Death Certification Reforms in England and Wales

Update for Coroners

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Document Purpose	For Information
Gateway Reference	18125
Title	Death Certification Reforms in England and Wales - Update for Coroners
Author	Department of Health
Publication Date	**25 September 2012**
Target Audience	Coroners
Circulation List	
Description	This update has been prepared for coroners in response to frequently asked questions raised by coroners about the proposed reforms to the death certification process due for implementation in April 2014.
Cross Ref	N/A
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
Contact Details	Death Certification Programme Team deathcertification@dh.gsi.gov.uk
For Recipient's Use	

First published September 2012
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

Death Certification Reforms in England and Wales

Update for Coroners

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September 2012

Contents

INTRODUCTION

This update has been prepared for coroners to respond to frequently asked questions. It may also be of interest to other services and groups. Annex A includes a 2-page summary of changes resulting from the reforms. An extended version of the update with 20+ pages of supporting notes is available if it is required. All content is subject to review and consultation.

Questions answered by the update:

1. What are the aims of the reforms?
2. How will medical examiners achieve these aims?
3. How will the new process impact coroners and their officers and staff?
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1. WHAT ARE THE AIMS OF THE REFORMS?

The death certification reforms are intended to:

- **Increase safeguards for the public** by providing robust and independent scrutiny of the medical circumstances and cause of deaths and ensuring that the right deaths are notified or referred to a coroner;
- **Improve the quality of certification** by providing expert advice to doctors based on a review of relevant health records; and
- **Avoid unnecessary distress for the bereaved** resulting from unanswered questions about the certified cause of apparently natural deaths or from unexpected delays when registering a death.

The reforms will replace and extend current arrangements for completion of cremation forms 4, 5 and 10 which, despite their improvement in 2009, are often seen as an administrative requirement rather than as a necessary safeguard and as an supplementary check rather than an integral part of the death certification process.

2. HOW WILL MEDICAL EXAMINERS ACHIEVE THESE AIMS?

The aims of the reforms will be achieved through the appointment of medical examiners by upper-tier local authorities in England and local health boards in Wales, the creation of local medical examiner's services and the introduction of a unified process of certification that includes the 5 steps outlined below. These steps are part of the wider process illustrated in the flowchart on the next page.

