their duty to report a death to the Coroner**

Other jurisdictions where a coronial system operates include penalties where individuals fail to discharge statutory obligations relating to reporting deaths to the coroner, which range from fines to periods of imprisonment.

There is a difficult balance to achieve as we want to provide a sufficient deterrent so that all appropriate deaths are reported, but also to safeguard against over-reporting by individuals who wish to protect their professional reputation. We do not wish to see every death reported to the coroner as that does not use the resources

of the coroners' service to best effect and can only cause delay and distress for the bereaved.

As we propose that the Bill would impose a duty on a doctor, or other public service personnel, in the same way that the draft Coroners' Bill imposes a number of duties on coroners, we envisage that failure to discharge that duty would be an internal disciplinary matter, subject to the oversight of the relevant professional regulator, rather than a criminal or civil offence.

However, it is important to ensure that all appropriate cases are referred to the coroner. Coroners investigations have an important role in identifying areas where lessons can be learned with a view to preventing future deaths. Consequently, it could be argued that a deliberate failure to report a relevant death to the coroner might justify some kind of criminal sanction.

Also relevant is the Government's strategy in tackling concerns about health professionals, which was set out in a recent White Paper, "Trust Assurance and Safety – the Regulation of Health Professionals in the 21<sup>st</sup> Century". A key component is the move to extend the range of actions available to regulators where concerns have been identified so that the options of rehabilitation, remediation, and retraining are more readily available where appropriate. A common standard of proof is proposed across all regulators. The proposals suggest that the civil standard of proof with its sliding scale should be used. This enables an appropriate weight to be given to the implications for the medical profession where some cases may result in removal from a professional register and the consequent loss of livelihood.

**Q6. 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.**

**Q7. 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.**

**Q8. 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 21<sup>st</sup> Century"? If not, please give your reasons.**

### **Proposed Improvements to the Process of Death Certification**

We intend to take full account of the proposals, published on 24 July, which flow from the Department of Health's consultation on a second scrutiny of death certificates by doctors. The proposals will see all death certificates (cremations and

burials) subject to scrutiny by an independent 'medical examiner' attached to the clinical governance team in a Primary Care Trust.

At present, the certifying doctor indicates on the Medical Certificate of Cause of Death (MCCD) where he or she has reported a death and the registrar does not register in these cases until authorised to do so by the coroner. Advice and guidance to doctors on reporting deaths is included with the instructions for completing the MCCD. Revised guidance was placed on the General Register Office website last year. Provision for registrars to report a death is contained in regulations.

The medical examiner would have full access to medical records and would be empowered to discuss the circumstances of the death with relatives of the deceased. The examiner would refer cases on to the coroner if there was any cause for concern. The new medical examiner will not act as an intermediary between the medical profession and the coroner in the generality of cases. The Coroners Bill will provide for regulations which will set out the deaths which medical professionals should refer to coroners – as now, most of these will be cases where it is not possible for the doctor to certify the death because the cause is unnatural, unknown, or there are suspicious circumstances, or because the deceased had no recent contact with medical professionals.

**Q9. Do you foresee any practical difficulties arising from the introduction of a second scrutiny of death certificates and the list of reportable deaths?**

### **Referral process**

More detailed thinking on the mechanics of the referral process will take place after the Coroners Bill receives Royal Assent. The principles to guide the process will be that it keeps bureaucracy to an absolute minimum, does not add to delay for family members, and that it will be simple to use and understand. More detailed discussions between the coroner and his or her staff and the referring authority about particular cases will continue, as now, to be dealt with by telephone or e-mail.

**Q10. Do consultees agree with the principles which will inform a reporting system?**

## Questionnaire

We would welcome responses to the following questions set out in this consultation paper.

- Q1. 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?**
- Q2. Do you believe the proposed list of reportable deaths to the coroner is workable, effective and proportionate?**
- Q3. 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?**
- Q4. 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.)**
- Q5. Do you agree that the 14 day rule is arbitrary and unnecessary? If not, what length of time limit would you suggest?**
- Q6. 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.**
- Q7. 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.**
- Q8. 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 21<sup>st</sup> Century"? If not, please give your reasons.**
- Q9. Do you foresee any practical difficulties arising from the introduction of a second scrutiny of death certificates and the list of reportable deaths?**
- Q10. Do consultees agree with the principles which will inform a reporting system?**

