Death Certification Reform: Lessons from the Pilot Sites

The task of implementing the system of death certification set out in the Coroners and Justice Act 2009 will fall to Local Authorities in England and Local Health Boards in Wales. They will have to appoint medical examiners whose principal task will be to scrutinise and advise on the certification of all deaths that are not referred to and accepted by the coroner. Appropriate support for medical examiners will also have to be provided.

The new processes have been subjected to extensive piloting over several years. This paper aims to set out the principal lessons learned at the DH-funded pilot sites (Sheffield, Gloucester, Powys, North London and Leicester). It assumes that the reader is broadly familiar with the nature and aims of the reforms. A much more extensive ‘toolkit’ of guidance and support is being developed by the Department of Health’s implementation team; an as-yet incomplete draft is available at http://www.pathology.plus.com/NME/MEimplementationtoolkit/

How many medical examiners and medical examiner’s officers should be appointed, and when?

The number of appointments that can be made will inevitably be influenced by the funds available; the level of funding is set at national level and the service should make neither a profit nor a loss. The figures are of course based on the experience from the pilot sites, involving staff who are trained and are familiar with the role; it may be anticipated that new staff may be less productive during the first few weeks of employment and plans should be made to allow for that.

The pilots have demonstrated that the service does not necessarily need a medical examiner to be available at all times, but it is important that an MEO is available to answer the telephone during office hours, and during any extended hours that may be required by local circumstances. If the number of MEOs justified by the size of the population served might be insufficient to keep the office staffed during annual leave and sick leave, consideration should be given to collaboration with a nearby authority.

It is anticipated that most medical examiners and MEOs will start work a few weeks before the service goes live, so that they can gain experience of running the system in ‘shadow’ mode (as with the pilots, this will have to be done within the constraints of the pre-implementation legislation). Funds are being included in the startup costs to facilitate this. However, establishing the new service will demand a great deal of local communication with those involved, as explained below. For that reason we recommend that one ‘lead’ medical examiner and lead MEO be appointed on a part-time basis at least three months before the service goes live, to assist with communication and the organisation of the service.
Who will make a good medical examiner and MEO?

Draft job descriptions and person specifications have been provided through http://www.rcpath.org/committees/committees/medical-examiners-committee/medical-examiners-committee.htm and final versions will be distributed by the National Medical Examiner. Any doctor with a GMC licence to practise for 5 years can apply to be a medical examiner, but the role is likely to be more relevant to doctors whose experience is relatively broad and includes the certification of deaths and contact with the coroner. There are no comparable specific requirements for medical examiner’s officers, but the pilots demonstrate that a basic understanding of medicine and the healthcare system is needed, so applicants with a background in healthcare-related professions are likely to be at an early advantage. Good communication skills are essential in both roles. The training packages for medical examiners and MEOs have been developed with experience from the pilots very much in mind.

Where and how should medical examiners offices be established?

The answer depends on local demographics and the number of deaths needing scrutiny, so there is no prescribed location for a medical examiner’s office. They could be in proximity to local coroners’ offices, County Registration offices, Local Authority buildings or large General Practices. However, most of the pilot sites they have been in large hospitals. Location in a large hospital has proved to have advantages that largely relate to communication and transport. Medical examiners must examine medical records. At present, most general practices can deliver at least a summary of the health record in electronic form (or by fax). Comparatively few secondary care institutions have implemented full electronic healthcare records. Collaboration with hospital bereavement office staff is also facilitated by co-location with them.

These considerations indicate that there are potential advantages to having more than one medical examiner’s office, especially if the area is large or has more than one large hospital. However, keeping several offices open depends on an adequate workload and would demand well-coordinated electronic and telephone communication facilities between the offices.

The pilots have found that the office needs to be staffed from 8.30 am to 5pm, and should be open to the public from 10am to 4pm. However, extended access times and limited weekend working will occasionally be necessary, especially in locations with communities who traditionally ask for rapid certification of the death.

While a medical examiner’s officer should be available for contact throughout these times, medical examiners can complete their tasks at more limited times of the day. In the pilots, different medical examiners have developed their own working patterns. This has worked well, although oversight by a lead medical examiner may be advisable to ensure efficient working.

