Publication withdrawn

The draft regulations were withdrawn in April 2024.

The Medical Certificate of Cause of Death Regulations 2024 were laid before Parliament on 15 April 2024.

Read more about death certification form and the introduction of medical examiners.

STATUTORY INSTRUMENTS

2024 No. 000

MEDICAL PROFESSION, ENGLAND AND WALES

CORONERS, ENGLAND AND WALES

The Medical Certificate of Cause of Death Regulations 2024

Made - - - -

Laid before Parliament

Coming into force - -

CONTENTS

SCHEDULES

The Secretary of State makes these Regulations in exercise of the powers conferred by sections 20(1)(a) to (k), (m) and (o), and 176(3) of the Coroners and Justice Act 2009(**a**).

In accordance with section 20(3) of the Coroners and Justice Act 2009, the Secretary of State has consulted the Welsh Ministers, the Registrar General and the Statistics Board in relation to the forms prescribed under section 20(1)(m) of that Act.

PART 1
General

Citation, commencement and extent

1.—(1) These Regulations may be cited as the Medical Certificate of Cause of Death Regulations 2024 and come into force on [X].

(2) These Regulations extend to England and Wales.

Interpretation and application

2.—(1) In these Regulations—

"the Act" means the Coroners and Justice Act 2009;

"attending practitioner" in relation to a death, means a registered medical practitioner(**b**) who attended the deceased before their death;

(**a**) 2009 c. 25.
(**b**) The definition of "registered medical practitioner" in Schedule 1 to the Interpretation Act 1978 (c.30) was substituted by S.I. 2002/3135, Schedule 1, paragraph 10 with effect from 16th November 2009, to mean "a fully registered person within the meaning of the Medical Act 1983 who holds a licence to practise under that Act".

"the appropriate medical examiner" means a medical examiner to whom the death has been allocated by an English NHS body or a Welsh NHS body, as the case may be;

"attending practitioner's certificate" means the certificate referred to in section 20(1)(a)(i) of the Act which shall take the form of—

(a) in the case of a death of a child dying within the period of 28 days beginning with the day of the child's birth, the certificate in the form set out in Schedule 1, and

(b) in the case of any other death, the certificate in the form set out in Schedule 2;

"confirmed attending practitioner's certificate" has the meaning set out in regulation 9(2);

"English NHS Body" has the meaning set out in section 18A(4) of the Act;

"health record" has the meaning given by section 1 of the Access to Health Records Act 1990 ("health record" and related expressions)(**a**);

"medical examiner's certificate" means the certificate referred to in section 20(1)(h)(i) of the Act which shall take the form of—

(a) in the case of a death of a child dying within the period of 28 days beginning with the day of the child's birth, the certificate in the form set out in Schedule 3, and

(b) in the case of any other death, the certificate in the form set out in Schedule 4;

"relevant health records", in relation to a death, means health records containing information about—

(a) any disease or condition which may have led directly or indirectly to the death, or

(b) any other disease or condition which may have significantly contributed to the death;

"relevant attending practitioner", in relation to a death, means the attending practitioner who has—

(a) prepared the attending practitioner's certificate under regulation 3(1)(b)(i), and

(b) given such certificate to the appropriate medical examiner under regulation 3(1)(c)(i);

"relevant senior coroner", in relation to a death, means the senior coroner appointed for the coroner area(**b**) in which the body of the deceased person is located at the time of death;

"Welsh NHS Body" has the meaning set out in section 18B(3) of the Act.

(2) These Regulations apply in relation to a death that is required to be registered under Part 2 of the 1953 Act(**c**) which occurs—

(a) after the coming into force of these Regulations; or

(b) before the coming into force of these Regulations where—

(i) the death has not been so registered,

(**a**) 1990 c. 23. Section 1 was amended by section 74(1) and (2) of, and Schedule 16 (repeals and revocations) to, the Data Protection Act 1998 (c. 29). There are other amendments but none are relevant.

(**b**) For the meaning of "coroner area", see section 48 of the Coroners and Justice Act 2009.