**Thank you for participating in this consultation exercise**

## Comparison Tables

### Other Jurisdictions

Jurisdiction		Statutory Basis	Those with a Duty to Report	Reportable Deaths	Sanctions applied for non compliance
<b>Northern Ireland</b>		Coroners (Northern Ireland) Act 1959	Doctors, Police, Registrar of Deaths, Funeral Director, Prison Governor, any member of the public	<p>A doctor did not see or treat the deceased in the 28 days before they died</p> <p>A doctor did not treat the person during their last illness</p> <p>Sudden, violent or unnatural such as an accident, or suicide</p> <p>Murder</p> <p>Industrial disease of he lungs such as asbestosis</p> <p>Other circumstances which may require investigation</p>	Fine ( not exceeding level 2 on the standard scale)
<b>Australia</b>	<b>Northern Territory</b>	Coroners Act 1993	Individuals, doctors, police.	<p>A person dies where the death appears to have been unexpected, unnatural or violent or to have resulted , directly or indirectly, from an accident or injury.</p> <p>A person dies during an anaesthetic.</p>	Penalty: \$ 5,000

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Jurisdiction	Statutory Basis	Those with a Duty to Report	Reportable Deaths	Sanctions applied for non compliance
			<p>A person dies and the death appears to have occurred as a result of an anaesthetic and is not due to natural causes.</p> <p>A person dies who was a person held in care or custody</p> <p>A person dies and the death was caused or contributed to by injuries sustained while the person was held in custody.</p> <p>A person dies ad their identity remains unknown.</p> <p>A person dies outside the territory who normally resided in Northern Territory where a qualified medical practitioner in that place does not certify the cause of death.</p>	
<b>Capital Territory</b>	Coroners Act 1997	Individuals, Police, Prison Governors and others in similar roles	<p>A person is killed</p> <p>A person is found drowned</p> <p>A person dies or is suspected to have died, a sudden death the cause of which is unknown</p> <p>A person dies within 72 hours after or as a result of an operation of a medical, surgical, dental or like nature or an invasive medical procedure other than an operation or procedure prescribed by regulation prescribed by regulation to be a procedure exempted e.g. giving an intravenous injection, cardiac resuscitation.</p>	50 penalty units, imprisonment for 6 months or both
<b>Western Australia</b>	Coroners Act 1996	Individuals, doctors, those in whose care the deceased was	<p>A person dies and the death appears to have been unexpected, unnatural, or violent or to have resulted, directly or indirectly, from injury</p> <p>A person dies and death occurs during an anaesthetic or occurs as a result of an anaesthetic and is not due to natural causes.</p>	Penalty : \$1000

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

Jurisdiction		Statutory Basis	Those with a Duty to Report	Reportable Deaths	Sanctions applied for non compliance
			held e.g. police prison officer.	<p>A person dies and immediately before their death they were held in care. This would include those held in police custody, prison, or involuntary patients in psychiatric institutions or children in juvenile justice centres.</p> <p>A person dies and the death appears to have been caused or contributed to by any action of a member of the police force.</p> <p>A person dies in Western Australia where the cause of death has not been certified under the relevant legislation.</p> <p>A person dies and the death occurs outside Western Australia where the cause of death has not been certified by a qualified medical practitioner there</p> <p>A person dies whose identity is unknown.</p>	
	<b>Tasmania</b>	Coroners Act 1995	Individuals, doctors, police officer, prison officer	<p>A person dies and the body of the deceased is in Tasmania, or the death occurred in Tasmania, or the cause of death occurred in Tasmania or the death occurred while the person was travelling from or to Tasmania</p> <p>and the following apply»</p> <p>A person dies and the death is unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury or the cause is unknown</p> <p>A person dies and the death occurs during anaesthesia or sedation and is not due to natural causes</p> <p>A person dies who was held in custody or held in care immediately before death</p>	Maximum, Penalty: 10 penalty units

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

Jurisdiction	Statutory Basis	Those with a Duty to Report	Reportable Deaths	Sanctions applied for non compliance
			<p>A person dies who was escaping or attempting to escape from prison or police custody or from an institution or</p> <p>A person dies where a police officer or prison officer was attempting to detain that person when death occurred.</p> <p>A child dies under the age of one year and the death was sudden and unexpected.</p> <p>A person dies whose identity is unknown..</p>	
<b>Victoria</b>	Coroners Act 1985	Individuals, doctors, police	<p>A person dies unexpectedly</p> <p>A person dies from an accident or injury</p> <p>A person dies in an unnatural or violent way</p> <p>A person dies during or as a result of an anaesthetic</p> <p>The person was held in care immediately before they died. This would include those people in police custody, people in jail, involuntary patients under Mental Health Act 1996 and young people in juvenile justice centres</p> <p>A doctor has been unable to sign a death certificate giving the cause of death</p> <p>The identity of the person who has died is unknown.</p> <p>The second or subsequent death of a child of either parent, no matter what the circumstances in which the child died must be referred to</p>	Penalty: 10 penalty units