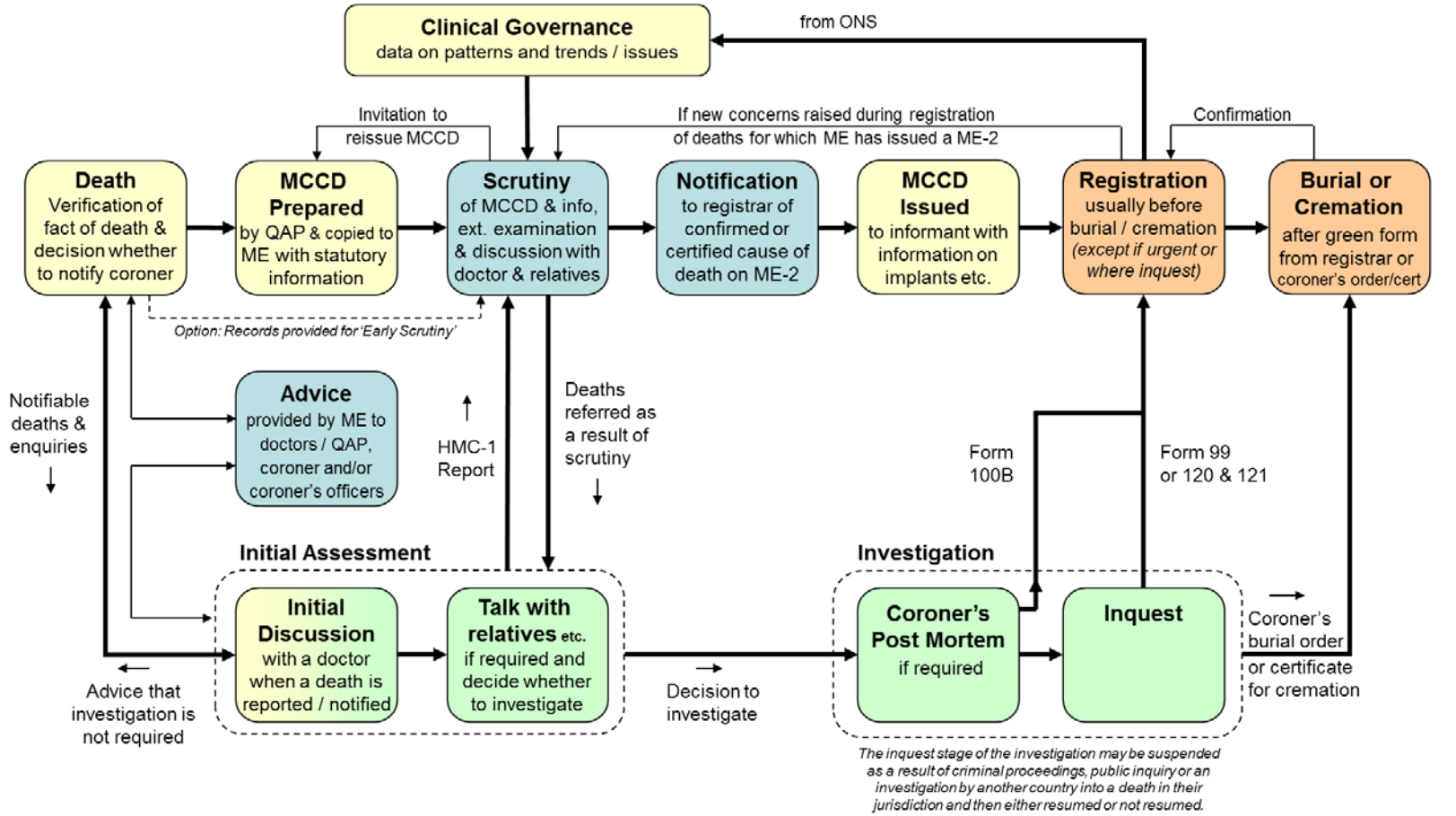
- **Provide advice to qualified attending practitioners** for apparently natural deaths where the cause is partly known. This will relieve coroner's officers and hospital bereavement officers of a responsibility that, in many cases, is based on experience rather than medical expertise and on unsubstantiated discussion rather than a review of records.
- **Carry out an independent scrutiny** of the medical circumstances and cause of apparently natural deaths to ensure that the right deaths are notified or referred to a coroner. Scrutiny comprises the five activities described in Annex B and, in most cases, includes a thorough but non-forensic external examination of the deceased person's body.
- **Discuss the death with a relative of the deceased person** (or with another appropriate person) to offer an opportunity for them to ask questions about the medical circumstances and cause of a death and to raise any concerns that might require a fresh MCCD to be prepared or the death notified to a coroner.
- **Provide general medical advice to coroners**, if requested in relation to specific cases, to assist with the coroner's decision on whether to conduct an investigation.
- **Confirm the medical cause of all deaths not investigated by a coroner** and provide a statutory notification to this effect to a registrar.

All activities carried out by or on behalf of a medical examiner need to be completed in accordance with standards and procedures set out in guidance published by the National Medical Examiner. Some activities can be delegated to officers and other people with suitable expertise and sufficient independence; however, where this is the case, accountability will remain with the medical examiner.

Regulations and guidance will require medical examiners to make clear and complete records for all activities (or ensure these are made) to:

- Provide relevant information to coroners for any death notified or referred after scrutiny.
- Identify local trends and patterns for use in scrutiny of other cases.
- Provide reports to local authorities / health boards to allow them to monitor performance against service standards.
- Enable medical examiners to conduct self-audits and peer -reviews to assess compliance with quality standards.