(**c**) Under section 48 of the Coroners and Justice Act 2009, "the 1953 Act" means the Births and Deaths Registration Act 1953 (c.20).

(ii) prior to the coming into force of these Regulations, a registered medical practitioner had not signed a certificate in the prescribed form in accordance with section 22(1) of the 1953 Act (registration of cause of death on receipt of medical certificate)(**a**) in relation to the death, and

(iii) a senior coroner is not under a duty to hold an inquest into the death under section 6 of the Act.

PART 2

Attending practitioner's certificate

Attending practitioner's certificate

3.—(1) An attending practitioner in relation to a death must, as soon as practicable after becoming aware of that death—

(a) review—

(i) the deceased person's relevant health records;

(ii) the results of any physical examination of the body of the deceased person undertaken by the practitioner or any other registered medical practitioner; and

(iii) any other information which the practitioner considers relevant,

with a view to establishing the cause of death to the best of the practitioner's knowledge and belief;

(b) either—

(i) prepare and sign an attending practitioner's certificate; or

(ii) where they are not able to establish the cause of death, refer the death to a relevant senior coroner; and

(c) where they have prepared and signed an attending practitioner's certificate, make available to an appropriate medical examiner—

(i) the attending practitioner's certificate; and

(ii) the deceased person's relevant health records and any other information considered under paragraph (1)(a).

(2) Paragraph (1) does not apply where—

(a) another attending practitioner has given an attending practitioner's certificate to an appropriate medical examiner in relation to the death;

(b) a relevant senior coroner has referred the death to an appropriate medical examiner under regulation 15(1); or

(c) a relevant senior coroner has decided there is a duty to conduct an investigation into the death under section 1 of the Act.

Attending practitioner's referral to a relevant senior coroner

4.—(1) If at that time there are exceptional circumstances to justify doing so, a referral under regulation 3(1)(b)(ii) may be made orally, but otherwise must be in writing.

(**a**) Section 22 was substituted by paragraph 14 of Schedule 21 to the Coroners and Justice Act 2009.

(2) An attending practitioner who makes a referral to a relevant senior coroner orally under paragraph (1) must, as soon as practicable afterwards, confirm in writing to the relevant senior coroner the information given orally.

(3) When making a referral under regulation 3(1)(b)(ii), or as soon as practicable thereafter, in addition to complying with the duties set out in regulation 2 of the Notification of Death Regulations 2019(**a**), the attending practitioner must provide to the relevant senior coroner any information referred to in regulation 3(1)(a) not already provided to the relevant senior coroner.

(4) Subject to paragraph (5), where a relevant senior coroner has—

(a) received a referral or notification of a death under any enactment; and

(b) decided there is no duty under section 1 of the Act to conduct an investigation in the death,

the relevant senior coroner must notify an attending practitioner of that decision and the reasons for it.

(5) Paragraph (4) does not apply to a referral to a relevant senior coroner under regulations 10(1) or 20(1).

(6) Where an attending practitioner receives a notification under paragraph (4), the practitioner must, as soon as practicable, comply with any duties of the practitioner under these regulations that had not been complied with prior to the referral or notification of the death to the relevant senior coroner.

Duties of medical examiner after receiving attending practitioner's certificate

5. Regulations 6 to 13 apply where an appropriate medical examiner is provided with an attending practitioner's certificate under regulation 3(1)(c)(i) or regulation 13(2)(b)(i) in relation to a death.

Medical examiner's scrutiny of cause of death

6.—(1) The appropriate medical examiner may undertake an external examination of the body of the deceased person, or, subject to paragraphs (4) to (7), instruct another individual to do so on their behalf, with a view to confirming the cause of death.

(2) The appropriate medical examiner must, as soon as practicable, with a view to confirming the cause of death—

(a) make whatever enquiries the examiner considers necessary;

(b) take into account any conclusions drawn from any enquiries made under sub-paragraph (a) and any information provided under regulations 3(1)(c) and 13(4); and

(c) take into account any other information which the examiner considers relevant.

(3) The appropriate medical examiner must make a record of any conclusions drawn from—

(a) any enquiries made under paragraph (2)(a); and

(b) taking into account the information referred to in paragraphs (2)(b) and (c).