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

Jurisdiction	Statutory Basis	Those with a Duty to Report	Reportable Deaths	Sanctions applied for non compliance
			the State Coroner.	
South Australia	Coroners Act 2003	Individuals, police officers, doctors.	<p>A person dies and the death is unexpected, unnatural, unusual, violent, or of unknown cause.</p> <p>A person dies during a flight on an aircraft, or on a vessel during a voyage.</p> <p>A person dies in custody</p> <p>A person dies as a result of or within 24 hours of the carrying out of a surgical procedure or an invasive medical or diagnostic procedure or the administration of an anaesthetic for the purposes of carrying out a medical or diagnostic procedure. Certain procedures are exempt and specified in regulations</p> <p>A person dies and the death occurs within 24 hours of the person being an inpatient in hospital or the person having sought emergency treatment in hospital.</p> <p>A person dies and they were a protected person under the Aged and inform Persons Property Act 1940 or the Guardianship and Administration Act 1993 or in the custody and guardianship of the Minister's under the Children's Protection Act 1993 or a patient at an approved treatment centre under the Mental Health Act 1993 or a resident of a licensed supported residential facility or accommodated in a hospital or other treatment facility for the purposes of being treated for drug addiction.</p> <p>A person dies and death occurs in the course or as a result , or within 24 hours, of the person receiving medical treatment to which consent was given under the Guardianship and Administration Act 1993</p> <p>A person dies and no certificate as to the cause of death has been given to the Registrar of Births, Deaths and Marriages.</p>	<p>For failure to report a death:-</p> <p>Maximum penalty: \$10,000 or imprisonment for 2 years</p> <p>Failure of a medical practitioner to provide the coroner with an opinion as to the cause of death:-</p> <p>Maximum penalty:</p>

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

Jurisdiction	Statutory Basis	Those with a Duty to Report	Reportable Deaths	Sanctions applied for non compliance
				\$5,000
	<p><b>New South Wales</b></p> <p>Coroners Act 1980</p>	<p>Individuals, police officers</p>	<p>A person dies a violent and unnatural death or a sudden death the cause of which is unknown</p> <p>A person dies having not been attended by a medical practitioner within the period of 3 months immediately preceding their death.</p> <p>A person died while under, or as a result of or within 24 hours after the administration of, an anaesthetic administered in the course of a medical surgical or dental operation or procedure or an operation or procedure of a like nature, other than a local anaesthetic administered solely for the purpose of facilitating a procedure of resuscitation from apparent or impending death</p> <p>A person dies within a year and a day after the date of any accident to which the cause of their death is or may be attributable.</p> <p>A person dies while in or temporarily absent from a hospital under provisions in the Mental Health Act 1990 and while the person is resident at the hospital for the purpose of receiving care, treatment or assistance.</p> <p>A person dies in lawful custody (police or prison), as a result of or in the course of police operations.</p> <p>A child who dies in care, or whose death is or may be due to abuse or neglect; or where the child was subject of a report made under the Children and Young Persons (Care and Protection) Act 1998 within 3 years of death, or the child is a sibling of a child who was the subject of a report under the Children and Young Persons (Care and Protection) Act 1998 within 3 years of death</p> <p>A person who is living in or temporarily absent from , residential care provided by a service provider authorised or funded under the Disability Services Act 1993 or a residential centre for handicapped persons.</p>	<p>Maximum penalty: 10 penalty units</p>

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

Jurisdiction		Statutory Basis	Those with a Duty to Report	Reportable Deaths	Sanctions applied for non compliance
	<b>Queensland</b>	Coroners Act 2003	Individual, police.	<p>A person dies and the death happened in Queensland</p> <p>A person dies and the death was caused by an event that happened in Queensland or the person's body is in Queensland or at the time of death the person lived in Queensland or the person, at the time of death, was on a journey to or from somewhere in Queensland.</p> <p>A person dies and their identity is unknown</p> <p>A person dies and the death was violent, unnatural or happened in suspicious circumstances</p> <p>A person dies and the death was not reasonably expected to be the outcome of a health procedure</p> <p>A person dies and a cause of death certificate has not been issued and is not likely to be issued and is not likely to be issued for that person.</p> <p>A person died whilst in care</p> <p>A person died whilst in custody.</p>	Penalty: 25 penalty units
<b>New Zealand</b>		Coroners Act 2006	Any one finding a dead body or knowing of a violent or an unnatural death must report this to the police who	<p>Where the deceased has died in a violent, or unnatural way, such as drowning, a car crash, or poisoning</p> <p>Where the cause of death is unknown</p> <p>When a person dies in prison</p>	

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

<b>Jurisdiction</b>	<b>Statutory Basis</b>	<b>Those with a Duty to Report</b>	<b>Reportable Deaths</b>	<b>Sanctions applied for non compliance</b>
		inform the coroner.	<p>When a person dies “in care”, e.g. in a psychiatric hospital or a children’s home.</p> <p>When a person appears to have taken their own life</p> <p>When a person dies while under anaesthetic or during or following a medical procedure, or as a result of anaesthetic or a medical procedure.</p>	

