Coroners and Medical Examiners:

Mutualism, Commensalism or Parasitism?

Professor Peter Furness
The National Medical Examiner

held at

The Medical Society of London
11 Chandos Street, London W1

on

Thursday, 9th February 2012

Guest Speaker

Professor Peter Furness

The Medico-Legal Society

A meeting of the Society was held at the Medical Society of London, 11 Chandos Street, Cavendish Square, London, W1G 9EB, on Thursday, 9th February 2012. The President, Ms Elizabeth Pygott, was in the Chair.
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Professor Peter Furness  
Diagnostic Histopathologist

The President: Good evening, ladies and gentlemen. This evening we are very privileged to have Professor Peter Furness with us to address the Society. He is a Diagnostic Histopathologist, with a special interest in renal disease, and served as Vice-President then President of the Royal College of Pathologists between 2005 and 2011. During that time he was involved in discussions around the Coroners and Justice Act 2009, especially the provision for death certification reform and the introduction of Medical Examiners; that is, for the cause of death. He established and chaired an intercollegiate working group to define the curriculum for training Medical Examiners and he worked with the Department of Health to set up the new service. He also obtained agreement that the Royal College of Pathologists would be the lead Medical Royal College for this new group of doctors, the Medical Examiners, and he established and was Foundation Chair of the Royal College of Pathologists’ new Medical Examiners Conference. So he has been highly involved in the new system that was envisaged under the Coroners and Justice Act 2009.

So it is with great pleasure that I welcome Professor Furness to address us tonight on Medical Examiners and Coroners, and he calls it Parasitism, Commensalism or Mutualism.  

(Applause)

Professor Furness: Thank you very much indeed, ladies and gentlemen. It is an honour to be asked to speak to Medico-Legal Society, but on this occasion it is a double honour, because it is the second time you have asked me, so last time I must have said something right. Last time I was speaking about the problems created by our legislation on the use of human tissue; so I was speaking about legislation passed in haste, and I was speaking largely about past history. This time I am invited to speak about the reforms of
death certification, so I am speaking about legislation that has been passed in the exact opposite of haste, and I am talking largely about the future. So that is rather more of a challenge. I hope that I can not only rise to that challenge but also enlist your support, because this is very much work in progress.

The defects of our current system of death certification have been dissected over many, many years by many, many reports; not limited to the Broderick Report in 1971, Luce in 2003, and then of course most recently Dame Janet Smith’s inquiry into the crimes of Harold Shipman. I don’t need to go through those reports sequentially, because as far as death certification is concerned they all came to basically the same conclusion. The problems were absolutely obvious, and it is interesting that it was the crimes of Harold Shipman, rather than the arguments of fine legal minds, that finally persuaded our politicians that something had to be done.

In respect of certifying death due to natural causes, there has been a steady drip of publications demonstrating that even when the medical cause of death is actually pretty obvious and there are no medico-legal implications, when death is clearly due to natural causes, our doctors really don’t know how to use the death certification system. On the screen is an example actually of how not to do it, from a teaching set, but this is not too atypical, I am afraid. The system defined by the World Health Organisation for international use demands a logical causal sequence. So what the doctor writes first in part 1(a) must be due to (must be caused by) what is written in 1(b), and so on, with a logical sequence. As a result, the last item in part 1 of the death certificate is regarded as the underlying cause of death, the ‘real’ cause of death; that is what the statisticians take most notice of. Anything in part 2 is supposed to be a contributory factor. And yet, in practice, a high proportion of certificates issued by doctors have a sequence that is obviously illogical, even if it contains reasonable and relevant terms that pertain to the case. That means that society’s information
on what causes its members to die is actually being left to individual doctors, often very
junior doctors, who make their best guess and then rush on to deal with the backlog of living
patients that they have left behind.

Harold Shipman showed vividly how reliance on that one individual doctor leaves the
system open to abuse. But the system that we have for cremation forms is supposed to have
additional checks and balances. Unfortunately, that has repeatedly been shown simply not to
work, not least by Harold Shipman, of course. ‘Examination of the body after death’ is
required; but too often that is turned into a quick look under the shroud. There is a
requirement for the second certifying doctor to speak to the first certifying doctor (which I
have often summarised as a phone call the entire content of which is: “Did you tell a fib on
the first part or not?” “No”. “Good”). But there is no requirement whatsoever for the second
certifying doctor to actually look at the case notes to see whether what the certifying doctor
says actually makes sense. For years, in my own hospital, I used to participate in helping to
complete second parts of cremation forms. I always thought the process was a bit of a joke,
but my local bereavement office actually eventually stopped asking me. I think I was too
much trouble for them, because I insisted on reading the case notes, as well as speaking to the
people that I had to speak to. Quite often I had to point out that the death certificate made no
sense or was wrong, and that caused trouble, because the doctor had to come back and do it
again. Sometimes I pointed out that the case ought to be referred to the Coroner for further
investigation. So they stopped asking me. I am afraid the system quite clearly had its
priority in getting the job done, rather than getting it right. I could give you many examples
of that, but my point is that the certification of death due to natural causes is a mess.

What about unnatural causes? Those cases, of course, should be referred to the
Coroner, and, as I am a medic rather than a lawyer, I hesitate to criticise the system for the
investigation of unnatural deaths, particularly in present company. But since I am on the subject I think it is reasonable to suggest that are have been a few difficulties…

Others have commented on the variation in practice in Coroners’ courts, the variations in how long the process takes and the need for improvements in these matters. This led in part to the development of the 2009 Coroners and Justice Act. I won’t attempt to comment on the legal processes, but I think it is reasonable for me to make some comment on the difficulty of actually getting this right.