(4) The appropriate medical examiner may only appoint another individual to undertake an external examination of the body of the deceased person for the purpose of paragraph (1) where—

(a) in the opinion of the examiner that individual has suitable expertise; and

(b) none of the circumstances in paragraph (5) apply.

(5) The circumstances are that the individual—

(**a**) S.I. 2019/1112.

(a) is the spouse, ex-spouse, civil partner or ex-civil partner of the deceased person ("D") or the relevant attending practitioner ("P");

(b) is, or was, living together with D or P as if they were a spouse or civil partner at any time during the period of 5 years ending with the death;

(c) is, or was at any time, closely related to D or P;

(d) is or had been a partner, employer, employee or associate of D or P;

(e) had attended D during the course of D's last illness;

(f) had a financial interest in D's estate; or

(g) has or had any other association, relationship or direct or indirect financial connection with D or P such as to give the appropriate medical examiner reasonable doubt as to the practitioner's objectivity to carry out an external examination of D.

(6) In paragraph (5), "closely related" means a parent, sister, half-sister, brother, half-brother, son, daughter, uncle, aunt, grandparent, grandchild, first cousin, nephew, niece, parent-in-law, grandchild-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepchild, step-parent, stepbrother or stepsister.

(7) In paragraph (6), references to step relationship and in-law are to be read in accordance with section 246 (interpretation of statutory references to stepchildren etc) of the Civil Partnership Act 2004(**a**).

Relevant attending practitioner to respond to medical examiner enquiries

7.—(1) The relevant attending practitioner must be available, as far as reasonably practicable, to respond to any enquiries that the appropriate medical examiner may have in connection with the attending practitioner's certificate.

(2) The appropriate medical examiner must make a record of—

(a) the relevant attending practitioner's response to any enquiries made under paragraph (1); and

(b) any discussions that take place between the examiner and the relevant attending practitioner in relation to the attending practitioner's certificate.

Medical examiner's duty to discuss the cause of death

8.—(1) The appropriate medical examiner, or someone acting on behalf of the examiner, must—

(a) take reasonable steps to discuss the cause of death with a person who is qualified to give information concerning the death under sections 16(2) or 17(2) of the 1953 Act or any other person whom the examiner considers appropriate;

(b) offer a person mentioned in sub-paragraph (a) an opportunity to raise any matter which might cause a relevant senior coroner to think that there is a duty to investigate the death under section 1 of the Act; and

(c) make a summary record of any discussion under sub-paragraphs (a) or (b) and its outcome.

(2) Paragraph (1) does not apply where, in the case of a death for which a revised attending practitioner's certificate has been completed under regulation 13(2)(a), the appropriate medical examiner or someone acting on their behalf has previously complied with the requirements of paragraph (1) in relation to the death.

(**a**) 2004 c. 33.

Medical examiner's confirmation of cause of death

9.—(1) Paragraph (2) applies where, after complying with regulations 6 and 8 in relation to a death, the appropriate medical examiner is satisfied that—

(a) the cause of death stated on the attending practitioner's certificate relating to the death is correct; and

(b) that certificate is duly completed.

(2) The appropriate medical examiner must, as soon as practicable, confirm the cause of death as stated on the attending practitioner's certificate by signing that certificate ("the confirmed attending practitioner's certificate").

Medical examiner's referral to a relevant senior coroner

10.—(1) The appropriate medical examiner must, as soon as practicable, refer the death to the relevant senior coroner where—

(a) after complying with regulations 6 and 8 in relation to the death, the appropriate medical examiner is unable to confirm the cause of death; or

(b) in the course of complying with regulations 6 and 8 in relation to the death, the appropriate medical examiner forms the opinion that the duty to notify a relevant senior coroner arises under regulation 2 of the Notification of Death Regulations 2019.

(2) If at that time there are exceptional circumstances to justify doing so, a referral under paragraph (1) may be made orally but otherwise must be in writing.

(3) An appropriate medical examiner who notifies a relevant senior coroner orally under paragraph (2) must, as soon as practicable afterwards, confirm in writing to the relevant senior coroner the information given orally.