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

**Table of the Luce Report Recommendations**

<b>Those with a Duty to Report</b>	<b>Reportable Deaths</b>
<p>Doctors, other health professionals, police, care inspectorate personnel, fire service personnel, and funeral service staff</p>	<p>Any violent or traumatic death, including all traffic deaths, work place deaths, deaths from apparent self harm, from injury, fire or drowning, or other unnatural cause in the home or any other place, or as a result of the operations of the law and order services.</p> <p>Any death of a person detained in a prison, military detention, in police custody, in a special hospital or under statutory mental health powers, or of a person resident in a bail or asylum hostel.</p> <p>Any death from a range of communicable diseases defined from time to time as needing investigation by the coroner.</p> <p>Any death in which occupational disease may have played a part.</p> <p>Any death in which lack of care, defective treatment, or adverse reaction to prescribed medicine might have played a part, or unexpected deaths during or after medical or surgical treatment</p> <p>Any death which occurs from any cause of a woman who is either pregnant, or within a year of delivery, termination of pregnancy, ectopic pregnancy or miscarriage.</p> <p>Any death of a child looked after by or on behalf of a social services authority, or on the at risk register, or in a family in which another child is or has been looked after or on the at risk register, or of a child being privately fostered.</p> <p>Any death in which the use of addictive drugs may have played a part.</p> <p>Any other death which a doctor may not certify as being from natural disease or old age.</p> <p>Any death which is the subject of significant unresolved concern or suspicion as to its cause or circumstances on the part of any family member, or any member of the public, any health care, funeral services or other professionals with knowledge of the death.</p> <p>Any death in respect of which the Registrar has significant continuing uncertainties.</p>

## About you

Please use this section to tell us about yourself

Full name	
<b>Job title</b> or capacity in which you are responding to this consultation exercise (eg member of the public etc.)	
<b>Date</b>	
<b>Company name/organisation</b> (if applicable):	
<b>Address</b>	
<b>Postcode</b>	
If you would like us to acknowledge receipt of your response, please tick this box	<input type="checkbox"/> (please tick box)
Address to which the acknowledgement should be sent, if different from above	

**If you are a representative of a group**, please tell us the name of the group and give a summary of the people or organisations that you represent.

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## **How to respond**

Please send your response by Friday 7 September 2007 to:

**Coroner Reform Team**

**Coroners' Unit**

**Ministry of Justice**

**5.08, 5<sup>th</sup> Floor  
Steel House  
11 Tothill Street  
London  
SW1H 9LH**

**Tel: 020 7210 0312**

**Fax: 0870 739 5849**

**Email: coroners@justice.gsi.gov.uk**

### **Extra copies**

Further paper copies of this consultation can be obtained from this address and it is also available on-line at <http://www.justice.gov.uk/index.htm>

### **Publication of response**

A paper summarising the responses to this consultation will be published within three months of the closing date of the consultation. The response paper will be available on-line at <http://www.justice.gov.uk/index.htm>

### **Representative groups**

Representative groups are asked to give a summary of the people and organisations they represent when they respond.

### **Confidentiality**

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000

(FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Ministry.

The Ministry will process your personal data in accordance with the DPA and in the majority of circumstances; this will mean that your personal data will not be disclosed to third parties.

## Partial Regulatory Impact Assessment

### The groups affected and the likely impact

The following groups have been identified as those on which these proposals may impact:-

- Coroners
- Coroners' officers
- Doctors and other public service personnel with a duty to report (doctors, nurses, midwives, dentists, police, fire service, etc)
- Users of the coroner service
- Voluntary groups dealing with issues related to bereavement

We have included these groups and their representatives in our consultation list so they will be able to participate in the consultation process. This will facilitate the identification of any other consequences of introducing this statutory duty.

### Referrals to the coroner

The changes we propose to the statutory framework will clearly define the types of death which doctors or others should report, doctors would be less likely to report a death to the coroner unnecessarily, and other public service personnel would have greater awareness of the need to involve the coroner when the circumstances of the death demand. The intention is to put existing good practice on a statutory footing, and to ensure consistency of approach across England and Wales. Consequently, we do not anticipate that the number of referrals will increase significantly.

### Sanctions

We have identified the following impacts to the criminal justice system if a criminal sanction against those who wilfully fail to report an appropriate death to the coroner was used:-

- The Courts
- Legal Aid

As the anticipated volume of possible cases is no more than 5 cases per year, the additional resource and financial impact is likely to be very small.

## 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 time scale 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.**

## 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 the Ministry of Justice Consultation Co-ordinator, Laurence Fiddler, on 020 7210 2622, or email him at [consultation@justice.gsi.gov.uk](mailto:consultation@justice.gsi.gov.uk)

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

**Laurence Fiddler  
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 under **the How to respond** section of this paper at page 30.

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