Improving the Process of Death Certification in England and Wales

Overview of Programme
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For Recipient's Use
The purpose of this booklet is to provide an overview of the Death Certification Programme. It is intended for anyone who may have an interest in the proposed improvements to the process of death certification.

The booklet is likely to be updated on a regular basis to reflect changes in the Programme. You are currently reading version 6 which was released in July 2009. If you would like to check that you have the most recent version, please go to the Death Certification website at www.dh.gov.uk/deathcertification.

For further information email DeathCertification@dh.gsi.gov.uk
Improving the Process of Death Certification

**Death Certification – Almost unchanged since 1935**

- **1840’s** Registrar General distributed first books of forms for use when certifying the cause of death. These became known as MCCDs.
- **1874** Registered Doctors required to provide a written statement of the medical cause of death unless they know that an inquest is to be held.
- **1885** Registrars required to report to the Coroner any sudden deaths or deaths where the cause was unknown. This extended previous requirement to report deaths that appeared to be due to violence or were attended by suspicious circumstances.
- **1903** Cremation Regulations formalised the role of the Medical Referee and defined use of Cremation Forms A - F.
- **1911** International Classification of Diseases adopted by the UK and made available to Doctors to improve the certification of death.
- **1926** Disposal prohibited without Registrar’s certificate or Coroner’s order. Attending Doctor required to deliver MCCD to Registrar in prescribed format before Registrar issues certificate for disposal. Attending Doctor must have seen the deceased person in the 14 days prior to death or seen the body after death.
- **1935** Cremation Regulations changed to widen definition of Doctors who can provide secondary certification (Form C) and to move responsibility for the appointment of Medical Referees from crematoria to the Home Office.
- **1935 to 2000** Arrangements for death certification and particularly the effectiveness of secondary certification for cremations reviewed by a number of committees and working parties: differences of opinion prevented any of the recommendations being taken forward.
“Current arrangements are confusing and inadequate”

The Government accepts the conclusion of the Shipman Inquiry’s Third Report published in June 2003 that existing arrangements for death certification are confusing and provide inadequate safeguards. The Fundamental Review of Death Certification and the Coroner Service in England and Wales chaired by Tom Luce in 2003 came to a similar conclusion.

The Government’s response to the Shipman Inquiry was set out in Learning from Tragedy, Keeping Patients Safe published in February 2007. This led to the publication of a Consultation on Improving the Process of Death Certification which outlined a programme of work to design, pilot and implement a rigorous and unified system of death certification for both burials and cremations in England and Wales. The Programme will:

- Improve the quality and accuracy of medical cause of death certificates (MCCDs)
- Introduce a single system of effective medical scrutiny applicable to all deaths that do not require a Coroner’s post mortem or inquest
- Provide improved information on cause of death to strengthen local clinical governance and public health surveillance.

The Programme recognises that it needs to achieve these outcomes without imposing undue delays on bereaved families or unacceptable burdens on medical practitioners or others involved in the process. It also needs to ensure that the new system is transparent, proportionate, consistent and affordable.
The Vision …

**Common approach** to the medical certification and subsequent registration of all deaths not requiring coroner’s post-mortem or inquest. Unified arrangements for burial and cremation. Simpler process for Funeral Directors. Removal of current inequalities.

**Robust, proportionate and consistent scrutiny** and confirmation of all medical certificates of cause of death (MCCDs) by an independent 'Medical Examiner'. Out of hours Medical Examiner’s service where it is needed by local communities to comply with religious practices.

**Close working relationship** between the Medical Examiner and Coroner and between their officers. Medical Examiner able to issue MCCD for reportable deaths that do not require a coroner’s post-mortem or inquest.

**Transparent process** in which the certified cause of death is explained to relatives after it has been scrutinised and, if relatives have concerns, enables the death to be reported to the Coroner. Informant signs the MCCD during registration to confirm that the cause of death has been explained.

**Focus on speed and convenience:** Electronic transmission used to enable efficient scrutiny. Confirmed MCCD can be collected from local hospital or GP or, if required, sent by secure post.

**Registrar able to provide final check** prior to completing authorisation for disposal without needing to understand medical terminology.

**Routine analysis of information** on cause of death for local clinical governance and public health surveillance. Identification of areas where training and development is required to improve quality and accuracy of MCCDs prepared by primary certifiers.
Getting there …

The Programme is working with a wide range of stakeholders to design, test and pilot the proposed new system for death certification. The Department of Health has worked with the Coroners Unit in the Ministry of Justice and the General Register Office to include relevant provisions in the Coroners and Justice Bill introduced in the House of Commons on 14 January 2009.

Current timescales for the work are summarised below.

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Public consultation undertaken

The Consultation on Improving the Process of Death Certification was published in July 2007 and responses invited by October 2007.