(4) When making a referral under paragraph (1), or as soon as practicable thereafter, in addition to complying with the duties set out in regulation 2 of the Notification of Death Regulations 2019, the appropriate medical examiner must provide the following information to the relevant senior coroner in relation to the death—

(a) the information provided under regulation 3(1)(c)(ii) in relation to the death;

(b) any record made under regulation 7(2);

(c) any record made under regulation 8(1)(c); and

(d) any other information the medical examiner considers appropriate,

except where that information has already been provided to the relevant senior coroner.

(5) Where, after receiving a referral under paragraph (1), the relevant senior coroner decides that there is a duty to conduct an investigation into the death under section 1 of the Act—

(a) the relevant senior coroner must notify the appropriate medical examiner of that decision; and

(b) the appropriate medical examiner must notify the relevant attending practitioner of that notification.

(6) Where, after receiving a referral under paragraph (1), the relevant senior coroner decides that there is no duty to conduct an investigation into the death under section 1 of the Act, the relevant senior coroner must—

(a) notify an appropriate medical examiner of that decision and the reasons for it; and

(b) provide the examiner with a copy of any information relied upon in making that decision, except where that information was provided under paragraph (4).

(7) After receiving a notification under paragraph (6), the appropriate medical examiner must—

(a) notify an attending practitioner of the relevant senior coroner's decision and reasons for it; and

(b) make available to the attending practitioner any information provided under paragraph (6)(b).

(8) Where an appropriate medical examiner notifies an attending practitioner under paragraph (7), an attending practitioner and an appropriate medical examiner must comply with any duties under these regulations in relation to the death that had not been complied with prior to the referral to the relevant senior coroner under paragraph (1).

Confirmed attending practitioner's certificate to be given to registrar

11.—(1) The appropriate medical examiner must, without unreasonable delay after confirming the cause of death under regulation 9(2), notify a registrar that the cause of death has been confirmed by giving the confirmed attending practitioner's certificate to the registrar.

(2) After complying with the duty in paragraph (1), the appropriate medical examiner must, without unreasonable delay, take reasonable steps to ensure that a person referred to in regulation 8(1)(a) is aware that the confirmed attending practitioner's certificate has been given to the registrar.

Invitation to attending practitioner to issue a revised attending practitioner's certificate

12.—(1) Where an informant(**a**) provides the registrar with information which leads that registrar to believe that the cause of death stated on the confirmed attending practitioner's certificate may need to be revised, the registrar must consult an appropriate medical examiner as to any such revision.

(2) After consultation with the registrar in accordance with paragraph (1), the appropriate medical examiner must either—

(a) make available to an attending practitioner the information provided under paragraph (1), invite the attending practitioner to revise the attending practitioner's certificate and inform the registrar of the invitation to revise; or

(b) inform the registrar of the examiner's reasons not to invite the attending practitioner to revise the attending practitioner's certificate.

Revised attending practitioner's certificate

13.—(1) Where an attending practitioner has been invited to revise the attending practitioner's certificate under regulation 12, the attending practitioner must, as soon as practicable, review—

(a) the deceased person's relevant health records;

(b) the results of any physical examination of the body of the deceased person undertaken by the practitioner or any other registered medical practitioner;

(c) any information provided under regulation 12(2)(a); and

(d) any other information which the practitioner considers relevant,

with a view to establishing the cause of death to the best of the practitioner's knowledge and belief.

(2) Where the attending practitioner agrees to revise the attending practitioner's certificate, the attending practitioner must, as soon as practicable—

(**a**) "Informant" is defined in section 20(7) of the Coroners and Justice Act 2009 as, in relation to a death, "the person who gave particulars concerning the death to the registrar under section 16 or 17 of the 1953 Act".

(a) revise the attending practitioner's certificate; and

(b) make available to an appropriate medical examiner—

(i) the revised attending practitioner's certificate;

(ii) any information considered under paragraph (1) that has not already been provided to the examiner; and

(iii) any other information relevant to establishing the cause of death, except where that information was provided under regulation 3(1)(c).

