15 June 2016

Dear Sir/Madam

Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Policy and Draft Regulations

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 170,000, which continues to grow every year.

The Association welcomes the opportunity to respond to the Department of Health’s Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Policy and Draft Regulations. Please find enclosed the BMA’s submission.

Having invested many years contributing to the Death Certification Steering Group, the BMA is very pleased to see the government’s commitment to introducing the Medical Examiner system and we continue to support the rationale behind the need for such changes. Our response however also highlights areas of concern and ongoing debate, specifically regarding the impact on the required attending practitioner and the non-forensic examination of the deceased.

We hope that our submission is useful – please do not hesitate to contact us for more information if required.

Yours sincerely

Hilary Lloyd
Policy Director
Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Policy and Draft Regulations

The BMA has been calling for an improved system to scrutinise the certification of death for many years and has continued to contribute throughout the process from the development of the Coroners and Justice Act 2009 through to our ongoing participation with the Death Certification Implementation Programme Board and Reference Group. No statutory system can ever provide complete protection against those intent on covering up criminal activity, but we believe the new system will provide a more consistent and fair scrutiny of all deaths.

However, these important principles will not be achieved unless the new system is practical, fair and appropriately funded for all doctors involved within the process. This is particularly important at present where demands on doctors’ time are increasing and resources are continually being stretched. Our response therefore reflects the concerns of our members in how the new system may impact on their daily working lives.

We have provided specific comments to the majority of the questions, however there are some we have not answered as we either feel the answers are outside of the BMA’s remit or that we do not have policy to formulate a clear position.

Question 6: 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?

There needs to be clear guidance to the attending practitioner that they only need to provide the relevant items from Schedule 1, regulation 1 if they are not already included on the MCCD, otherwise information may be duplicated, wasting time and increasing cost.

In Schedule 1, regulation 1 (p) “a copy of the relevant health records of the deceased person”, further clarification is needed to determine what the definition of “relevant” is. We also have more general concerns regarding the supply of this information which we explain under question 22.

Questions 7: Do you agree that the medical examiner should have discretion about whether an independent non-forensic external examination of the body is necessary?

Yes – it seems appropriate, given their experience and role to have the flexibility and discretion to make this decision.

Question 8: 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?

There are differing views on this issue among doctors. Some feel that principally such an examination should be carried out by a medically trained professional. We have already had some discussions with the Department on this and have made it clear that GPs would not be able to undertake this work. One other suggestion has been that pathologists currently carrying out Coroner post-mortems may be able to undertake this work on the basis that their workload may decrease further if the Medical Examiner System reduces the need for post mortems. This suggestion would however require further exploration and discussion.

Other doctors consider that with the appropriate training, guidance and accountability, the external examination could be conducted by a non-medical professional. We cannot therefore provide a firm view on this issue.
Question 9: Under regulation 26, do you agree that the medical examiner process should be suspended during a period of emergency?

We agree that the process could be suspended during a period of emergency, but there would need to be rigorous standards and procedures in place (in addition to legislation and regulations) to manage such an emergency to ensure the deceased and their families are respected appropriately.

Question 10: Do you agree that during a period of emergency any registered medical practitioner could certify the cause of death in the absence of a qualified attending practitioner?

Yes, but again there would need to be appropriate standards and guidance in place to manage the situation to establish clear lines of responsibility and accountability.

Question 11: Are the proposed certificates and medical examiner forms set out in schedules 2-7 fit for purpose? If not, please say why.

As far as we can determine, without testing them in practice, the forms appear to be fit for purpose.

Question 12: In relation to regulation 5 of the NME regulations, what other aspects should standards cover for monitoring medical examiners’ levels of performance?

Although not specifically in relation to regulation 5, we feel it is appropriate to mention that many of our members who are interested in becoming Medical Examiners have already completed the relevant training that was introduced some time ago. We therefore ask for further clarification as to whether there will be requirements for additional training or a need to undertake the training again given the lapse in time.

We also seek confirmation that those applying and being appointed as medical examiners in addition to being registered and have practiced during the last 5 years, do not require a license to practice.

Question 13: Do you agree with the estimates of costs and benefits of the death certification reforms set out in the consultation impact assessment?

Yes as a whole we support the costs and benefits of the reforms, however as explained in question 5, we do still have real concerns that doctors time remains appropriately funded and that this process does not impact on their time spent treating living patients.

Question 14: Do you agree that a death should be notifiable if it is “otherwise unnatural”?

Yes this seems appropriate.

Question 15: 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.

Although there may be an understanding between more experienced members of the medical and coronial professions of the meaning, there is currently considerable variation in the level of training medical students and trainees receive around death certification and other medico-legal areas and therefore we feel it would be appropriate and necessary to issue a definition and guidance.

Question 16: Do you agree that provision needs to be made with regard to poisoning, given that cases of poisoning are rare?

Yes
Question 17: 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?

Yes

Question 18: Do you believe there is a sufficient understanding of “neglect”? If not, should this be made clearer in the draft regulations rather than guidance?

Yes

Question 19: 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.

Yes

Question 20: 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?

Yes, this will allow for greater flexibility in cases where there is insufficient resources or time to confirm in writing at the time of notification.

Questions 21: 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.

It is not clear why a surgical environment would present a more challenging case for duplication of notification. It would seem sensible that in a team of medical professionals treating a patient, where unexpected death occurs in a theatre, the surgical lead and the patient’s consultant would agree between them who would notify the coroner. This is referred to within the guidance for registered medical practitioners under para 20.

Question 22: Do you have any other comments about the draft Regulations?

Within the consultation, Chapter 2, para 2.9 and footnote 5 states that part of the attending practitioner’s duty will be to complete the MCCD and provide the medical records and any additional information to the Medical Examiner. It states that the information needed to accompany the copy of the MCCD and relevant medical records is less than required in the Cremation 4 form in the current system and can also be provided as part of the records rather than written out on a separate form.

We question the assumptions provided within the footnote (that this will generate less work than the current process) especially with regards to general practitioners who hold the patient’s medical records and will often therefore be required to provide the additional information either as part of an expected death or in referring the death to a Senior Coroner.

In the current system, the doctor has a statutory duty to complete the MCCD (where no fee is charged) and is then (in those cases where cremation is requested) is asked to complete cremation form 4 where a fee can be charged. The fee covers the costs of undertaking the work as it is not normally part of a doctor’s terms and conditions of service (unless agreed separately by their employers) and therefore they are required to undertake the work outside of their contracted hours. We are not looking to replicate the fee system currently in place, however we are concerned as to how the additional work needed (i.e. collating and recording the information and/or supplying the relevant medical records) will be funded.
This is particularly important in general practice as the time and resources required to undertake this additional work, if not funded centrally, will be a direct cost to the practice as an independent contractor.

One suggestion to ensure the additional work is funded appropriately is to include this within the Capitation fee as this will be weighted with regards to the average age of the practice’s patient population. Those practices in areas where there are a high population of elderly patients, will inevitably be involved more regularly in confirming death and providing the relevant information. A similar method would need to be considered in secondary care, where certain doctors may have much larger volumes of patients dying within hospital. We therefore request that further discussion and consideration with us, the Department of Health and other relevant stakeholders is required to clarify this particular issue.

**Question 23:** 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.

Yes

**Question 24:** 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)?

Yes

**Question 25:** Do you have any other comments about the guidance?

No