Over ten years ago now, Roberts, Gorodkin and Benbow published a very relevant paper in the Journal of Clinical Pathology. They had taken descriptions, admittedly quite short descriptions, of the circumstances around sixteen deaths. Those descriptions are on the pieces of paper that I have circulated around the room (Figure 1). They circulated them to all the 143 Coroners who were working in England and Wales. On the basis of those details, which included the pathologist’s recommendation for the cause of death, they asked the coroners to suggest a verdict and to provide an explanation for the logic behind their suggestion. 64 Coroners responded, which is less than half, but is actually a good response rate for this sort of survey. I suspect that those 64 were actually the most committed and, arguably, the best Coroners in the country. They were the ones who were concerned to get what they were doing right. They were motivated and willing to do a bit of extra work on it. Despite that, as you will see, there was no unanimity whatsoever in the verdicts, which are set out at the bottom of the second side of the hand-out and on the screen now (Figure 2). The case numbers are on the left-hand side and “Natural Causes” are down the first column. There was no unanimity on the correct verdict for any of the cases. That is not too surprising. But in at least five of the cases it wasn’t even possible to identify a preferred or majority verdict. These aren’t particularly unusual causes of death. They are, however, on the borderline of what is and what isn’t a ‘natural’ cause of death.
As individuals, I find that most Coroners tend to have fairly firm opinions on individual cases; but it is clear that as a group Coroners can’t make their minds up. I make this point this not, absolutely not, as a criticism of Coroners. I have already said I think these responses are probably from the most committed Coroners in the country; Coroners who want to get it right. My intention is to demonstrate that that this task is is difficult; it requires good judgment in difficult circumstances. Yet this distinction between death due to ‘natural’ causes and death due to ‘unnatural’ causes is at the very heart of the proposed division of work between Coroners and the new Medical Examiners of the cause of death.

These are all cases that were actually referred to the Coroner for investigation, so the real situation is probably worse than that. Ask yourself: are Coroners actually considering all the right cases? In the case of Harold Shipman, clearly not. For Coroners, making these difficult decisions is core business. Coroners are trained to do it. But when it comes to deciding whether or not to refer a case to the coroner for such investigation, the decision is usually left to a junior doctor. That junior doctor will have little experience, and will probably have a list of living patients waiting to be seen. That junior doctor will probably be assisted by a bereavement officer who, at best, has as their first priority making things as easy as is possible for the bereaved. At worst, the priority might be to have a quiet life, getting the job done, rather than getting the job right. So do we really think that they will make good judgments all the time?

I was once asked by a psychiatric registrar whether he ought to put ‘starvation’ or ‘dehydration’ on a death certificate for natural causes in respect of a patient who had been in a psychiatric hospital for a month. Seriously, that happened. He thought it was reasonable.

Recognising and ensuring that there is appropriate referral to the Coroner has always been a serious problem, so it is not surprising that some Coroners have devised rules to try to ensure that they actually get to hear about cases that might possibly need a coronial
investigation. There are local rules such as ‘All deaths within 24 hours of admission to hospital must go to the Coroner’. That of course means that if you die at home and your GP thinks you probably had a myocardial infarct, your GP can write the death certificate. But if you make it as far as hospital before you die and you are plugged in on the coronary care unit to the most advanced electronics that the Health Service can buy, meticulously recording your ventricular fibrillation, then if you die: the Coroner has to be informed. It’s potty.

Another popular instruction amongst coroners is ‘I want to hear about all deaths under the age of 16’. So if a child dies after twelve months of battling with leukaemia, the Coroner has to be informed. It is understandable, because of the problems with referral, but it’s frankly crazy. It’s inconsistent, it’s wasteful and it results in a bad service for the bereaved.

I have probably ranted enough on that point, and many such rants from many people over many years didn’t do a lot until Harold Shipman persuaded the Government to introduce the Coroners and Justice Bill. During its passage this Bill turned into a huge dog’s breakfast of different bits and pieces. It includes provisions on matters as disparate as child pornography, court procedure and the profits that infamous old criminals make out of selling their memoirs. It is only the first sections, on death certification and coroner reform, that interest me.

Most of these provisions have not yet been implemented, but the 2009 Act introduced Medical Examiners, who will have to provide independent scrutiny of every death certificate issued in England and Wales where there is not referral to the Coroner. Crucially, and for the first time, there will be an obligation for a doctor specialising in certification of death to review the relevant medical case notes. There will also be a duty to speak to the relatives. I will say that again, because it sounds mundane. Medical Examiners will have to examine the medical case notes. That’s new.
They will speak to the relatives to ask whether the relatives understand the proposed cause of
dead and whether they are aware of any circumstances around the death that suggest that
some further investigation or action might be needed. That’s new.

Isn’t it rather amazing that those are **new** provisions?

This whole process will be overseen by a new national office holder (not yet
appointed) known as the National Medical Examiner. From reading the legislation, it
appears to me that he or she will have relatively little power, beyond the responsibility for
issuing guidance; although the Act does state that “Medical Examiners must have regard to
any such guidance in carrying out their functions”. I am not at all clear what will happen if
Medical Examiners choose to ignore the guidance of the Chief Medical Examiner. I hope
they don’t.

The system will be funded entirely by a fee levied (in effect on the estate of the
deceased) by way of a certification fee. The cremation forms will be abolished and the fee, it
has been promised by our politicians, will not exceed the current total of the cremation form
fees. The difference is that the fee will apply to every death, whether the disposal is by burial
or by cremation. When that was proposed, several of us quoted the words of Sir Humphrey
from ‘Yes, Minister’; we said “That’s very **brave**, Minister…” There have been a few
flurries about a new ‘death tax’ in the tabloid Press, but not very much. In retrospect this
arrangement for funding is probably why this particular section of reforms has not, at least
yet, succumbed to the need for the Government to make economies. There have been some
lengthy delays, principally due to our parliamentary system, but implementation is now
scheduled for 2013, in pretty much the form in which it was originally planned.