(3) Paragraphs (4) to (6) apply where, after fulfilling the duties in paragraph (1), the attending practitioner does not agree to revise the attending practitioner's certificate in relation to a death.

(4) The attending practitioner must, as soon as practicable, make available to an appropriate medical examiner—

(a) the attending practitioner's certificate;

(b) any information considered under paragraph (1)(b);

(c) any other information relevant to establishing the cause of death, except where that information was provided under regulation 3(1)(c); and

(d) the attending practitioner's reasons for declining to revise the attending practitioner's certificate.

(5) The appropriate medical examiner must, as soon as practicable—

(a) review the information provided under paragraph (4);

(b) comply with the duties set out in regulations 6 to 8 afresh, to the extent that the examiner considers appropriate; and

(c) comply with the duties set out in regulations 9 to 11 afresh.

(6) When complying with regulation 11 pursuant to paragraph (5)(c), the appropriate medical examiner must inform the registrar of—

(a) the attending practitioner's decision not to revise the attending practitioner's certificate and the reasons for that decision; and

(b) any other information the examiner considers relevant.

Attending practitioner's availability to fulfil duties

14. Where an attending practitioner is unable to carry out any duties imposed on the practitioner under this Part within a reasonable time, another attending practitioner in relation to that death must carry out those duties.

PART 3

Medical examiner's certificate

Relevant senior coroner referral to a medical examiner

15.—(1) Where a relevant senior coroner is notified of a person's death under regulation 2 of the Notification of Deaths Regulations 2019 because the circumstances described in regulation 3(1)(e) or (f) of those Regulations apply, the relevant senior coroner must refer that death to an appropriate medical examiner.

(2) Paragraph (1) does not apply where a relevant senior coroner has decided there is a duty to conduct an investigation into the death under section 1 of the Act.

(3) In making a referral under paragraph (1), the relevant senior coroner must make available to the appropriate medical examiner the reasons for the referral and a copy of any information relied upon in making it.

Duties of medical examiner after receiving referral from relevant senior coroner

16. Regulations 17 to 23 apply where a death is referred by a relevant senior coroner to an appropriate medical examiner under regulation 15(1).

Referral by relevant senior coroner: medical examiner's duties

17.—(1) The appropriate medical examiner may undertake an external examination of the body of the deceased person, or, subject to paragraphs (4) to (7), instruct another individual to do so on their behalf, with a view to establishing the cause of death to the best of their knowledge and belief.

(2) The appropriate medical examiner must, as soon as practicable and with a view to establishing the cause of death to the best of the examiner's knowledge and belief—

(a) review the deceased person's relevant health records;

(b) make whatever enquiries the examiner considers necessary; and

(c) take into account any information—

(i) provided under regulation 15(3), and

(ii) which the examiner considers relevant.

(3) The appropriate medical examiner must make a record of any conclusions drawn from taking into account the information referred to in paragraph (2).

(4) The appropriate medical examiner may only appoint another individual to undertake an external examination of the body of the deceased person for the purpose of paragraph (1) where—

(a) in the opinion of the examiner, the individual has suitable expertise; and

(b) none of the circumstances in paragraph (5) apply.

(5) The circumstances are that the individual—

(a) is the spouse, ex-spouse, civil partner or ex-civil partner of the deceased person ("D");

(b) is, or was, living together with D as if they were a spouse or civil partner at any time during the period of 5 years ending with the death;

(c) is, or was at any time, closely related to D;

(d) had attended D during the course of D's last illness;

(e) is or had been a partner, employer, employee or associate of D;

(f) had a financial interest in D's estate; or

(g) has or had any other association, relationship or direct or indirect financial connection with D such as to give the appropriate medical examiner reasonable doubt as to the individual's objectivity to carry out an external examination of D.

(6) In paragraph (5), "closely related" means a parent, sister, half-sister, brother, half-brother, son, daughter, uncle, aunt, grandparent, grandchild, first cousin, nephew, niece, parent-in-law, grandchild-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepchild, step-parent, stepbrother or stepsister.

