**Medical Defence Union response to Department of Health consultation**

**Introduction of Medical Examiners and reforms to death certification in England and Wales**

The Medical Defence Union is a mutual, non-profit making organisation whose members include around 50% of the UK’s doctors. Our medical members pay an annual subscription in return for access to the benefits of membership that can include advice about death certification, and advice and assistance with medico-legal matters related to coroners’ inquests. Our response to the consultation is based on our experience in providing advice and assisting doctors with these matters. We have responded only to questions that fall within our expertise and are relevant to our members and their work.

Chapter 4 *Death certification regulations*

**Q6. Do you believe the provision of ‘administrative and clinical information’ set out in schedule 1 is necessary and sufficient for all deaths, either for a medical examiner’s scrutiny or for a coroner’s investigation? If not, what would you add or delete and why?**

A6. Yes, with the exception of paragraph 1(l) of Schedule 1. For a regulation to require a busy doctor to be in a position to provide information about ‘the times of availability to respond to any enquiries about the death from the relevant medical examiner’ may be overly burdensome and probably impractical in many cases.

It is reasonable to expect a doctor to identify him or herself clearly and to provide contact details so that the medical examiner can follow up if necessary. However, doctors’ first duty must be to their patients and because of the demands on their time of secondary and primary care, they may often not be able to guarantee where they will be. They will understand the need to make themselves available in a timely manner to assist the medical examiner with enquiries, but it is unreasonable and impractical to expect them to always provide times of availability, though they will no doubt do so if they are able to. A requirement to provide a telephone contact number and email address should ensure medical examiners can make timely contact with attending practitioners.

**Q7. Do you agree that the medical examiner should have discretion about whether an independent non-forensic examination of the body is necessary?**

A7. Yes.

**Q8. In your view, are there sufficient safeguards if a person without a medical qualification but with suitable expertise and sufficient independence carries out a non-forensic external examination of the body on behalf of the medical examiner?**

A8. It is difficult to answer this question without more detail about how this will be achieved in practice. We note that in the steering group and in the pilot project it was considered that those who prepare bodies for funerals or who are employed as mortuary technicians could undergo further training to build the necessary skills to carry out a meaningful examination of the body.

Asking a non-medical person to undertake an external examination would technically be an act of delegation by the medical examiner. The GMC regulates all doctors, including medical examiners and its guidance (*Good Medical Practice*, 2013, paragraph 45) states that doctors who delegate ‘must be satisfied that the person… has the appropriate qualifications, skills and experience’ to undertake the delegated task. The regulations use different terminology and refer to medical examiners needing to satisfy themselves that the person ‘has suitable expertise’. Ideally doctors who complied with the statutory requirement should also be compliant with their ethical, professional obligations. We suggest this point is discussed with the General Medical Council.

Where the person is medically qualified (and it appears that the regulations would make this possible) the safeguards may create a specific difficulty in one circumstance. This could apply in regulation 8(5)(e), which is similar in wording to regulation 19(5)(d), and prevents a person who attended the deceased in their last illness from carrying out an external examination of the deceased. This may prevent a pathologist in a small hospital (who is likely to have the requisite expertise) from carrying out the examination if he or she, for example, reported on tests undertaken before death. Similarly in general practice, where several doctors and nurses were involved in caring for the deceased in their last illness but where one was in overall charge of care, it would appear that the regulations exclude all of them from carrying out the examination. In the absence of any easily available alternative person, this may cause unnecessary delay and, although such instances will be rare, we suggest it would be reasonable for the medical examiner to be able to exercise discretion. The phrase ‘unless the medical examiner determines it is reasonable to do so’ could be added to the regulations referred to above.

**Q9. Under regulation 26, do you agree that the medical examiner process should be suspended during a period of emergency?**

A9. Yes.

**Q10. Do you agree that during the period of an emergency any registered medical practitioner could certify the cause of death in the absence of a qualified attending practitioner?**

A10. Yes.

**Q11. Are the proposed certificates and medical examiner forms set out in schedules 2-7 fit for purpose? If not, please say why.**

A11. Yes. The MCCD form and neonatal death forms are formatted so the GMC number is filled in seven boxes; this seems a simple way of ensuring that a digit of the GMC number is not inadvertently omitted. We suggest the same format is also used for medical examiner notification forms. Other forms may benefit from this standardisation too.

We note that regulation 24 allows for electronic transmission of documents, unless originals are required. Given this provision, it would be helpful if the forms and certificates were appropriately formatted so that a doctor could type directly on to a form, save it, and then send it electronically.

Chapter 5 *Notification of deaths to coroners regulations*

**Q14. Do you agree that a death should be notifiable if it is “otherwise unnatural”?**

A14. Yes, because the list in regulation 3(2)(a-g) cannot be assumed to be an exhaustive catalogue of all circumstances where a death should be notified to the coroner.