That, of course, is more than what one can say about the part of the Coroners and
Justice Act relating to the Chief Coroner. I don’t propose to dwell on the coronial reforms in
any detail; I am not a Coroner; but it is important to note that the office of Chief Coroner was
proposed for the first time, at least in part, to try to encourage consistency and quality in the standards and practice of Coroners. The post was then abolished as a cost-cutting exercise and has now been reintroduced in a somewhat watered-down form. This resuscitation has been largely as the result of lobbying by organisations representing the bereaved, of which the British Legion, I think, got the most publicity. I should think that is a point that Coroners might note and perhaps feel a little concerned about, because nowadays the bereaved are politically a very powerful force, if they choose to be. Many of them want to change what Coroners do and how they work.

The Act also created a post called the Medical Advisor to the Chief Coroner, recognising that such advice would be essential. Indeed the Act mentions the possibility of several deputy Medical Advisors to the Chief Coroner. As far as I am aware – and I would be delighted if someone can correct me – that post has not been resuscitated alongside the Chief Coroner. That is a point that I will return to.

Changing a process of death certification, a process that has fossilised into the fabric of our society over a century or more, was never going to be easy. Some of you may know that I have a track record of not always being entirely complimentary about the Department of Health, but on this particular subject I think they have actually done a brilliant job, at least so far. We now have a system for training Medical Examiners of the cause of death that is almost complete and ready to go, even though we are actually quite a few months away from even considering the first appointments. Crucially, the Department of Health organised not just a pilot, but several pilots of the Medical Examiner system, probing how the system would work, where the problems would be, what the benefits would be, what the costs would be, and so on. That has been very important, because this new system will have to work in primary care as well as secondary care; in cities and in rural communities. It will have to work in ethnically diverse communities, where there are very different traditions and
expectations from different religions around the procedures at the time of death. All these will have to be considered. I think no-one can claim to have broad experience of all of them, but they have now all been tested.

The whole process has been mapped to death. The Department of Health has a process expert who managed to tease out the existing process across (I think it was) sixteen huge sheets of paper, which were plastered around the walls of a room nearly as big as this one. That made everyone feel rather unwell, so he also produced this rather jolly process map, shown on the screen now. I am not sure I understand it all that much better, but I particularly like the junior doctor who seems to be filling out death certificates and, with a rather worried expression, tossing them through a crack in the bridge into the river below.

The proposed new process is a good deal simpler than the previous one (Figure 3). It is still not as simple as I would like. I don’t propose to go through the new process in any detail; I think that would be tedious, although we can discuss it later, if anyone wants to. But I do think it is worth considering the information that has come out of the pilots in respect of this new process.

Perhaps the most eloquent testimony to this being an improvement is in the observation that there are some centres where a pilot ran and was scheduled to finish; Department of Health support and money ran out, and yet the people locally decided that this was actually such a good idea that, as far as the law allows, they decided to continue doing it. So we must be getting something right; it must be some sort of an improvement. What are the benefits that we can claim, on the basis of these pilots?

First of all, we haven’t caught the next Harold Shipman. I think it is reasonable to hope that that is because Harold Shipmans are actually quite rare, rather than that we have missed him. If you look at the inquiries into Harold Shipman’s crimes, it is very clear that there were quite a number of people who knew, or at least strongly suspected, that there was
something going seriously wrong; but they didn’t really have anybody to tell and, not for the first time, nobody thought it was really their job to stand up and say “Something very suspicious is going on here”. Medical Examiners, when they are in post, will have precisely that job. So I am reasonably confident that if we had another Harold Shipman he would be stopped, at least a lot earlier than the two or three hundred patients who he actually managed to kill before he was caught. Medical Examiners have a far, far better chance of catching the next Harold Shipman than the system of medical revalidation that the General Medical Council is currently developing. Shipman would have passed that with flying colours; by all accounts he was extremely intelligent, kept up to date and his patients thought he was wonderful, presumably with the belated exception of the ones that he killed.

Slightly to everyone’s surprise, I think, this has proved to be extremely popular with the bereaved. To start with some of us were a little worried. I think bereavement officers were particularly worried that it might not be too popular having a figure of authority, the Medical Examiner, poking in his nose and asking a whole lot of questions at such a time. It might be perceived as intrusive. But in practice, that is not what happened. Every pilot that has been run has produced pilot Medical Examiners who have commented, with some surprise, that they don’t just get co-operation from the relatives, they get gratitude. They get gratitude because someone in authority is taking an interest. Someone in authority is asking them questions to make sure that everything is all right, to make sure that they understand the process that led to the relative’s death, to find out whether anything could have been done better. It seems this comes over as a bit of a novelty, but a good novelty.

That, I think, augurs well for another benefit that is hoped will emerge from the Medical Examiner system, and that is improvements in the health service. It was always envisaged that Medical Examiners would be liable to pick up problems with the delivery of healthcare, principally from examining the medical case notes and spotting things that went
wrong. But since then we have had Mid-Staffordshire and its Inquiry. That was a failure of the healthcare system that we now know produced far more premature deaths than Harold Shipman ever managed. The report of the inquiry isn’t yet published, but it is quite clear from the evidence given that lots of people again knew that something was wrong but didn’t have a channel with which to put things right. There were lots and lots of individual relatives producing complaints, but the management of the hospital wasn’t taking any notice of those complaints, if they got to hear about them at all. If there had been a Medical Examiner in that system, there would have been an obligation on the Medical Examiner to take it further, including taking it beyond the management of the local health service if things didn’t improve. You may call me naïve, but I am convinced that lives would have been saved as a result.

The pilots, of course, have demonstrated that a proportion of death certificates have to be corrected by the Medical Examiner. We knew full well that would happen, not really because of disagreements about the process that caused death, but because doctors don’t know how to fill in the death certificates. So our Office of National Statistics will get better data, and our policy-makers and politicians and our public health physicians will have better data with which to make their decisions.