(7) In paragraph (7), references to step relationship and in-law are to be read in accordance with section 246 (interpretation of statutory references to stepchildren etc) of the Civil Partnership Act 2004.

Medical examiner's duty to discuss the cause of death

18. The appropriate medical examiner, or someone acting on behalf of the examiner, must—

(a) take reasonable steps to discuss the cause of death with a person who is qualified to give information concerning the death under sections 16(2) or 17(2) of the 1953 Act or any other person whom the examiner considers appropriate;

(b) offer a person mentioned in paragraph (a) an opportunity to raise any matter which might cause a relevant senior coroner to consider that there is a duty to investigate the death under section 1 of the Act; and

(c) make a summary record of any discussion pursuant to paragraph (a) or (b) and its outcome.

Preparation of medical examiner's certificate

19. Subject to regulation 20(1), the appropriate medical examiner must, as soon as practicable after complying with regulations 17 and 18 in relation to a death, prepare and sign a medical examiner's certificate.

Medical examiner's referral back to a relevant senior coroner

20.—(1) The appropriate medical examiner must, as soon as practicable after complying with regulations 17 and 18 in relation to a death, refer the death back to a relevant senior coroner where the examiner—

(a) is unable to establish the cause of death to the best of the examiner's knowledge and belief; or

(b) forms the opinion that the duty to notify a relevant senior coroner arises under regulation 2 of the Notification of Death Regulations 2019.

(2) If at that time there are exceptional circumstances to justify doing so, a referral under paragraph (1) may be made orally but otherwise must be in writing.

(3) An appropriate medical examiner who refers a death back to a relevant senior coroner orally under paragraph (2) must, as soon as practicable afterwards, confirm in writing to the relevant senior coroner the information given orally.

(4) When making a referral under paragraph (1), or as soon as practicable thereafter, in addition to complying with the duties set out in regulation 2 of the Notification of Death Regulations 2019, the appropriate medical examiner must provide the following information to the relevant senior coroner—

(a) the deceased person's relevant health records and any other information that was considered under regulation 17(2);

(b) the record made under regulation 17(3);

(c) any record made under regulation 18(c); and

(d) any other information the medical examiner considers appropriate,

except where that information has already been provided to the relevant senior coroner.

(5) Where, after receiving a referral under paragraph (1), the relevant senior coroner decides that there is a duty to conduct an investigation into the death under section 1 of the Act, the relevant senior coroner must notify the appropriate medical examiner of that decision.

(6) Where a relevant senior coroner has received a referral under paragraph (1) and decided that there is no duty to conduct an investigation into the death under section 1 of the Act, the relevant senior coroner must—

(a) notify the appropriate medical examiner of that decision and the reasons for it; and

(b) provide the examiner with a copy of any information relied upon in making that decision, except where that information was provided under paragraph (4).

(7) After receiving a notification under paragraph (6), the appropriate medical examiner must comply with any duties of the examiner under regulations 17 to 19 and this regulation in relation to the death that had not been complied with prior to the referral to the relevant senior coroner under paragraph (1).

Medical examiner's certificate to be given to a registrar

21.—(1) The appropriate medical examiner must, without unreasonable delay after preparing and signing a medical examiner's certificate under regulation 19, notify a registrar that a certificate has been prepared by giving the medical examiner's certificate to the registrar.

(2) The appropriate medical examiner must, without unreasonable delay, take reasonable steps to ensure that a person mentioned in regulation 18(a) is aware that the medical examiner's certificate has been given to the registrar in accordance with paragraph (1).

Registrar's invitation to medical examiner to issue a revised medical examiner's certificate

22. Where an informant provides the registrar with information which leads the registrar to believe that the cause of death stated on a medical examiner's certificate may need to be revised, the registrar must provide that information to the appropriate medical examiner and invite the examiner to revise the medical examiner's certificate.

Revised medical examiner's certificate

23.—(1) Where an appropriate medical examiner has been invited to revise the medical examiner's certificate under regulation 22, the examiner must, as soon as practicable and to the extent they consider appropriate, review—

(a) the deceased person's relevant health records;

(b) any information provided under regulation 22; and

(c) any other information which the examiner considers relevant,

with a view to establishing the cause of death to the best of the examiner's knowledge and belief.