**Q15. Do you believe there is sufficient understanding between members of the medical and coronial professions as to the meaning of ‘unnatural’ and that further definition is not required? If not, we would be grateful for suggestions as to what the guidance may include.**

A15. Yes, doctors were previously aware that unnatural deaths should be notified to a coroner and will be familiar with its practical meaning.

**Q16. Do you agree that provision needs to be made with regard to poisoning, given that cases of poisoning are rare?**

A16. Yes.

**Q17. Do you believe that ‘poisoning, the use of a controlled drug, medicinal product or toxic chemical’ sufficiently covers all such circumstances of death? If not, should the guidance be broadened?**

A17. Yes the definition is clear.

**Q18. Do you believe there is a sufficient understanding of “neglect”? If not, should this be made clearer in the draft regulations rather than guidance?**

A18. Taken together the regulations and the guidance provide a clear definition of what is intended by neglect.

However, paragraph 15 of the ‘Draft guidance for registered medical practitioners’ has the potential to cause confusion. If it is reasonable to suspect that the death resulted from some culpable human failure and must be referred to the coroner, it is irrelevant whether the death is due to natural causes. To add this as a sub-clause has the potential to cause confusion and we suggest it would be clearer to omit ‘albeit from natural causes’ from paragraph 15.

**Q19. Do you agree that regulation 3(2)(e) - “occurred as a result of an injury or disease received during, or attributable to, the course of the deceased person’s work” - is clear that it includes any death that has occurred as a result of current or former work undertaken by the deceased, including cases such as mesothelioma or other asbestos related cases? If not, we would be grateful for alternative suggestions**.

A19. Yes.

**Q20. Do you agree that it should be possible to make notifications orally, but that where an oral notification is made the information must be recorded in writing and confirmed?**

A20. Yes.

**Q21. Do you agree that regulation 3(6) should prevent duplication of notification? We would be particularly grateful for views on how this would work in a surgical environment.**

A21. Yes. Deaths occurring in hospital are generally discussed by teams at morbidity and mortality meetings and this would include surgical teams. The question of notification to the coroner would be expected to come up in such discussions, but to reinforce this the guidance could also mention that such meetings should routinely discuss whether a death has been referred to a coroner.

**Q22. Do you have any other comments about the draft Regulations?**

A22. No.

**Q23. In relation to the guidance, do you agree with the examples used under each category of death? If not, we should be grateful for further examples or suggestions for definitions.**

A23. Yes, though please see A18, above.

**Q24. Also in relation to the guidance, do you agree that no specific reference is needed as to whether certain deaths will be subject to jury inquests or not (such as those that have occurred under state detention)?**

A24. Yes, we agree. Whether there would be a jury inquest should not affect the decision to notify the coroner of an unnatural death.

**Q25. Do you have any other comments about the guidance?**

A25. Although the method of remuneration is described, there is no mention of the indemnity arrangements for medical examiners. We assume this is because they will be indemnified by the local authority but if they will be expected to make their own indemnity arrangements, they will need to know. Either way, there will need to be clarity about the indemnity arrangements.

Chapter 6 *Cremation regulations*

**Q26. After the changes are brought in, there will be no provision for medical examiners to be involved in the certification of the cremation of body parts. Do you agree that the requirement to complete a statutory application form and provide a registration document and a certificate from the hospital trust or other authority holding the body parts will provide sufficient scrutiny prior to the cremation of body parts? If not, what further scrutiny do you think would be needed, in the absence of medical referees?**

A26. One of the functions of the current cremation regulations is to ensure that no body, or body part, is cremated without there being a declaration that there are no hazardous implants which could cause damage if incinerated. For body parts the declaration requires that they are released in a suitably safe and prepared condition.

We do not suggest medical examiners should be required to assess the safety of body parts for incineration, but someone must have this responsibility. Perhaps this could be addressed in amendments to the cremation regulations which we understand will be subject to consultation at a later date.

**Q27. Do you agree that this proposal will provide a sufficient level of scrutiny in stillbirth cases? If not, what further scrutiny do you think would be needed, in the absence of medical referees?**

A27. Yes, as is made clear in the consultation document there are local and national mechanisms to ensure there is sufficient scrutiny of stillbirth cases.

**Q28. Do you agree that investigation and clearance for cremation by a coroner provides sufficient assurance for cremation to take place without a further check by a medical referee based at the crematorium? If not, what further scrutiny do you think would be needed, in the absence of medical referees?**

A28. Our comments here reflect our response in A26. In the absence of the coroner making a declaration that the body of the deceased is released for cremation in a suitably safe and prepared way there may be a risk that a hazardous implant might remain. We do not suggest that medical examiners should be responsible for ensuring the body of the deceased is free from hazards before cremation, but in the interests of safety someone must be identified as responsible for this.