Most of the interviews with bereaved relatives are conducted by telephone. However, there are occasions where a face-to-face meeting is needed, so there should be access to a room where such meetings can be scheduled to occur without interruption. The pilots found that such cases are infrequent, but they are always important and potentially difficult.

Who needs to know, and who might need to be persuaded?

The following key groups need to be considered – not listed in order of priority. The overwhelming conclusion from the pilot sites is that these reforms, once they are established and running smoothly, are welcomed (or at least recognised to be an improvement) by all the groups involved.
We have even seen some locations establishing pilot sites without the benefit of central funding, because they wish to reap the benefits. But **during and before implementation, good communication with the following groups is crucial.** This work is one of the main reasons for the recommendation that a lead medical examiner be appointed a few months before the reforms ‘go live’.

**Local leaders**

It is important to identify relevant local opinion-formers and people in positions of authority – e.g. in a hospital, the Medical Director and CEO; the hospital chaplaincy. Contact them early and get them on-side. Their assistance in presenting the new system at large staff meetings can be invaluable.

**Bereaved relatives**

Those who have just suffered bereavement need careful explanations, probably supplemented by an explanatory leaflet which they can read and re-read. At the start of the pilots there were concerns that enquiries from the medical examiner’s office would be seen as intrusive and might be resented. Experience has shown precisely the opposite. Most relatives are pleased to be offered an explanation of what is on the death certificate, and to be given the opportunity to express any concerns to an independent authority – even though the large majority have no such concerns and are complimentary about the care given.

**Relatives requesting for urgent release of the body**

Understandable concerns have been expressed that the new process might cause delays, especially by groups that traditionally wish to bury or cremate the dead within a day of the death. On average the pilots do indicate that there is an increase of about half a day in the time taken to complete the processes of certification. This does not take account of the considerable reduction in delays incurred where, in the past, the Registrar has had to reject an inappropriately completed certificate. Such rejections have become extremely rare in the pilot sites.

A small pilot in Leicester looked specifically at the needs of the large Muslim population, and a pilot in north London looked at the needs of the Jewish community. Both demonstrated that the new system could accommodate their needs, as long as the need for urgency is transmitted to the medical examiner’s office. Relatively few cases actually needed the attendance of a medical examiner out of normal office hours or at weekends. However, it is important to discuss the reforms with local representatives of relevant groups, to allay their concerns and to establish appropriate local procedures.

Having accurate contact details for the family, and preferably more than one contact, are especially important when urgent release is requested.

**Transplant teams**

The need for urgent scrutiny of potential cadaveric organ donors needs to be understood and discussed with the teams involved. During the pilots it was recognised that under data protection legislation it would be unlawful for a medical examiner to examine medical records for this purpose without consent before the patient had died – and such patients are rarely in a position to give consent. It is nevertheless practicable for the medical examiner’s office to be made aware of any impending need for urgent scrutiny. The pilots reported that their involvement did not delay organ donation, but this remains a potential problem which will be kept under observation.
Bereavement officers

NHS bereavement officers undertake different roles in different locations; some provide a purely administrative function, others provide quite extensive counselling and support. Local practices need to be considered when establishing the medical examiner’s office. Bereavement officers might see this reform as a threat to their role. The experience of the pilots is that such fears are rapidly allayed by experience, as they discover that the service delivers expertise not previously available to them, to assist with getting the death certificate right and to provide explanations to the relatives that require clinical experience.

Doctors

In secondary care, death certification has usually been delegated to the most junior doctors in a medical team. They need to have the new system explained to them, but they are usually delighted to have the expert support of a medical examiner in a task with which they have usually had relatively little training.

Consultants have initially been more sceptical, but with time most of the consultants in the pilot sites have become very supportive.