Meetings were held with the majority of the key stakeholders to discuss the proposed changes.

Local meetings were held with councillors and community / faith leaders where requested.

The major themes arising from the consultation included:

- Preventing delays to funerals
- Arrangements for appointing and employing Medical Examiners – including their relationship to Primary Care Trusts and Coroners
- Collaboration with the Ministry of Justice to co-ordinate death certification reforms with Coroner reforms.

In total, 157 written responses were received. The source of these responses is shown above.

Note: A further public consultation is planned for early 2010 to obtain feedback on the regulations required by the proposed process.
## Improving the Process of Death Certification

### Responses to themes arising from the consultation

<table>
<thead>
<tr>
<th>Preventing Delays to Funerals</th>
<th>Employment of Medical Examiners</th>
<th>Coordination with Coroner Reforms</th>
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<td>• Registrar can issue a Deferral of Registration to allow burial or cremation prior to registration where it is necessary to do so.</td>
<td>• Medical Examiners will be appointed by PCTs to ensure close links with NHS clinical governance teams but will be required to perform their function independently of any public authority.</td>
<td>• DH and MoJ have established close working arrangements between the teams responsible for the reforms to Death Certification and for the Coroner reforms.</td>
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<td>• Use of part-time Medical Examiners to maximise flexibility.</td>
<td>• PCTs will involve the Coroner in their arrangements for appointing Medical Examiners.</td>
<td>• The National Medical Advisor to the Chief Coroner will act as an important interface between Medical Examiners and Coroners.</td>
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<td>• Consideration of different models of service provision including an out-of-hours ‘emergency Medical Examiner service’.</td>
<td>• Medical Examiners will provide general medical advice to the Coroner.</td>
<td>• Joint Legislation (Coroners and Justice Bill) introduced in Parliament on 14 January 2009.</td>
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<td>• Training all Medical Examiners to understand the needs of different faith communities</td>
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The Improving the Process of Death Certification Programme is working closely with a wide range of stakeholders and is being co-ordinated by a DH led steering group that includes:

- Clinicians / Medical Referee
- NHS Managers
- Representatives from professional and regulatory bodies in the NHS
- Coroners
- Representatives from the Coroner’s Officers Association
- Representatives from the funeral industry and burial and cremation authorities
- Representatives from the bereavement services and local government
Improving the Process of Death Certification

Stakeholders are actively engaged

Members of the Steering Group and other stakeholders are actively engaged in directing and supporting the work of the Programme as outlined below.

- Design of the improved process of death certification and review / development of the associated forms and procedures.
- Development of guidance for Medical Examiners on the proportionate and effective scrutiny of MCCDs.
- Development of guidance on the role of the Medical Examiner in providing medical advice to Coroners and in working with NHS colleagues to support clinical governance.
- Development of guidance on the appointment, independence and accountability of the Medical Examiner and on the local support and infrastructure they require.
- Design and development of accredited materials required to train and assess new Medical Examiners and their support officers.
- Piloting, testing and evaluating the proposed arrangements – in particular with regard to throughput, timescales and resources.
Overview of Proposed Process for Death Certification

**Death**
- Verification of death & decision on whether death is reportable

**MCCD**
- "Unconfirmed" MCCD prepared by Attending Doctor

**Preparation for Scrutiny**
- ME-1 prepared by MEO with relatives

**Scrutiny**
- Cause of death confirmed by ME and discussed with relatives

**Authorisation**
- ME-2 signed to release body and allow death to be registered

**Registration**
- Informant meets with Registrar to register death (except if inquest)

**Disposal**
- After Conf / Def or Disposal Order from Coroner

**Reportable Deaths & Enquires**
- Advice provided by ME to Attending Doctors, Coroner and/or Coroner's Officers

**Initial Assessment**
- Initial Discussion with a doctor when a death is notified
- Talk with Relatives to review medical history & decide if to issue 100A

**Advice**
- Provided by ME to Attending Doctors, Coroner and/or Coroner's Officers

**Investigation**
- Cause of death confirmed by ME and discussed with relatives
- If new concerns raised during registration of deaths for which ME has issued ME-2

**Coroner's Post Mortem**
- if required

**Inquest**
- Appeal against Coroner's decision or finding

**Confirmation of Disposal**
- After Conf / Def from Registrar or Disposal Order from Coroner

**Clinical Governance**
- Data on patterns and trends / issues

**Confirmation of Disposal**
- Form 99 or 120 & 121

**Form 100B**

**Form 100A / HMC-1**
(also used to notify RMEs and NFAs)

**Deaths**
- for which MCCD needs to be reissued prior to authorisation for registration & disposal

**Key:**
- Process relevant for all Deaths
- Process relevant for deaths where cause is known, natural and not suspicious
- Process relevant for deaths where cause is unknown or may be unnatural or suspicious
- Is likely to require additional time

**Abbreviations:**
- ME = Medical Examiner
- MEO = Medical Examiner's Officer
- RME = Registrar of Medical Examiners
- NFA = Notifiable Death

**Note:**
- ME-1 is the proposed name of the form used to document information required for scrutiny and ME-2 the Medical Examiner's Authorisation to release the body and register the death. The Attending Doctor holds on to the original MCCD until a copy has been scrutinised by the ME and the cause of death has been confirmed and discussed with relatives, s/he then issues the confirmed MCCD so it can be used to register the death.