Overview of Process for Death Certification *(from April 2014)*



Key:

Process step(s) carried out by:	Doctors, clinicians & other healthcare staff	Medical Examiner's Service	Coroners and their officers and staff	Registrars, funeral directors & cemetery / crematorium staff

Abbreviations & Notes: QAP = Qualified attending practitioner. ME = Medical examiner. Statutory information required with the copy of the MCCD may be documented in records. External examination may be delegated in certain conditions. The HMC-1 Report is issued by a coroner for deaths that have been reported, notified or referred but do not need to be investigated.

Draft v013a (18-Jun-12)

3. HOW WILL THE NEW PROCESS IMPACT CORONERS AND THEIR OFFICERS AND STAFF?

It is anticipated that the new process will change the national average caseload of reported deaths and investigations (i.e. post-mortem examinations and inquests) as shown below. These changes, which are likely to take 2-3 years to settle out, are based on feedback from the death certification pilots and validated by a detailed study carried out in Sheffield. The changes are a logical outcome of reforms which are intended to ensure that the right deaths are reported to a coroner and to increase safeguards for the public.

- 20 – 25% **decrease** in deaths reported to a coroner
- 15 – 20% **increase** in deaths investigated by a coroner

The increase in investigations is based on a 2 – 10% increase in the number of post-mortem examinations leading to the issue of a coroner's 100B form and an increase of around 35% in the number of inquests. Since a post-mortem examination is required in all 100B cases and in 90% of inquests, the overall increase in the number of post-mortem examinations is likely to be comparable with the increase in investigations.

Using national averages reported in Coroners Statistics for 2011: reported deaths would decrease from 46% of registered deaths to around 35%; and investigations would increase from 20% of registered deaths to around 24%. On these figures, investigations as a proportion of reported deaths would increase from 43% to 68%.

The changes in caseload noted above are national averages and are likely to differ in each area depending on its current baselines and local factors. It is also noted that the decrease in number of deaths reported to a coroner is unlikely to lead to a similar reduction in workload because many of the cases that will no longer be reported by doctors will be those that would have required relatively little time for initial assessment. The overall impact on workload for coroners and their officers and staff will need to be assessed separately in each area over a period of 2-3 years.

Medical examiners will not investigate any death because 'investigation' is and remains the function and prerogative of the coroner. Medical examiners will also need to comply with the Death Notification Regulations and associated guidance in the same way as any other registered medical practitioner.

It is anticipated that the medical examiner's statutory duty to notify or refer deaths to a coroner will be underpinned by guidance published by the National Medical Examiner that medical examiners are expected to talk with coroners (directly or via their officers) about any death where there is an unusual interplay of circumstance and medical factors. These discussions, which initial estimates suggest may be necessary in 5% of registered deaths, would ensure that medical examiners do not decide for themselves what is considered trivial or negligible or ignore possible 'Touche-type' cases. The nature and extent of these discussions will depend on the ability of coroners and medical examiners to establish close collaboration between their services and to develop the mutual trust and respect that is essential for the system to work effectively.

4. WHEN WILL THE REFORMS TAKE EFFECT?

The reforms are now expected to be implemented in **April 2014** following the activities outlined below. *[The dates are provisional and subject to review and change]*

October 2012 → December 2012	**Publish consultation** on draft regulations and carry out associated communication activities.
November 2012 → May 2013	**[Establish and brief an 8-10 person national / regional implementation support team and] prepare guidance and other materials** to facilitate implementation. Confirm that upper-tier local authorities / local health boards have nominated a senior manager to lead configuration, planning and preparation for implementation of an individual, joint or regional local medical examiner's service and invite these people to attend a briefing just prior to introduction of the regulations.
May 2013 → June 2013	**Lay updated regulations** and introduce them (with a commencement date of April 2014) after completion of Parliamentary procedures.
May 2013 → August 2013	Work by nominated leads to **configure local medical examiner's services,** initiate any commissioning arrangements and to invite expressions of interest in roles as a medical examiner / medical examiner's officer (directly or via a commissioned route) and arrange for applicants to have access to eLearning materials.
August 2013 → October 2013	Nominated leads to co-ordinate **local appointment of a lead medical examiner and lead medical examiner for each service area**. These people would need to be able take up their role from late 2013 / early 2014 to assist with local planning and preparation.
October 2013 → January 2014	**Complete appointment of all medical examiners and officers** and / or any associated commissioning arrangements. Also complete all local planning and preparation so that office facilities are available and local briefings / training sessions are scheduled.
January 2014 → March 2014	**Provide local briefings / training** and local support to ensure doctors and all related services are ready to implement the new process. **Establish local medical examiner's offices** from early March 2014 and use 'retrospective scrutiny' to get the process working alongside existing legislation.
April 2014	**Commence regulations and implement new process** moving from 'retrospective scrutiny' to 'real-time scrutiny'.