As predicated, doctors don’t know when to refer to the Coroner and, to some extent, depending on the location, pilots have seen a reduction in referrals to the Coroner. Often this has been because the Medical Examiner doesn’t put up with the doctor saying “Well, I know it’s natural causes but I am not absolutely sure what to put on the death certificate, so I’ll refer it to the Coroner. (Job done).”. But in other categories referrals to the Coroner have actually increased. For example, in the pilot in Sheffield it seems that in many cases the system had the occupation of the deceased registered as ‘Retired’. The Medical Examiner, whenever there was a respiratory death, said ‘Retired what?’ When that was answered, quite
a proportion of these were deaths of people who had worked in Sheffield’s heavy industry, the steel and the coal, and the deaths were potentially related to industrial disease. Such deaths have to be referred to the Coroner and there is a potential, at least, for compensation for the family, but the doctors didn’t realise.

Which, not before time brings me back to the title of my talk.

Coming as I do from a background of biological science, I have used Mutualism, Commensalism and Parasitism, which are the three main categories of symbiosis; in other words, two completely different organisms living together; the ways in which two different organisms can interact. My justification is that coroners and medical examiners will be rather different organisms who will have to coexist.

Parasitism, of course, is a situation where one organism gains benefit at the expense of the other. I sincerely hope that that won’t be the model between Coroners and Medical Examiners, but, let’s be practical, we will have lots of Coroners and we will have even more Medical Examiners. They will have a very wide range of personalities, rubbing along together in little groups all over the country. It would be naïve to think that there won’t be disagreements. We will have two parallel systems for documenting deaths, depending on the natural/unnatural distinction, which I have demonstrated is extremely difficult to make. One will be overseen by the Ministry of Justice, with an emphasis on crime, and the other overseen by the Department of Health, with an emphasis on healthcare. One staffed by people entirely with a medical training, and one by people with a background in law. Remember that the 2009 Act stipulates that new Coroners will have to have a training in law, not medicine. The concept of the medical Coroner is over. The message seems to be that the job of the Coroner really is to focus on the law, rather than the medicine. So there is a serious danger of conflict. Medical Examiners might see Coroners as a good place to dump as much of their work as possible; anything with the merest suspicion of an unnatural cause
could be removed from the books. Coroners might see Medical Examiners as a problem and react by telling them what to do, and of course Coroners have considerable power to tell doctors what to do. Medical Examiners might react by using the current bottom line of “I don’t know what the cause of death is, so it’s your job”. Improving the service to obtain benefits for society and the bereaved (the benefits I have outlined) could very easily take second place if that happens.

I now move on to commensalism, in which two different organisms co-habit. They rub along together, but neither really gets benefit from or harms the other. It is better than parasitism; at least, it is better for one of the organisms concerned; but I am not sure it is a great deal better for society or for the bereaved. The examples that I have circulated amongst you illustrate the extent to which this division of deaths into ‘natural’ and ‘unnatural’ is actually an artificial construct. It is a line drawn on a continuum of a huge number of cases where every single case is different. If a member of your family were to die in a way which is somewhere close to that line, I suggest that what you would want is a system that helps you through the process in a seamless way, not one that flip-flops between two disconnected authorities that aren’t working together.

In which case, wouldn’t mutualism be a good idea? Different organisms collaborating to make the best of the strengths of each?

There is scope, I believe, for this new system to do this, and in so doing to deliver a seamless service for the benefit of the bereaved as well as for the benefit of society.

At one level, Medical Examiners will need legal advice, and one would hope that the logical place to go first for that would be the local Coroner.

On the other hand, Coroners are mostly, and will be exclusively, lawyers. They will need medical advice. Traditionally most Coroners have obtained medical advice in a rather ad hoc way, commonly from a few doctors they know and trust, often the pathologists who
do post-mortems for them. There is nothing in the legislation or currently the guidance to stop Coroners from carrying on practising in exactly that way. But Medical Examiners, once they are established and developed, will actually represent a whole new medical specialty; a medical specialty of death certification. Coroners will have to work with the practitioners of that new specialty on a day-to-day basis. Medical Examiners will be obliged to keep up to date in the processes by which death may be caused across the whole of medicine, including any new procedures and drugs, and any new complications that may or may not be expected from them. That process of keeping up to date will be enforced as never before by the introduction of medical revalidation. So surely it makes sense for most Coroners to get their advice, at least in the first instance, from Medical Examiners.

That is a basic level of co-operation; it could go a lot further than that.

Consider those crazy rules that I mentioned earlier; the ‘less than 24 hours in hospital’ and ‘anyone under 16’ rules. I am sure there are others. They cause inconvenience and potentially anguish to the bereaved; a price that is exacted in an attempt to ensure that everything that should be referred to the Coroner is referred to the Coroner. It is based on an assumption that the doctors don’t know what they are doing, which is currently an entirely reasonable assumption; but if Coroners can actually trust their local Medical Examiners, then mindless tick-box rules like that surely become completely unnecessary.

Mutualism could go further than that, if there is a will to make it happen. Have a look at those cases circulated by Roberts et al. (Figure 1) and you will see that there are a few in there that aren’t really of value for a Coroner to investigate at all. Ask yourself the question: ‘What is a Coroner trying to achieve in investigating a death?’ Then go beyond the formulaic, ‘to investigate unnatural causes’, or the three purposes of a Coroner. Ask ‘why?’ one more time. Ask why the Coroner wants to do that. Fundamentally, what is the Coroner’s service trying to achieve?
The underlying answer, surely, is to identify deaths where something went wrong; someone did something wrong; something bad happened that might perhaps have been prevented; so that next time we can do something a bit better. If you look on the task of the Coroner in that way, rather than the rather sterile natural/unnatural split, there are some deaths in that list where surely the Coroner has less to add than would be gained by a half decent review of the process by the local hospital’s morbidity and mortality system. For example, look at death number 4; a death due to a late complication of cardiac transplantation. Having a cardiac transplant is manifestly not a natural process; but in that case, and indeed the other cardiac transplant case on that list, it seems clear that the patient would have died earlier if that unnatural process had not actually occurred. There is less evidence of neglect in that scenario than there is in many a bronchopneumonia occurring in a nursing home. Yet you can see how many Coroners didn’t think this could quite be issued as ‘natural’ causes (Figure 2).