(2) Where the appropriate medical examiner agrees to revise the medical examiner's certificate, the examiner must, as soon as practicable—

(a) comply with the duties set out in regulation 18 afresh, to the extent that the examiner considers appropriate;

(b) comply with the duties set out in regulations 19, 20 and 21(1) afresh; and

(c) without unreasonable delay, take reasonable steps to ensure that the informant is aware of the re-issuing of the certificate to the registrar under regulation 21(1).

(3) Where the appropriate medical examiner does not agree to revise the medical examiner's certificate, the examiner must either—

(a) inform the registrar of their decision not to revise the certificate and the reasons for it; or

(b) make a referral to a relevant senior coroner under regulation 20.

PART 4

Miscellaneous provisions

Manner of providing documents

24.—(1) In these Regulations any requirement to—

(a) give an attending practitioner's certificate or a medical examiner's certificate or other document to a person may be satisfied by causing that certificate or document to be given by an electronic communication; and

(b) sign an attending practitioner's certificate or medical examiner's certificate may be satisfied by providing an electronic signature but only where the certificate to be signed is also in electronic form.

(2) In this regulation—

(a) "electronic communication" has the meaning given in section 15(1) of the Electronic Communications Act 2000(**a**);

(b) "electronic signature" has the meaning given in section 7(2) of that Act(**b**).

Availability of certificates and forms

25. The Secretary of State must—

(a) make the certificates set out in Schedules 1 and 2 available to registered medical practitioners; and

(b) make the certificates and forms set out in Schedules 3 and 4 available to medical examiners.

PART 5

Consequential amendments

Amendments to the Notification of Death Regulations 2019

26.—(1) The Notification of Death Regulations 2019 are amended as follows.

(2) In regulation 2 (duty to notify a relevant senior coroner of a death), for paragraph (2), substitute—

"(2) But the duty in paragraph (1) does not apply if the registered medical practitioner reasonably believes that—

(a) the relevant senior coroner has already been notified of the death under these Regulations; or

(b) a referral has been made to the relevant senior coroner under regulations made under section 20(1) of the Coroners and Justice Act 2009."

(3) In regulation 3 (circumstances in which the duty to notify arises)—

(a) in paragraph (1), in each place it occurs, for "attending medical practitioner" substitute "attending practitioner"; and

(b) in paragraph (2)—

(**a**) 2000 c. 7; the definition of "electronic communication" was amended by the Communication Act 2003 (c. 21), Schedule 17, paragraph 158.

(**b**) Section 7 was amended by S.I. 2016/696, Schedule 3, paragraph 1.

(i) for the definition "attending medical practitioner", insert ""attending practitioner" means a registered medical practitioner required under regulations made under section 20(1) of the Coroners and Justice Act 2009 to prepare a certificate of cause of death in relation to a deceased person"; and

(ii) in the definition of "certificate of the cause of death" for "section 22(1) of the Births and Deaths Registration Act 1953" substitute "regulations made under section 20(1) of the Coroners and Justice Act 2009".

Signed by authority of the Secretary of State for Health and Social Care

Name
Minister of State
Department of Health and Social Care

SCHEDULES

SCHEDULE 1

Regulation 3

Attending practitioner's certificate – live-born child dying within the first 28 days of life

[Insert form]

SCHEDULE 2

Regulation 3

Attending practitioner's certificate – other cases

[Insert form]

SCHEDULE 3

Regulation 18

Medical examiner's certificate – live-born child dying within the first 28 days of life

SCHEDULE 4

Regulation 18

Medical examiner's certificate – other cases.

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations make provision for the certification of deaths in England and Wales by attending practitioners and medical examiners. They apply to deaths occurring before the coming into force of these Regulations where a medical certificate of death has not been signed and a senior coroner is not under a duty to hold an inquest into the death, and deaths occurring after the coming into force of these Regulations.

Part 2 of these Regulations makes provision for the completion and confirmation of an attending practitioner's certificate in relation to a death.