**This is a high-level process map and is a working draft for review and continued development during piloting. It does not cover still births or out-of-country deaths or disposals**
Improving the Process of Death Certification

Starting the Process

- Doctors who are not sure what to write as the cause of death on the MCCD will be able to call the Medical Examiner for guidance. This will increase the quality and accuracy of the MCCDs and reduce the number of deaths that are unnecessarily reported to the Coroner.

- The current practice for Doctors to report deaths to the Coroner will become a statutory duty. When Doctors report a death to the Coroner they will discuss it with the Coroner’s Officer but will not prepare an MCCD – even if they know the cause of death. If the death is “accepted” as reportable by the Coroner, the Doctor will be asked to complete and transmit a Reportable Death Form (RDF).

- When a Doctor writes an MCCD for a non-reportable death a copy will be transmitted to the Medical Examiner for scrutiny. In a hospital setting, the Bereavement Office may co-ordinate this activity. The original MCCD will be held by the Bereavement Office or the GP Practice until it has been scrutinised and the cause of death has been confirmed.

- When an MCCD is received by the Medical Examiner, his/her Officer (MEO) will contact appropriate relatives etc. to collect information required for scrutiny. This will be documented on the ME-1 and will focus on the circumstances leading to death. Where possible, the MEO will use information collected from relatives etc. by the clinician or paramedic who verified the death. It may also be possible for the ME-1 to completed on behalf of the MEO, particularly for deaths in hospital, by a Bereavement Services Officer.
• The scrutiny undertaken by the Medical Examiner will provide additional safeguards for burials and will replace the largely discredited process of secondary certification currently in place for cremations. It will also incorporate the activities of the Medical Referee currently attached to each crematorium. In undertaking scrutiny, the Medical Examiner will make whatever enquiries are seen to be necessary and proportionate. This may include requesting and reviewing medical notes, making use of data collected for clinical governance and talking with the Attending Doctor, other doctors, relatives etc.

• When a death that has been reported to the Coroner is subsequently found not to require a coroner’s post-mortem or inquest, the Coroner will send a Form 100A and/or HMC-1 to the Medical Examiner who will carry out a light scrutiny to confirm the cause of death. (In the current system, the 100A is sent to the Registrar).

• If an Attending Doctor exists and is available when the Coroner issues a 100A / HMC-1, s/he will prepare an MCCD and transmit it to the Medical Examiner in the same way as for a non-reportable death. If there is no Attending Doctor or s/he is not available, then the MCCD will be prepared and signed by the Medical Examiner. (In the current system, if there is no Attending Doctor, the MCCD is prepared by another Doctor and the death registered as “uncertified” or the Coroner carries out a post-mortem and issues a 100B).

• If, during Scrutiny, the Medical Examiner decides that the death is reportable, s/he will report it to the Coroner with reasons for doing so. This activity is currently undertaken by the Registrar and can be difficult if it requires medical knowledge or causes distress for bereaved families.
Scrutiny, Confirmation & Acceptance

- If, during Scrutiny, the Medical Examiner decides that the death is not reportable but that the MCCD is incorrect then s/he will talk to the Attending Doctor and agree the changes that need to be made. The Attending Doctor will re-issue the MCCD incorporating the agreed changes and will send a copy of the new MCCD to the Medical Examiner.

- If, during Scrutiny, the Medical Examiner identifies clinical governance issues s/he will work with colleagues to initiate and monitor appropriate action.

- When the Medical Examiner has completed her/his scrutiny s/he will prepare and sign an ME-2 to confirm the cause of death. The Medical Examiner or his/her Officer will then discuss the confirmed cause of death with the informant or nominated relative (in an appropriate way) and - if there are no new concerns - complete and sign the final section of the ME-2. This final section of the ME-2 provides the name of the person with whom the confirmed cause of death has been discussed, their relationship to the deceased and the date and time of the discussion. It also states that the relative / representative has been advised that the informant registering the death will need to sign the reverse of the MCCD to confirm that this discussion has taken place. These arrangements are intended to provide evidence of transparency that is not achieved in a consistent way in the current system.