There are also deaths on that list where referral to the Coroner is expected, but in reality it is actually because of a public health concern, rather than because of a problem in law. Something in the system could be improved, but there is no suggestion really of any illegal acts. At present there is a list of infections where, if they appear on the death certificate, the Registrar has to inform the Coroner. Glanders is one of them. I mention that because I can actually remember what glanders is. The list has quite a few others that I can’t remember, because I have no idea what they mean, because many of the terms are so archaic. Most doctors couldn’t tell you what is on that list. But they are largely infections where there is a potential public health concern. So, if it is a public health concern, wouldn’t it make more sense to have the investigation initiated by the Medical Examiner, whose main concern is actually to feed information about problems into the health service, rather than the
Coroner? If it is public health, isn’t the evaluation better led by a doctor, rather than a lawyer?

The answer to that question has always been that frankly it was only the Coroner who could be relied on to do the job properly. But if you have got well trained professionals on both sides of this natural/unnatural divide, is not there scope for the Coroner to focus on cases where something seems to have gone wrong in law and the Coroner can do some good as a lawyer, while the Medical Examiner sorts out cases where something seems to have gone wrong with the health service that doesn’t involve any legal liability or implications?

In saying that, I have just proposed a division of work that doesn’t actually rely on the phrase ‘natural causes’, which underlies the cases that were circulated to you (Figure 1). That is because none of us really know, much less agree on, what ‘natural’ means. For example, the paper by Roberts includes a discussion on whether or not gastrointestinal infections are ‘natural causes’. Their cases clearly indicate that a lot of Coroner think they aren’t natural in this affluent country, where such infections are now relatively rare. Look at that in a global context and it’s nonsense, because gastrointestinal infection is one of the commonest natural causes of death in the world. What matters is not that it is gastrointestinal infection, but was anyone culpable in transmitting that gastrointestinal infection? Is it a legal problem or is it a medical problem?

So can we get rid of this natural/unnatural divide? It seems obvious to me that Coroners and Medical Examiners ought to work closely together to deliver this service, probably in adjacent offices, although that has not been proposed as a requirement. If they do work together, the whole business of referral or otherwise to the Coroner in borderline cases comes to matter a lot less, because every death will be certified and investigated appropriately. Crucially, for those deaths that have implications for public health or the quality of the healthcare systems, appropriate steps will be taken, whether it is the Coroner or
the Medical Examiner who is overseeing the case. Will Coroners and Medical Examiners work together like that? I believe that many of them will, at least as far as the legislation allows; but, as I stressed before, we will have a service made up of a kaleidoscope of personalities and we can be confident that some of them won’t. Some will have arguments.

Do we have any system to sort out such disputes? No, we don’t.

Medical Examiners will be led by the National Medical Examiner. There will be at least 500 Medical Examiners, so they will not all behave as one might hope. The National Medical Examiner will merely have the power to issue guidance.

Coroners will be led (if that is the right word) by the Chief Coroner. As far as I can tell, the Chief Coroner will have no more power than the National Medical Examiner in terms of correcting bad behaviour (perish the thought) amongst Coroners.

It is obvious to me that the National Medical Examiner and the Chief Coroner ought to work closely together, if we are going to have any hope of the two systems working together in mutualism to deliver a seamless service. So let’s hope that when they are appointed they are both sensible people who actually get on with each other. I say that because there is no sign that I can see that the systems they work in will ask or expect them to collaborate in that way. I mentioned earlier that the post of Medical Advisor to the Chief Coroner seems to have been abolished and not resuscitated. That seems to me regrettable, but, if that is the world we are in, it seems sensible that the Chief Coroner should, in the first instance, source medical advice from the National Medical Examiner. I raised that idea informally with civil servants I had been working with on this business, anticipating that they had probably thought of that already. Not a bit of it. They were filled with horror by the proposal. “No, no, that wouldn’t work”, they said. “Why not?”, I asked, naively. “Different Government departments”, they said. “The National Medical Examiner is
Department of Health and the Chief Coroner is Ministry of Justice”. That seemed to be the end of the argument. No further discussion required; that obviously made it impossible.

From that I conclude that producing a seamless system does not actually seem to be the aim if there are different Government departments involved. Mutualism is not how Government departments work. I think that is rather regrettable.

In conclusion, I hope I have painted an optimistic picture of long overdue reforms that are about to be implemented that will improve the quality of our statistics on how members of our society die; will improve the quality of our health services and Mid-Staffordshire will never happen again; will hopefully ease the pain of the bereaved at least a little; our public health services will be better informed; and we will catch the next Harold Shipman with much greater efficiency, to name but a few benefits.

I have also highlighted some of the problems and pitfalls. If you can see any others, or if you can see any ways around those pitfalls, I would be delighted to continue the conversation with you.

Thank you very much for your attention. (Applause)

The President: Well, Professor Furness has very kindly agreed to take questions, so, if you would like to ask one, would you say who and what you are. Thank you very much.

Discussion

The President: Diana Brahams.

Mrs Brahams: Diana Brahams, lawyer. Can you tell me what the basic qualifications, or, if you like, from whose ranks you expect some of these Medical Examiners to be formed?

Professor Furness: The regulations so far will state that it is anyone with a medical qualification, with a licence to practise from the GMC, who has been on the Medical
Registrar for five years or more and is in medical practice at the time of appointment. So it is very broad. That is intentional partly because you can see the difficulty of suddenly finding 500 doctors. If they were all autopsy active pathologists, there would be none left to do the Coroners’ autopsies, so the intention is to recruit them from a broad background. It is clear that there are a lot of GPs out there who are interested in this job. Because we anticipate recruiting people from a very broad background we have put a lot of work into the training programme. We have a very extensive e-learning programme already built and available – it’s already online, you can have a look at if you want - and we are in the process of developing some face-to-face learning for Medical Examiners before they actually start work in earnest. So I hope we have got that covered.