Existing pilot areas and self-funded early-adopters will continue to provide advice and scrutiny for apparently natural deaths **to the extent that it is practicable to do so alongside existing legislation**.

5. WHO IS RESPONSIBLE FOR IMPLEMENTING THE REFORMS?

Upper-tier local authorities in England and local health boards in Wales will be responsible for establishing an individual, joint or regional medical examiner's service to provide advice and scrutiny for apparently natural deaths in their area. Where a joint or regional service is established, it would be the responsibility of a lead authority or board.

In practical terms, the chief executive of each (lead) authority or board will want to nominate a senior manager to configure the service and take responsibility for planning and preparation. Whilst this nomination is entirely a local matter, the DH Death Certification Programme has recommended that the nominee has working knowledge of and / or close links with the local authority coroner and registration service (with which the medical examiner's service is closely aligned) or with the public health function. In any event, the nominee will almost certainly need to work closely with representatives from all three of these services and from other services and local organisations impacted by the reforms. It is anticipated that in many areas the nominee would **consult the relevant senior coroner(s)** and, if the coroner wishes to be involved, invite him or her to participate in a local steering group providing executive-level oversight for the work.

Where a medical examiner's service is commissioned rather than provided by a (lead) authority or board, the organisation that is commissioned will need to have appropriate governance arrangements to ensure that its medical examiners and their officers can act with sufficient independence.

As indicated in the outline timetable on page 10, the nominated managers would be invited to attend a regional / national briefing session just before the regulations are introduced so that they are able to start configuration without delay once the regulations are in place.

6. WHAT AREA WILL EACH MEDICAL EXAMINER SERVICE ENCOMPASS?

Each upper-tier local authority in England and local health board in Wales will need to decide whether to establish its own local medical examiner's service or to establish a joint or regional medical examiner's service in collaboration with one or more adjacent authorities or boards.

There will be no requirement for upper-tier local authorities or local health boards to collaborate with each other; however, national assumptions are currently based on each area providing advice and scrutiny for between 5,000 and 5,500 deaths each year with an average of 2,100 at each office. On these figures, there are likely to be approximately 80 separate medical examiner's service areas with an average of 2-3 offices each.

It may be appropriate for some medical examiner's service areas to be co-terminous with one or more coroners' districts; however, this would be easier in areas where coroners' districts are co-terminous with the whole of one or more upper-tier authority / health board area.

7. WHO WILL BE THE MEDICAL EXAMINERS?

The Coroners and Justice Act 2009 sets the minimum requirement that, at the time of their appointment, all medical examiners must have been a registered medical practitioner for at least five years and either be in practice or have practised during the last five years.

Regulations will add that a medical examiner's appointment must be terminated if the examiner ceases to be a registered medical practitioner or if the appointing authority / board conclude, after due process, that the examiner is not meeting the standards and expected levels of performance set out in guidance published by the National Medical Examiner.

Regulations will also specify that:

- Medical examiners must have completed prescribed **training** before taking up their appointment
- Medical examiners must be sufficiently **independent** of any death for which they provide advice or scrutiny.