- If the MEO is unable to address questions or concerns about the cause of death, s/he will arrange for the informant / relative to talk, and if necessary meet, with the Medical Examiner who can then decide whether or not to re-open the scrutiny.
Authorisation, Registration & Deferral

- Once the confirmed cause of death has been discussed with the informant / relative, the Medical Examiner issues the ME-2 to the Attending Doctor, Registrar, Funeral Director (where one has been appointed) and Disposal Authority. The ME-2, which includes a statement of the confirmed cause of death and other key information, authorises the:
  - Attending Doctor (or Bereavement Office / GP Practice) to issue the original and now confirmed MCCD so that it can be used by a qualified informant to register the death;
  - Registrar to accept a request for an appointment to register a death or arrange for a Deferral of Registration (see below);
  - Funeral Director to prepare the body for burial, cremation or other form of disposal where this requires changes which may render it unsuitable for a coroner’s post-mortem.
  - In most cases, the Registrar should be able to meet with the informant to register the death before disposal and, if there are no new concerns, to issue a Death Certificate and Confirmation of Registration. If disposal needs to take place before the informant is able to register the death – for example to comply with religious practices - the Registrar will be able to talk with the informant by phone to carry out a final check for any new concerns and then issue a Deferral of Registration. This conversation may also be possible at an out-of-hours / out-of-office meeting with an Emergency Registrar.
Completing the Process

- As part of the registration process, the informant will need to sign the reverse of the MCCD to confirm that the cause of death shown on the certificate has been discussed with him/her, or with another person with whom s/he has spoken, and that that they are not aware of any new information or concerns that might require the death to reported to the Coroner.

- If the informant raises new concerns during registration of a death, the Registrar has a duty to refer the death to both the Medical Examiner and the Coroner. If the new concerns relate to a death for which the Medical Examiner has scrutinised the MCCD, the Medical Examiner will review these and decide whether to reissue the MCCD or formally report the death to the Coroner for investigation.

- Disposal Authorities will require either a Confirmation or Deferral of Registration from the Registrar (or a Disposal Order from the Coroner) before the disposal can go ahead. After the funeral, the Disposal Authority will send a Confirmation of Disposal to the Registrar endorsed with the date, place and method of disposal. If disposal took place prior to registration, the informant will need to meet with the Registrar to register the death and do so on the date agreed during the Deferral process. (Note: If new concerns are raised after registration, the coroner will still be able to stop the disposal going ahead pending a decision to investigate.)

- At the end of each month the Medical Examiner will receive an electronic copy of the Public Health Mortality file from the Office of National Statistics with a complete list of all deaths registered in the relevant district(s) during the period. This file will be used, together with local data, to undertake a routine analysis of MCCD information for clinical governance to identify trends, patterns and unusual features such as those revealed by Shipman’s pattern of deaths.
Improving the Process of Death Certification

Piloting the Proposed Changes

The Programme is committed to piloting the proposed improvements and in particular to evaluate the practicality of specific procedures and forms. To date, key elements of the reforms have been evaluated successfully in a pathfinder pilot established at the Sheffield Teaching Hospitals NHS Foundation Trust in collaboration with the HM Coroner for South Yorkshire (West) and in a community-wide pilot in Gloucestershire. Further pilots are currently being initiated in Powys, Essex and on a national basis with Faith Communities.

Pilots that start in a hospital environment will be extended in a phased approach to include deaths in the community and eventually to test the complete process. This requires careful design and communication because the new processes need to be piloted alongside the existing system.

Interim findings from the pilot in Sheffield show that:

- Fewer deaths have been reported to the coroner (down from 36% to 28%)
- The new process does not delay the provision of a confirmed MCCD
- All MCCDs scrutinised and confirmed as part of the pilot have been accepted by the Registrar.
- “Including a Medical Examiner in the process improves quality and accuracy of the MCCD and provides a better service to bereaved families.”
The Programme anticipates that the proposed changes will be welcomed by bereaved families and will provide significant benefits to many of the other stakeholders involved in the process. Some of the anticipated benefits are summarised below.

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<td>Bereaved Families</td>
<td>Simpler process. Increased transparency: confirmed cause of death explained and easier to raise concerns. Improved quality of certification.</td>
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<td>Funeral Directors</td>
<td>Less time / work involved in arranging completion of forms. Notification of confirmed cause of death helps meet health and hygiene requirements.</td>
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<td>Coroner</td>
<td>Fewer investigations / post-mortems where deaths are unnecessarily reported by doctors. Medical advice available from Medical Examiner.</td>
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<tr>
<td>Registrar</td>
<td>Less paperwork. Easier to proactively monitor and manage workload. No requirement to understand / interpret medical information on MCCD.</td>
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