**Mrs Brahams:** And what about conflicts of interest?

**Professor Furness:** Conflicts of interest have been discussed at length, and there are clearly guidelines on personal conflicts of interest - for example, deceased cared for by doctors you have worked with or know members of the family, that sort of thing, as you would expect. When the legislation was being discussed there was a great deal of concern about conflicts of interest in relation to employers, because the fear was that the Medical Examiner would be employed by the organisation under whose care the death occurred - and Mid-Staffordshire now looms large. The initial proposal was that primary care trusts would employ the Medical Examiners. That everyone thought was a bit unsatisfactory, particularly since that would put the Medical Examiner and Harold Shipman under the same ‘employer’. Primary care trusts are now in the process of being dissolved by the Health and Social Care Bill - that is part of the reason for delay to the system, induced by Parliamentary process - so Medical Examiners will be employed by local authorities, putting them potentially closer to Coroners. I think that’s a good idea but it has caused some consternation amongst local authorities and has delayed the implementation a bit further. But that is currently the plan,
because local authorities on the whole won’t have responsibility for hospitals or GPs. Deaths in local authority nursing homes is potentially still there, but I think the distance is great enough and nowadays most nursing homes are run privately anyway, aren’t they?

Mrs Brahams: Thank you.

Dr Paul Knapman: My name is Paul Knapman, and I am a fairly recently retired Coroner, and I think this system actually is a very good idea and I think it is very laudable, and I think that you have identified a lot of the potential difficulties that there will at the start. Whether or not they iron themselves out in time we will see. The one thing that I can see as being a difficulty is the extra cases that Coroners will have that will be difficult. We already live in a society where people have a propensity to question and blame, etc., and I believe that this (and this is not a bad thing) will mean that families will complain more about the treatment that the deceased had. A Coroner’s Officer may sideline this perfunctorily. Rather unfortunately, this has been happening in the past, I rather suspect. So Coroners will have more cases with difficult inquests, and we already have a system where I think Coroners are very busy indeed. We have actually about one quarter the number of Coroners in England and Wales per capita than in New Zealand, which has recently gone through some legislative change. That is a matter which you haven’t highlighted quite so much, but I just share with you that that is a worry that I would have if I was still a Coroner.

Professor Furness: Thank you. I am certainly well aware of those concerns and obviously it is a new system and we don’t know exactly what will happen. My understanding is that the pilots on the whole have shown that fewer deaths are referred to the Coroner when this system is in place. Coroners, of course, have been quick to point out, as you suggest, that the ones that are removed from their workload are the straightforward and simple ones, so that is no great saving. As far as the relatives are concerned, I think there is a lot of scope there for using the fact that when people are invited to express their concerns
and it is done well you can actually defuse them. I have in mind a case that I had to deal with just very recently, where a 94-year old lady who was actually incredibly active and self-caring went into hospital, deteriorated and died. Her daughter found that a ‘Do not resuscitate’ order had been made without any consultation the relatives and without any knowledge of the previous health of the lady concerned, which is a breach of NHS guidance. She was hopping furious. Now, what I think should have happened in that case is not thump the table, “This must be investigated by the Coroner”, but a discussion with a Medical Examiner with sufficient authority to say “Look, the Coroner in this case is going to record a verdict of natural causes; your mother died of bronchopneumonia; but you nevertheless have a legitimate cause for complaint against the health service. Here is how to write a letter to the Medical Director. I, too, will be making a report about this. Something will be done”. Result: Happy relative. Well, no, obviously not happy, but hopefully a lot less angry and frustrated. So there is scope, if we can get it together, to sort things out in that way. In fact your concern about workloads was in part behind my suggestion that we ought to try to abandon the natural/unnatural split and have Coroners and Medical Examiners working together so that they can between them work out where the responsibilities lie. You’re shaking your head. I know that is to a large extent defined in law, but being part of a team I am sure has more scope for efficiency than being two competing camps.

**Dr Mansell:** Martin Mansell; I am a nephrologist. The medical negligence lawyers seem to be increasingly keen to use the inquest as the first step on an investigation of a possibly contentious death and families are increasingly represented by lawyers at inquests. How do you see the changes you have described altering that process in the future, if at all?

**Professor Furness:** I can’t see that changing really very much at all from the changes I have been describing, because, of course, the relatives will continue to have the right to insist on referral of the case to the Coroner. I could speculate that there may be some
cases where the Coroner feels more empowered to say “No. It is clearly natural causes. This must be dealt with by the Medical Examiner, who will make sure that any problems in relation to the delivery of healthcare will be appropriately addressed”. That is speculation. But, as I have said, deaths do not divide into natural/unnatural and I am discussing a relatively narrow area around the borderline where I think there is room for manoeuvre.

Miss Platt: Eleanor Platt, lawyer. Will the Medical Examiner make the system slower in obtaining death certificates, etc.? I am really talking now about the practicalities, because part of the problem for certain communities is the availability of Medical Examiners at weekends and Bank Holidays, and my understanding is that they do not intend to be so available.