Communication with general practitioners and their practice managers is important and potentially more problematic. General practitioners have been less likely than hospital doctors to ask for advice on how to complete the MCCD. Initially they may resent the change in practice and may object to having to ask their staff to provide health records for scrutiny. It may be necessary to point out that the reforms represent a statutory requirement; but it would be preferable to point out that experience from the pilots demonstrates that once the system is established, GPs value the support just as hospital doctors do. Primary care participation in the pilots was voluntary, but not one of the practices that enrolled in the large Sheffield pilot withdrew from the pilot once they had experienced the benefits.

Personal contact was important in achieving this. We recommend that the local lead medical examiner and/or medical examiner’s officer should attempt to visit as many practices as possible before implementation, to explain how the new process will work.

Objections to the reforms may come, directly or indirectly, from doctors who were regularly in receipt of fees for the completion of cremation forms, as this source of income will cease. It should be explained that the reforms are in large part to correct the long-recognised inadequacies of the cremation form system and that the doctors’ trade union, the BMA, therefore supports their implementation. It should also be appreciated that there will no longer be a requirement for the certifying doctor to externally examine the deceased unless s/he wishes to, nor for extensive cremation form completion, with attendant time-saving advantages.

Local Clinical Governance leads (and others responsible for quality issues)

Medical examiners have a responsibility to ask relatives if they have concerns about the care provided to the deceased. Serious allegations which may have hastened death must be referred to the coroner to investigate, but medical examiners are also expected to feed information to appropriate individuals within the healthcare system about any lesser concerns that seem to them to be justified. The importance of this was recognised in the Francis report into poor standards of care at the Mid-Staffordshire hospital (Chapter 14). It is important that all know in advance that this will happen, and what routes will be used to transmit this information. Reassurance should also be given that medical examiners will recognise that the distress of bereavement can make some individuals unreasonably angry; they will only transmit concerns that seem to them to have reasonable justification.
In this context it should be stressed that in the pilots, many relatives welcomed the opportunity to compliment those who have provided care. Medical examiners should consider how best to transmit such compliments to those concerned, as a valuable counterbalance to the less frequent need to transmit information about complaints.

**Coroners (and coroner’s officers)**

The coroners involved in the pilots have been very supportive; they have seen the improvements that result (and may be able to assist by explaining the benefits to their colleagues). However, there are real concerns to be addressed.

Scrutiny and advice from medical examiners reduces considerably the number of unnecessary referrals to the coroner. However, the pilots have also shown an increase in referrals to the coroner that previously would have been inappropriately certified as deaths due to natural causes. Many of these justify an inquest. Obviously this represents an important improvement in the system, but the increase in inquests results in a considerable increase in the workload of coroners. It is an increase that will not be recognised by any system for funding coroners that is based simply on the total number of cases investigated.

The magnitude of this effect varies in different sites. The largest was in Sheffield where there has been a stable increase of about 25% in the number of inquests held; but approximately one third of these may relate to the area’s history of heavy industry, where the certifying doctor may not have considered the possible contribution of industrial lung disease justifying referral to the coroner. It is important to realise that the change in coroner workload did not occur immediately; it adjusted to a new level as the medical examiner system matured.

The Department of Health has recognised that this is an additional burden which will have to be funded. It will be important to ensure that additional resources made available as a result are used appropriately to adjust the capacity of the coronial system.

Communication is again crucial. Coroners officers may initially be concerned that their role is being eroded; but they rapidly recognise that they are no longer having their time wasted by unnecessary or medically complex queries. Coroners may need to be persuaded that with a trained medical examiner in place they can relax many of the ‘local rules’ for automatic referral to the coroner, such as the widespread ‘Any death within 24 hours of admission to hospital’ rule.

**Registrars**

Communication is again essential, but the pilots show that registrars (of births, marriages and deaths) welcome the improved standards of death certification which medical examiners bring. Registrars are currently expected to identify inappropriate causes of death, but they are not medically trained so they welcome the input of medical expertise into the scrutiny process. The new system typically reduces the number of death certificates which the registrar has to reject from several each week to almost zero, with obvious benefits for all concerned.

**Funeral directors**

Funeral directors have usually been responsible for collecting the statutory fees for certificates needed to permit cremation. These fees will be abolished.