Comments on the DRAFT Death Certification Regulations

**Regulation 2 – interpretation**

The third line down which states ‘attending practitioner’s certificate’ has incorrect lettering. To ensure consistency with the whole of that regulation 2, the ‘(a)’ should be removed from this line. Continuing with this regulation, further down under the definition of ‘general practice provider’, the sub-letters ‘(b)’ and ‘(c)’ should be ‘(a)’ and ‘(b)’.

**Regulation 3 – qualified attending practitioner**

Regulation 3(2) provides a mechanism to ensure that if a patient dies in the community and is seen by a GP in the 28 days preceding death who is then unable to certify the cause of death, then another GP at the practice can certify it.

However, the definition of ‘general practice provider’ is limited to NHS general practice only. Although there is not a vast amount of independent (non-NHS) general practice in England and Wales, there is some. The regulation should take account of this if, as we assume, the legislative intention is for the death to be certified by the medical examiner in circumstances where, if it was an NHS practice, regulation 3(2) would apply.

At sub-section (2)(ii), it would be helpful for the sake of clarity to insert the word ‘both’ at the start of this sentence to make it absolutely clear.

**Regulation 4 –** **qualified attending practitioner’s duty to complete an attending practitioner’s certificate etc**

Although the consultation suggests the qualified attending practitioner will be required to keep the original certificate securely, there is nothing within this regulation providing for that. We suggest an additional sub-section is added to make this a requirement.

**Regulation 6 – availability of relevant qualified attending practitioner to answer questions from the medical examiner**

The wording of the regulation links to the comments we made above (in the consultation response at A6 - relating to the schedule of information to be provided in accordance with Schedule 1, paragraph 1(l) of the regulations). It is difficult to see how providing a schedule of availability would be more effective than attending practitioners giving the medical examiner their telephone number and email address. A schedule of availability will also add to administrative tasks with no obvious benefit. We suggest the last part of this regulation is amended so that the regulation requires that an attending practitioner must: ‘respond to any questions the medical examiner may wish to make in relation to the death.’

**Regulation 8 – medical examiner’s scrutiny of death following provision of attending practitioner’s certificate**

See our response A8 above. In regulation 8(5)(e) we suggest the phrase ‘unless the medical examiner determines it is reasonable to do so’ is added.

Our comment also applies to also regulation 19(5)(d) and regulations 5(4)(d) and 7(3)(d) of the DRAFT Death Certification (Medical Examiners)(England) Regulations.

**Regulation 10 – medical examiner’s referral to a senior coroner**

Regulation 10(6) states:

“*Where, after receiving a referral under paragraph (1)* [i.e. from a medical examiner]*, the senior coroner decides that there is a duty to conduct an investigation into the death under section 1 of the Act (duty to investigate certain deaths) –*

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

*(b) the medical examiner must notify the relevant qualified attending practitioner of that notification*.”

Paragraph (b) appears to be an unnecessary duplication of effort. Why can’t the coroner notify both the medical examiner **and** the attending practitioner of the decision to investigate the death at the same time?

There is nothing within this regulation setting out the procedure to be followed if there is any disagreement between the medical examiner and qualified attending practitioner. For the sake of clarity, this should be considered as a reason for referral to the coroner. We understand the intention of the consultation document to be that if there is a dispute, this should be referred to the coroner, but the regulations need to make that clear as otherwise it may be confusing for practitioners. In addition, sub-section 9 of regulation 10 refers to administrative and clinical information that needs to be sent to the coroner. To ensure consistency with regulation 5(6)(b), this should set out that it does not include the information at paragraph (1)(t) of schedule 1.

**Regulations 11 and 14**

These draft regulations do not set out what should happen if the qualified attending practitioner does not agree to issue a fresh certificate. The consultation envisages this will result in referral to the coroner. In order to make this clear, it would be helpful if this could be set out explicitly in the regulations. Although it is unlikely to happen routinely, it would assist doctors who face this issue if the regulations give clear guidance.

A similar point arises in respect of regulation 23.

**Regulation 12 – medical examiner’s confirmation of attending practitioner’s certificate and notification to the registrar**

Regulation 12(2)(b) requires the medical examiner to provide the attending practitioner and registrar with a copy of the notification of the confirmed cause of death on the same day the form is completed. Although we appreciate the legislative intent is to avoid delay on the part of the medical examiner, a statutory requirement to provide the form (in person, or by email or fax) on the same day it is produced may be impractical.