Professor Furness: No, they will be so available, depending on the locality. Financial constraints and that political promise to keep the fee down to the current cremation form fee has put constraints on it, but the intention is explicitly that in those areas where there is a significant sized community whose rituals demand rapid disposal of the body, out of hours availability will be made possible. I was actually part of a small pilot to test that in Leicester, where we have more than the average number of individuals of faiths that expect rapid disposal. In fact, what we found was that even with a need for rapid disposal it was actually quite unusual to have to get a Medical Examiner to work out of office hours. They had to be on call and available. It didn’t turn out to be necessary as often as we had thought. That was one of the lessons from the pilots. In practice, if a system is working efficiently, the pilots tell us, it shouldn’t delay certification significantly, and of course whenever you get a case where the Registrar rejects the death certificate it makes it an awful lot faster. The biggest delays come in rural communities where there is a problem with gathering together the information if things are spread over a geographic distance.
**Dr Keith Rix:** Keith Rix, forensic psychiatrist and part-time law lecturer. I have two questions. Forgive me if you have answered first and I missed it. Will these Medical Examiners be full-time or part-time and, if they are full-time, what sort of a career structure will exist for them? My second question is this. The Medical Examiners will have, I presume, a personal knowledge of the facts of the case from a medical point of view. One envisages that sometimes they will be called to give evidence at the inquest. Will they be there as professional witnesses or as expert witnesses, or would it make any difference if there was such a distinction brought?

**Professor Furness:** First, part-time/full-time: it is anticipated that the majority will be part-time. That will be preferred because what we really want is doctors who are still in medical practice. So no career structure is really envisaged and we believe that most of these will come from individuals who are probably moving towards retirement and want a change of scene before that, so lots of experience, but still part-time. Medical Examiners acting as witnesses in inquests: I have to admit I had never considered that and I don’t think it will happen very often, because if there is a need to refer to the Coroner the instruction to the Medical Examiner is “Tell the Coroner straightaway, don’t try to investigate yourself”. So in cases with inquests I can’t see really what the Medical Examiner could bring, other than if you want someone with a relatively impartial medical background to help with some interpretation of the case notes or other information. On the whole, in my experience, at inquests that is usually the job of the people who wrote the case notes. On your distinction between expert and professional I don’t know the answer, because I can’t really envisage the circumstances where a Medical Examiner would have a major role in an inquest. I may be wrong. That would be interesting to find out.

**Judge Suzanne Norwood:** You say that families and friends and the bereaved are filled with gratitude at the sight of a Medical Examiner. When I was bereaved - and I had no
cause for complaint about anything - I should have hated to have a perfect stranger come in and start asking me if I was happy about my husband’s death. Would I be compelled to see him, or could I say “No. Go away”? (Laughter)

Professor Furness: You are quite right that the delight is not entirely universal. I was describing the overall average experience of pilot Medical Examiners when interacting with the bereaved. The Medical Examiner would be obliged to have spoken to the relatives. It can, if necessary, be very brief. So if you choose to say “Go away”, it could be argued that the Medical Examiner had spoken to you. I don’t think he would have done his job very well and he would probably have to ask whether there was some other member of the family who would be willing to speak to him or her. You spot the difficulty?

Judge Suzanne Norwood: I don’t think it should be compulsory.

Professor Furness: Well, there is always the possibility – I am not referring to your present circumstances, but in the generality, there is the possibility that the person to whom the Medical Examiner speaks has something to do with the death that might lead to referral to the Coroner.

Judge Suzanne Norwood: Nobody is going to say to the Medical Examiner “Yes, I did him in”. (Laughter)

Professor Furness: Quite right. These are processes that will have to be worked out. I think the “I refuse to talk to you” will probably lead to “Can I speak to someone else then?”

Judge Suzanne Norwood: And if I say “No”? I am sorry. I know I am being difficult, but this seems to me another opportunity for the state to interfere in private matters.

Professor Furness: Well, the state has to certify deaths and investigate whether there is a problem with the death, and don’t Coroners interfere into private matters rather a lot for that very purpose? Part of the function is finding out whether the health service has a
problem. I think sorting out problems like Mid-Staffordshire, with an estimated couple of thousand premature deaths, is a reasonable justification for looking gently into private matters, rather more justification than there is in many Coroners’ cases.

The President: I have a couple of questions. Number one is: are you envisaging any problem in being able to recruit the number of Medical Examiners that are required? Then, secondly, a completely unconnected question is what happens, as quite often happens when we investigate deaths in a Coroner’s Court, when we have no next of kin? So who are they going to speak to?

Professor Furness: If there are no next of kin, then clearly that part of the investigation can’t be completed, but the Medical Examiner would have to record what steps had been taken to try to find the next of kin. So that is reasonably straightforward. Recruitment is a worry. 500 doctors from the current health service is a potential problem and we don’t know what is going to happen. If anecdote has any value, I am getting a steady stream of doctors from various specialties, but quite a lot of GPs, saying “How do I find out more about this job? Is it really going to happen? When is it going to happen?” A lot of people thought it was abolished with the Chief Coroner and are now saying “Is it back again?” In fact it never went, and I am directing them to the website with the e-learning; if they go through the first module of that they will have a good idea what the job involves. So there is certainly interest, but I have to admit I don’t know whether that is just a small number of oddballs or a ground swell.

The President: Is that the right sort of interest, yes. Time is moving on. Dr Dean, and then I will take one more question and then we will bring proceedings to a close.

Dr Dean: Peter Dean. I do work as a Coroner, so I am interested in this area from that point of view as well, but I would just like to return to natural deaths. We still will be involved in investigating many deaths which are still theoretically ‘natural’ deaths. If we
think back to *Touche* in the Court of Appeal, you can only really infer a death is natural if you don’t feel there is any unnatural component, and an unnatural component could be the failure to provide appropriate medical care, so it is important that we still do need to look at a considerable amount of natural deaths if concerns are expressed by the family or any other properly interested persons. That is just an observation. I would be grateful for any comments on that. But the other point is a practical problem, which is that at the present time if there is a cremation absorbed in all the fees will be a payment to the doctors who fill in the appropriate parts of the cremation form. With the new system my understanding would be that the Medical Examiners will be asking for a fee from the families involved and a lot of the system, hopefully, will be funded from those fees. Now, if a case is referred to the Coroner, at the present time there is no payment for a Disposal Certificate and how long will it be before relatives in the family pick up on the fact that if you can refer a case to the Coroner you won’t have to pay the £80 to the Crown? (Laughter)

**Professor Furness:** The incentive to refer to the Coroner has been noticed and has stimulated much muttering and stroking of chins amongst the Civil Service. I think there we are relying on the fact that the Coroners will not want to take on cases unnecessarily and will be empowered to bounce them straight back to the Medical Examiner.