In some areas funeral directors may wish to take on delegated responsibility for external inspection of the body, as discussed below.
Mortuary staff

Mortuary staff need to be aware of the new processes, but in the pilots they have not identified any problems.

It is likely that in most areas the medical examiners will wish to approve individual anatomical pathology technicians to undertake external examinations on their behalf. This will necessitate a brief training process; a proforma approach has been developed and is available as part of the DH implementation toolkit.

Crematorium medical referees

This role will be abolished by the reforms, along with the cremation forms. But medical referees are likely to be well placed to re-train and apply for positions as medical examiners.

Who will conduct external examinations of the body, and how?

The reforms specify the need for an external examination of the body by a medical examiner, or by someone approved by a medical examiner. It will often be impractical for the medical examiner to do this in person. The certifying practitioner can be asked to do it, although unlike the old cremation form system there would be no additional fee and the law provides no method to make this compulsory. In hospital, the mortuary staff (Anatomical Pathology Technicians) will be well placed to conduct examinations; discussions with them and with relevant managers will be needed. In the community, general practitioners are unlikely to be willing to make a journey specifically for this purpose but Funeral Directors may be willing to undertake the task. It may be necessary to offer a small fee for the service. However, the medical examiner must approve whoever conducts the examination and must be confident that it is done properly. To facilitate this, it may be appropriate to ask those concerned to complete the relevant section of the online training package. A proforma including a checklist of observations has been developed to assist with this task.

The pilots have not been able to test fully arrangement for external examinations, because it requires the new legislation to be in force, but it is obvious once again that good and early communication is needed.

As the role of ‘Crematorium medical referee’ will cease to exist, it will be particularly important that the presence of cardiac pacemakers and radioactive implants is excluded. The former is most reliably checked at external examination.

What IT support is needed?

A medical examiner’s office needs at least two dedicated telephone lines (one of them for a fax machine) and at least one networked PC for each member of staff who will be working there simultaneously. There must be access to a secure email facility (such as is available in most NHS facilities and government offices).

The pilot schemes have used a variety of systems to document their work and provide analysis, including Excel spreadsheets and a locally produced Microsoft Access database. The experience in the pilots indicates that the process is more efficient if a purpose-built database is used.

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1 As a result of experience in the pilots, it is anticipated that there might be exceptions made to this rule when organising an external examination would be unusually difficult or time consuming and the medical examiner is confident that there are no causes for concern in relation to the death. At the time of writing his point has not yet been decided.
It is obviously not cost-effective for every Local Authority to procure its own purpose-built database for medical examiners. Furthermore, if all medical examiners’ offices use the same system, it will facilitate uniform and semi-automated reporting to the office of the National Medical Examiner (NME) – which itself is a pre-requisite for the NME fulfilling his/her statutory requirements.

A Microsoft Access database has been developed for this purpose and is available free of charge. There are recognised security issues associated with this solution, which must be addressed; a fuller discussion is available at http://www.pathology.plus.com/NME/MEimplementationtoolkit/#_Toc378255078.

A printer, a fax machine and a secure internet connection will also be necessary.

**What other problems have arisen in the pilots?**

Some of the problems in the pilots relate to running ‘two systems at once’, because the legislation has not changed yet so the old requirements, such as those around cremation forms, still have to be satisfied.

Problems that are likely still to be of relevance after the legislation is implemented include:

- Managing the expectations of families around ‘turnaround times’. The new process should not introduce significant delays, once it is ‘bedded in’, but relatives have always resented delays in processing the documentation and medical examiner’s officers tend to become the target of such displeasure.
- Obtaining accurate information on how to contact the next of kin is crucially important if delays are to be avoided.
- You should expect that different medical examiners and medical examiners officers will sometimes make different judgements; this does not necessarily mean that either opinion is wrong. Openly discussing disagreements can cause distress to relatives and can discredit the service in the eyes of clinical staff. But it is important to develop a system where difficult decisions can be discussed in confidence with other MEs and MEOs, in an attempt to develop some convergence.
- In some particularly difficult areas it is often valuable to develop a working relationship with relevant specialists to obtain their advice (e.g. microbiologists on the clinical and coronial significance of hospital-acquired infections).