Regulation 3 requires an attending practitioner to complete an attending practitioner's certificate stating the cause of death, or alternatively to refer the death to a relevant senior coroner in specified circumstances.

Regulation 4 sets out the obligations of attending practitioners and relevant senior coroners where a case has been referred by an attending practitioner to a senior coroner, and the process for making such a referral.

Regulation 6 requires the appropriate medical examiner to make appropriate enquiries and take into account specified information with a view to confirming the cause of death.

Regulation 7 requires the relevant attending practitioner to be available to respond to any enquiries that the appropriate medical examiner might have in connection to the attending practitioner's certificate, and that the appropriate medical examiner must make a record of any response to such enquiries.

Regulation 8 requires the appropriate medical examiner (or someone acting on their behalf) to discuss the cause of death with the prospective informant or such other person as considered appropriate.

Regulation 9 requires the appropriate medical examiner to confirm the cause of death by signing the attending practitioner's certificate once they are satisfied that the specified conditions have been met. In the alternative, regulation 10 requires the appropriate medical examiner to refer the death to the relevant senior coroner in specified cases, and sets out the requirements of appropriate medical examiners and relevant senior coroners following such a referral.

Regulation 11 requires that, where an appropriate medical examiner is able to confirm the cause of death stated on the attending practitioner's certificate, that without unreasonable delay the confirmed attending practitioner's certificate is given to the registrar and that reasonable steps are taken to notify a prospective informant that they have done so.

Regulation 12 provides that a registrar must consult with an appropriate medical examiner where an informant provides the registrar with such information which leads that registrar to believe that the cause of death stated on the confirmed attending practitioner's certificate may need to be revised. The appropriate medical examiner may invite an attending practitioner to revise the attending practitioner's certificate.

Regulation 13 sets out the requirements on attending practitioners and appropriate medical examiners where the appropriate medical examiner has invited the attending practitioner to revise the attending practitioner's certificate.

Regulation 14 provides that another attending practitioner must carry out any duties imposed under Part 2 where the attending practitioner is unable to do so within a reasonable time.

Part 3 of these Regulations makes provision for the completion of a medical examiner's certificate in relation to a death.

Regulation 15 requires a senior coroner to refer a death to the appropriate medical examiner in certain cases.

Regulation 17 requires a medical examiner, upon receipt of a referral made under regulation 15, to complete a medical examiner's certificate stating the cause of death, or alternatively to refer the death to a relevant senior coroner in specified circumstances.

Regulation 18 requires the appropriate medical examiner to discuss the cause of death with the prospective informant or such other person as considered appropriate.

Regulation 19 requires the appropriate medical examiner to issue a medical examiner's certificate where the appropriate medical examiner is able to establish a cause of death. In the alternative, regulation 20 requires the appropriate medical examiner to refer the death back to the relevant senior coroner in specified cases, and sets out the requirements on appropriate medical examiners and senior coroners following such a referral.

Regulation 20 sets out the obligations of appropriate medical examiners and relevant senior coroners where a case has been referred by an appropriate medical examiner back to a senior coroner, and the process for making such a referral.

Regulation 21 requires that, where an appropriate medical examiner has issued a medical examiner's certificate under regulation 19, that without unreasonable delay the certificate is given to the registrar and that reasonable steps are taken to notify a prospective informant that they have done so.

Regulation 22 provides for a registrar to invite an appropriate medical examiner to prepare a fresh medical examiner's certificate where an informant provides the registrar with such information which leads that registrar to believe that the cause of death stated on the confirmed attending practitioner's certificate may need to be revised..

Regulation 23 sets out the requirements on appropriate medical examiners where the registrar has invited the appropriate medical examiner to revise the medical examiner's certificate.

Part 4 of the Regulations makes various miscellaneous provisions regarding the electronic sending or completion of documents (regulation 24) and the availability of certificates and forms (regulation 25).

Part 5 of the Regulations sets out various consequential amendments to regulations 2 and 3 of the Notification of Death Regulations 2019.

A full impact assessment of the effect that this instrument will have on the costs of business, the voluntary sector and the public sector is available from [x].