The regulatory requirement for independence is underpinned by section 19(5) of the Act which prohibits local authorities or local health boards from taking any role in relation to the way that medical examiners exercise their professional judgement as medical practitioners – in other words, from having any influence on whether a medical examiner confirms or certifies a particular cause of death. The regulatory requirement for independence will also be reinforced by standards that require medical examiners to provide advice and scrutiny in an impartial way, to make reasonable enquiries where these are necessary, make their own decision on whether to confirm or certify any particular cause of death and ensure that the reasons for their decisions are clearly documented.

Medical examiners can come from any medical speciality or from general practice and include doctors who have recently retired from practice.

Guidance will advise that medical examiners should be (or have been) consultant grade doctors in hospitals [and hospices] or their equivalent in general practice. This advice is based on feedback from the death certification pilots that there is a significant risk to effective delivery of the service unless all medical examiners have the seniority, experience and credibility to provide advice to senior medical colleagues and to coroners on a peer-to-peer basis.

Guidance will also provide a recommended job-specification and person specification. It is strongly recommended that these are used by local authorities / local health boards to achieve consistency across England and Wales and, critically, to ensure that medical examiners have the right vision, expertise, experience, credibility, pragmatism as well as excellent communication skills.

Given the importance of the medical examiner's service working in close collaboration with the local coroner's service and other related services, it is anticipated that most local authorities / health boards will choose to invite coroners, superintendent registrars, local directors of public health and medical directors of local NHS Trusts to participate in a properly constituted local appointments panel for medical examiners in their area.

8. WHO WILL BE THE MEDICAL EXAMINER'S OFFICERS AND WHAT WILL THEY DO?

The medical examiner's officer (MEO) function must be provided by people who have **suitable expertise and sufficient independence** to enable medical examiners to confidently delegate responsibility for the activities outlined below. These people may be employed or contracted in substantive posts as an MEO or provide the MEO function alongside, or as an integrated part of, work for another (probably related) service.

The related services that are most likely to be able to provide the MEO function are centralised bereavement services in hospitals and hospices (for deaths that occur in large acute hospitals) and coroner's services (for deaths in other care settings) ; however this would inevitably require the recruitment of additional staff.

The term "MEOs etc." is used below to refer to people in substantive posts as MEOs and people providing the MEO function alongside or as part of other work.

MEOs etc. will receive and collate information required for scrutiny by a medical examiner, co-ordinate the work of a medical examiner's office and **use information documented by medical examiners** to:

- Make enquiries to obtain additional information about a particular death or about local trends, unusual patterns or clinical governance issues that might provide contextual information relevant to the death.
- Provide advice to qualified attending practitioners about the practitioners' preliminary view of a cause of death (if one has been formed) or discuss a certified cause of death.
- Discuss a death with relatives or other appropriate people to offer them an opportunity to ask questions about the certified cause of death or to raise concerns about the circumstances or cause of the death that might require a fresh certificate to be prepared or for the death to be notified or referred to a coroner.
- Where necessary, discuss deaths with a coroner's officer and / or formally notify or refer a death to a coroner.

The four activities listed above require a high-level of clinical knowledge, confidence in talking with doctors, a natural empathy for talking with bereaved people and the ability to maintain standards whilst co-ordinating many different tasks often under considerable time pressure. These activities constitute about 30% of the workload of MEOs etc.; the other 70% is more administrative in nature but no less important in ensuring that their medical examiners are given the right information in a timely manner, that appropriate records are kept and that statutory notifications are signed by a medical examiner and sent to a registrar without delay.

MEOs etc. will need to be recruited / assigned with considerable care to ensure that they meet the criteria noted above and, critically, can be relied on by medical examiners to carry out their work in an way that enables medical examiners to provide impartial advice and to provide robust, proportionate and independent scrutiny of apparently natural deaths.

MEOs etc. will be invited / encouraged to complete relevant parts of the eLearning materials that have been prepared for medical examiners.

9. WHERE WILL MEDICAL EXAMINERS AND MEDICAL EXAMINER'S OFFICERS BE BASED?

The location of medical examiner's offices is a matter for each (lead) local authority / local health board and the following information (and associated notes) is included as illustrative guidance for local configuration.

