

Introduction of Medical Examiners and Reforms to Death Certification in England and Wales

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PURPOSE

- Overview of proposed introduction of Medical Examiners and reforms to the process of Death Certification in England and Wales.
- The SofS indicated the reforms would be introduced from April 2018. The Strategic Programme Board is reviewing timing of implementation in light of consultation responses.
- Recent consultation has provided direction in preparing for implementation.

BACKGROUND CONTEXT

- **SHIPMAN INQUIRY 2003** existing arrangements for death certification are confusing and provide inadequate safeguards.
- CONSULTATION 2007 Outlined the design, piloting and implementation of a medical examiner system of death certification.
- CORONERS AND JUSTICE ACT 2009 enable reforms to introduce medical examiner system.
- FRANCIS INQUIRY 2013 renewed calls for introduction of medical examiners.
- **LEARNING NOT BLAMING** Secretary of State for Health Jeremy Hunt announcement of a suite of policies to make the NHS the largest learning organisation in the world.

The vision ...

- A common, simpler approach.
- Robust, proportionate, independent and consistent scrutiny.
- A transparent process.
- Focus on speed and convenience.
- Reduced delays and distress.
- Improved quality of information on cause of death.
- Learning from errors and poor practise.
- Focus for implementation is bereaved people and doing what's best for them.

Flow chart - the medical examiner's role in death certification

Doctor proposes cause of death, sends relevant information to the medical examiner, or provides access to it.

Medical examiner scrutinises information provided by the doctor together with relevant information from health records. Cause of death confirmed.

Medical examiner's office discusses with bereaved families the cause of death; opportunity to raise any concerns about the care or any matter that might require a coroner to investigate a death.

Bereaved family receives confirmed MCCD and authorisation form for the collection of body. ME transmits a confirmation of scrutiny to the registration office.

Note: subject to MOJ decision on Health & Safety form about implants) and Body Release form, which needs to be handed to the funeral director.

Informant appointment at registration office, collects the Certificate for Burial or Cremation (Green Form). (Death can be registered at the same time or at a later date if necessary).

Note: MCCD and ME Notification needed to register the death, unless the coroner is involved.

Green Form handed to funeral firm, if one is used, providing the appropriate authority before burial or cremation can take place.

Establishing the system and recruitment

- Legislation every death scrutinised by a medical examiner or investigated by a coroner.
- Responsibility Local Authorities in England, Local Health Boards in Wales.
- **Experienced doctors** recruited as medical examiners, assisted by medical examiners' officers.
- LA and LHB Set-Up costs funded by DH.
- Running costs largely financed by a single public fee. DH will cover the
 ME costs associated with those cases that are referred to the coroner by a
 medical examiners.

Changes to current system

- Cremation Forms some will be abolished (forms 4, 5 and 10).
- Medical referees no longer required.
- Registrars no longer need to question medical causes of death.
- Coroners focus on cases that are appropriate.
- **Medical Examiners** scrutinise every death not requiring a coroner investigation, provide expert advice, confirm the doctor's MCCD ensuring the cause of death is accurate, discuss the cause with the family and address any concerns they may raise, identify patterns.

Benefits of the new system

- Bereaved people
 - Consistency
 - Independent
 - Expert
 - Assurance
- Prevention
 - Public Health targeting
 - Clinical governance and feedback

- Improvement
 - Identify patterns and trends
 - Early detection of malpractice
 - Cause of death statistics
 - Certification skills of doctors
 - Coroners' focus

Next steps

- Updating the Impact Assessment
- Going back to Social Reform (Home Affairs) sub-Committee
- Implementing the new Governance arrangements
- Wider considerations
 - Digitisation and Information Technology
 - Timing of Implementation

Programme Governance Structure

Medical Examiner Strategic Programme Board

The primary decision-making body for the programme

Members: DH, LGA, SOLACE, DCLG, GRO, MoJ, ONS, RCPath, Welsh Government, NPR.

Observers: Northern Ireland, Scottish Government

Medical Examiner Implementation Delivery Board

Less senior; meets monthly to provide national leadership on the reforms, support collaborative working between delivery partners, support and ensure delivery of national programme deliverables

Members: DH, LGA, DCLG, Welsh Government, DWP, GRO, ONS, RCPath, BMA, RCGP, NHS England, NAFD/SAIF, Coroners' Society, Chief Coroners Office, Medical Examiners Pilot sites.

Observers: Northern Ireland, Scottish Government

Medical Examiner Local Delivery National Working Group

Meets monthly. Working level forum to support collaborative working between national and local delivery partners, supporting delivery of practical support to LAs, hold LAs to account for local implementation and communication to stakeholders etc.

Members: DH, LGA, DCLG, GRO, RCPath, NAFD/SAIF, local NHS stakeholders, Medical Examiners Pilot sites.

Medical Examiner Local Delivery Forum

Weekly or fortnightly conference calls. Supports networking, mutual challenge between LA-level partners to ensure successful local implementation by LAs.

Members: Local implementation leads

Sub-committees: Provides Expert Advice/Input

- Death Certification Reforms Reference Group
- MCCD Working Group
- GRO Registration Projects Steering Group
- Life Events and Population Sources Management Board
- ONS Life Events Redevelopment Project Board
- RCPath Committee on Training
- E-LFHC Medical Examiner Project Committee

Work Streams:

- · Legislation and Infrastructure
- Local Authority Implementation
- Finance
- People
- * II
- Communications

Accountable/Reports

aads Into

Informal survey of LA CEs

- Lead individual responsible for leading establishment of ME service
- Has planning for implementation begun locally?
- Early view on positioning of ME service in relation to management of coroners, registrars cemetery and crematoria and the NHS?
- Planned collaboration with other LAs?
- Discussion at the Health and Wellbeing Board?
- Draft LA checklist
- Responses to <u>DeathCertification@dh.gsi.gov.uk</u> by 23 December

Contact us

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