For example, the medical examiner may have a clinical role and, after completing the form, could be called away suddenly and unexpectedly to assist at an emergency. If the need to attend to other patients as a priority resulted in the form not being provided that day, the medical examiner could be in breach of this requirement. The regulations need to take account of the fact that medical examiners may have other clinical responsibilities that must take priority. We suggest the regulation is amended to include the phrase ‘or as soon as is reasonably practicable’.

The same point applies in regulation 22(2)(b).

**Regulation 13 – finalisation of attending practitioner’s certificate**

The definition of ‘days’ needs to be clear. We have been unable to find any definition within the draft consultation or the regulations. Days could be taken to mean calendar days or working days. We assume the regulations intend the definition of days to be working days. If the definition were to be calendar days, the timescales set out may be overly optimistic, particularly as in a number of cases the qualified attending practitioner is likely to be a GP and the surgery will not be open seven days a week. In addition, the timescale for the informant (in most cases the relatives) to register the death runs from the date of the medical examiner’s confirmation, and qualified attending practitioners are therefore likely to come under pressure from such informants. While we understand the reasons why this process should be completed as swiftly as possible, the requirement needs to be reasonable and practical and we suggest the regulation refers explicitly to working days.

This point also applies to regulation 22.

**Regulation 14 – registrar’s invitation to qualified attending practitioner to complete a fresh attending practitioner’s certificate**

Regulation 14(1) only applies to cause of death. It also needs to set out the procedure to be followed if a fresh certificate is required because of an error in completion which does not relate to the cause of death. For example, a GP may attend a patient just after midnight who had died and certify the patient’s death as having occurred when he or she actually attended. The informant may make a representation to the registrar that the patient actually died earlier, which would be the preceding day, and would necessitate a fresh certificate. Other administrative errors might include a misspelling of the patient’s name or an error in identifying (in a hospital case) the name of the consultant responsible for the patient.

**Regulation 16 –** **qualified attending practitioner subsequent unavailability to fulfil duties**

There may be occasions when there is no alternative qualified attending practitioner and it would be helpful if the regulations set out the procedure to be followed in such circumstances, even if they may be rare.

If the original qualified attending practitioner is a hospital doctor there is more likely to be somebody else easily available to take over this role but if, for example, the original qualified attending practitioner was the patient’s GP and the only GP in that practice, there will not be anybody else available. We believe the regulations should address what should be done in such circumstances.

We also suggest the word ‘promptly’ is included so that the sentence reads ‘… is unable to carry out any further duties imposed by this Part promptly …’. The regulation as currently drafted suggests the need for another qualified attending practitioner to take over will apply only when the qualified attending practitioner is unable to carry out any further duties on a permanent basis. However the regulations need to provide for other circumstances, such as if qualified attending practitioners go on annual leave or are otherwise away from their place of work for a reasonable period of time.

**Regulation 19 – medical examiner’s scrutiny of death following referral from senior coroner**

Paragraph 6 of regulation 19 states that the administrative and clinical information referred to in paragraph 2 does not include the information in Schedule 1, paragraphs 1(l), 1(s), 1(u) and 1(v). This means that the medical examiner is not required to consider if there are any hazardous implants or risk of communicable infection. If the medical examiner is not required to consider these health and safety risks it must be clear where the responsibility lies.

The same point applies to regulation 21(7)(b).

**Regulation 21 – Medical examiner’s referral back to the senior coroner**

Sub-section (7)(b), sets out that the information to be sent to the coroner should not include the information at paragraphs (1)(u) and (1)(v) of schedule 1. It is not clear why it is not necessary to provide this information to the coroner. It is possible it is believed that this information will already have been provided to the coroner previously. However, as the medical examiner may not have been involved in that process, it would seem sensible for the regulations to make sure these two potentially important pieces of information are provided to the coroner. We don’t think it would cause any undue burden to provide this information; whereas the implications of not providing it could be significant if the coroner was not previously aware of it.

**Regulation 24 – manner of providing documents**

Paragraph 1(a) of this regulation states that documents can be sent electronically where the intended recipient has consented in writing to receiving them in that way. The addition of the words ‘in writing’ add little to the meaning of this paragraph, apart from evidence of consent, but it does add an element of bureaucracy and possibly delay. We suggest the words in writing’ are omitted as it should be adequate for whoever has obtained consent to make a note. The guidance documents can be amended to explain that where consent is obtained orally, for example, a note should be made of the recipient’s agreement/wishes.

**Regulation 25 - Manner of completing medical examiner’s notifications**

In view of the timescales for complying with these regulations, it may be helpful if there could be more emphasis on the use of electronic communication when a medical examiner notifies the registrar and qualified attending practitioner at regulation 12 and when finalising the medical examiner’s certificate at regulation 22.

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