Deaths occurring at:	Effective location of medical examiners and MEOs etc.	Reason for location
Large acute hospitals	At each large acute hospital	To obtain timely access to relevant paper-based health records.
Smaller acute hospitals, specialist hospitals, community hospitals and hospices	At any convenient location including a coroner's office	The number of deaths and / or the typical size of relevant health records allow staff to scan agreed sections and send them electronically by secure email.
Other community settings (certified by GPs)		The majority of GP Practices use electronic patient records and can extract and email agreed sections of the records.

10. WHICH DEATHS WILL BE 'REPORTED' TO A CORONER, BY WHOM?

It is estimated that 35% of all registered deaths will be notified, referred or reported to coroners with 21% coming directly to a coroner and 14% arriving after advice and / or scrutiny from a medical examiner. The tables included below analyse these figures by category and by main care-setting: large acute hospitals (AH), community hospitals, specialist hospitals and hospices (CH) and outside hospital (OH).

Direct to coroner	% of registered deaths			
Main care settings >>	AH	CH	OH	**All**
• Clearly unnatural deaths (e.g. RTC, homicide) and deaths occurring in prison, police custody or other state detention	n/a	n/a	n/a	**9%**
• Apparently natural deaths reported by the police	< 1%	3%	11%	**7%**
• Apparently natural deaths *(of known or unknown cause)* notified or referred by a qualified attending practitioner without first obtaining advice from a medical examiner	2%	2%	7%	**5%**
Total reported, notified or referred directly to a coroner	n/a	n/a	n/a	**21%**

After advice or scrutiny from a medical examiner	% of registered deaths			
Main care settings >>	AH	CH	OH	**All**
• Notified or referred as a result of 'provisional' advice before scrutiny	< 1%	< 1%	1%	**1%**
• Notified as a result of initial check of case when statutory information received by medical examiner's office.	3%	1%	2%	**3%**
• During or as a result of scrutiny *(as outlined in Annex B)*	13%	2%	6%	**10%**
• Following concerns raised during discussion of the death with a relative / appropriate person or by an informant during registration	< 1%	< 1%	< 1%	**< 1%**
Total notified or referred to a coroner after advice or scrutiny	16%	3%	9%	**14%**

11. WHERE AND WHEN WILL I GET TRAINING IN THE NEW PROCESS?

Training in the new process of death certification will be arranged for coroners and coroner's officers and staff by the Coroners Training Group (CTG) of the Ministry of Justice and / or by the Judicial College in discussion with the Chief Coroner. This training is likely to include:

- **From August 2012**: Access to / use of eLearning materials that have been prepared for medical examiners. (*Please use the email address in section 12 below to request access*.)
- **From [April 2013]:** Regional face-to-face training events [potentially as part of training provided for coroners and coroner's officers in relation to the coroner's reforms].
- **From January 2014**: Local training events with medical examiners and MEOs etc. for representatives of all related services in each medical examiner's service area.

12. WHO DO I ASK FOR FURTHER ADVICE?

Further information on the reforms will be provided as part of the consultation and associated communications activities from October / November 2012.

If clarification on this update is required before the consultation, please obtain and read the supporting notes attached in Annex C to the **extended version of the update** and, if further advice is needed, email deathcertification@dh.gsi.gov.uk for the DH Death Certification Programme to forward to one or more of the following people for a response.

- Meena Paterson or Paul Ader - **DH Death Certification Programme**
- Dominic Smales or Geraint Davies - **Ministry of Justice**
- Andre Rebello, John Pollard or Chris Dorries – **Coroners Society of England and Wales**
- Glenn Taylor or Sally Bye - *On behalf of the* **Local Government Group**

Annexes

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Annex A: Summary of key changes to the current process of death certification

This annex provides a summary of key changes to the current process of death certification. These changes are necessarily described at a high-level and need to be read in conjunction with relevant detail in the update and its supporting notes.

1. Medical examiners will scrutinise all deaths not investigated by a coroner; scrutiny is part of a new unified process of certification that removes the requirement for cremation forms 4, 5 & 10.

2. Doctors will have a new statutory duty to notify a coroner in prescribed cases and circumstances; this duty will formalise and clarify current practice.

3. Attending doctors will continue to certify causes of death but the 14-day rule will be changed.

4. Doctors will not be required to see and examine the deceased person prior to a cremation; responsibility for external examinations will be transferred to medical examiners.

5. Doctors will only be able to issue a MCCD after a copy has been confirmed by a medical examiner; this should not create undue delay or unnecessary distress for the bereaved.

6. Doctors will be able to obtain advice on medical circumstances and causes of death based on a medical examiner's scrutiny of records; there will be less reliance on unsubstantiated discussion.

7. Medical examiners or an officer acting on their behalf must discuss a death with a relative or other appropriate person in all cases before the cause of death is confirmed or certified.

8. Medical examiners' advice and scrutiny and subsequent discussion with a relative etc. will ensure the right deaths are reported to a coroner and will improve the quality of certification.

9. Coroners will be able to ask medical examiners for general medical advice and medical examiners should talk frequently with coroners; it is essential that their services work in close collaboration.

10. Coroners will issue an HMC-1 Report to a medical examiner for any death which does not need to be investigated after being reported by a doctor; the HMC-1 Report replaces the current 'Form A'.

11. Medical examiners will be able to certify deaths where there is no attending doctor or none is available; this avoids the use of a post-mortem or inquest to enable registration of a death.

12. Medical examiners will issue a statutory notification to the registrar for all deaths where the examiner has confirmed or certified the cause; registrars must wait until this notification is received.

13. Attending doctors or their staff will finalise and issue the MCCD after receiving a copy of the statutory notification and information on any implants, medical devices and communicable infections.

14. Registrars will need to match the MCCD with the statutory notification from a medical examiner and, if new information is provided, may invite a fresh MCCD or report a death to a coroner.

15. The proposed fee for the medical examiner's service will replace, extend and make more effective use of the fee currently paid for completion of cremation forms 4, 5 and 10.

Annex B: Description of Scrutiny

The standard procedure for scrutiny will include the five activities outlined below.

1. **Review relevant health records** to follow the narrative of the last illness or condition, identify any anomalies that might require further enquiries and, where possible, establish a medical cause of death which can be compared with the cause certified by a qualified attending practitioner. *This activity must be carried out personally by a medical examiner*.

2. Carry out or arrange for a person with suitable expertise and sufficient independence to carry out a thorough but non-forensic **external examination** of the deceased person's body to:

   - Validate the cause established above (where it is possible to do so);
   - Identify any potentially unnatural features that would need to be notified to a coroner; and
   - Establish / validate the existence, type and (where relevant) the date of insertion of any implants or medical devices that would need to be removed prior to cremation.

3. **Scrutinise a copy of the medical certificate of cause of death** (MCCD) provided by a qualified attending practitioner together with additional statutory information. This scrutiny will assess whether the certified cause matches the cause established independently by the medical examiner and / or whether the certified is logical and sufficiently precise. It will also check that the certificate has been completed correctly and legibly. *This activity must be carried out personally by a medical examiner*.

4. Make any **enquiries** that are needed to clarify information in the health records or other statutory information and, where necessary, discuss the medical circumstances and cause with the qualified attending practitioner (or other doctors), healthcare staff and / or coroner (or coroner's officer). The enquiries may also involve use of local data and / or data provided by colleagues in public health or clinical governance to highlight relevant local trends, patterns or issues that the medical examiner may need in step 5 below. Enquiries and discussions can be delegated to an officer with suitable expertise and sufficient independence if the officer only provides information that has been documented by a medical examiner and passes any queries not covered by this information to a medical examiner.

5. **Consider** the results of the activities 1- 4 and decide whether the cause of death can be confirmed or certified if the subsequent discussion with a relative or other appropriate person does not identify any concerns that would require the death to be notified or referred to a coroner. *This activity must be carried out personally by a medical examiner*