**Dr Dean:** We have a duty to examine them and we might be accused of insufficient inquiry if a case……

**Professor Furness:** Coroners might be accused of insufficient inquiry at any moment with any case that currently isn’t examined thoroughly by them, and indeed in quite a few that are. I don’t accept that that is a serious a problem. We will have to see how it works, but clearly that incentive will have to be blocked in some way, if it proves to be a problem.
Ms Pownall: Sophie Pownall, lawyer. I wondered, what will happen in respect of fees and children and those who don’t have an estate to support them?

Professor Furness: My understanding is that children will not be exempted from the fees, but in cases of hardship …. You are suggesting that children don’t have the resources themselves to pay the fees after death. The individual who actually has to make the payment is the informant who registers the death, which in the case of children will normally be the parents. Sebastian, have I got that wrong?

Professor Sebastian Lucas: I thought there was some exemption for children under a certain age actually.

Professor Furness: Certainly there is an exception for those who are unable to pay and others who die intestate, such that the relatives won’t have to pay if the deceased actually has no resources. Again that has caused much thinking amongst the Civil Service, who are trying to working out what proportion that would be as they plan the budgeting. In respect of an exemption below a specific age, I am sorry; you have hit a lack of knowledge. There will be someone in the Department of Health who can give an authoritative answer, but I don’t know it.¹

The President: Well, I think on that note we will draw the evening’s proceedings to a close, and I would like to call upon Dr Roy Palmer to give a vote of thanks.

Professor Furness: Thank you.

Dr Palmer: Ladies and gentlemen, Peter has informed us very considerably on what is to come. You are an optimist. I hope you are right in your optimism. I suspect a good deal will depend on resource, and there isn’t a lot of that around at the moment. I am entirely with you on mutualism; it ought to be a mutual exercise. My worry, like yours, is

¹ Subsequent discussion with members of staff in the Department of Health has indicated that at present, there is no plan to provide exemption from the certification fees for deaths in childhood.
that the Department of Health and the Ministry of Justice don’t speak adequately (of course they speak, but not adequately) to each other and we don’t have joined up Government, and I think there is a real concern and real practical issues that you will be aware of. But, ladies and gentlemen, we have been extremely fortunate in that Peter was very busy indeed as the President of the Royal College of Pathologists and I know spent enormous amounts of time not just on the railway line to and from Leicester to London but also in the College and at meetings developing this whole Medical Examiner system, chairing the Committee that looked into, helping with the E-Learning programme, and I am sure that if your optimism is well placed the generations in future will have an enormous amount to thank you for. But it is my happy task this evening and my privilege to thank you for coming to speak to us this evening and informing us and entertaining us. Thank you very much indeed. (Applause)

The President: On behalf of the Society, just a small token of our thanks.

Professor Furness: Oh! Thank you very much.

The President: Thank you very much indeed and thank you for coming, and a safe journey home.
Figure 1. Index cases supplied to UK coroners for comment, as described in Roberts et al, “What is a natural cause of death? A study of how coroners in England and Wales approach borderline cases”. J Clin Pathol 2000; 53:367–373. (Reproduced with permission)

(1) A 52 year old man dies suddenly 3 days after an emergency laparotomy, performed for a perforated duodenal ulcer. At necropsy the pathologist finds deep vein thrombosis and a massive pulmonary embolus and makes the comment that the surgery will have increased the probability of deep vein thrombosis. There is no evidence at necropsy of operative mismanagement and the pathologist makes the comment that without surgery death would have occurred immediately.

Cause of death given by the pathologist:
1a Pulmonary embolus
1b Deep vein thrombosis as a result of immobilisation
1c Surgery for perforated duodenal ulcer.

(2) A 61 year old woman dies with bronchopneumonia 4 days after having a total hip replacement for severe osteoarthritis. There is no evidence at necropsy of operative mismanagement.

Cause of death given by the pathologist:
1a Bronchopneumonia
1b Immobilisation
1c Total hip replacement for osteoarthritis.

(3) A 60 year old man has severe cardiac failure secondary to ischaemic heart disease with an estimated life expectancy of several months. He has a heart transplant but suffers irreversible acute rejection and dies 3 weeks after transplantation.

Cause of death given by the pathologist:
1a Cardiac failure
1b Rejection of cardiac transplant
1c Ischaemic heart disease.

(4) History as above; however, the man survives 3 years after cardiac transplantation, dying in cardiac failure secondary to chronic rejection of the graft.

Cause of death given by the pathologist:
1a Cardiac failure
1b Rejection of cardiac transplant
1c Ischaemic heart disease.

(5) A 58 year old woman dies after developing pneumocystis pneumonia. She had suffered from end stage renal failure and received a renal transplant 6 months previously, after having been on dialysis treatment for 18 months. The pneumonia is believed to have resulted from the immunosuppressive treatment she received to prevent rejection of the transplanted kidney.

Cause of death given by the pathologist:
1a Pneumocystis pneumonia
1b Immunosuppressive treatment
1c Renal transplantation for end stage renal disease.

(6) A 25 year old man, known to suffer from epilepsy, dies in respiratory failure in an intensive care unit. He was admitted 10 days previously after suffering fractured ribs and trauma to the underlying lung as a result of falling in the street. From the report of witnesses at the time it appeared that the fall resulted from a grand mal epileptic fit.

Cause of death given by the pathologist:
1a Adult respiratory distress syndrome
1b Fractured ribs with pulmonary contusion
1c Fall after epileptic fit.

(7) An 84 year old woman falls at home and suffers a fractured neck of femur. She is admitted to hospital and dies 3 days later with bronchopneumonia. At postmortem examination she is found to have severe osteoporosis.

Cause of death given by the pathologist:
1a Bronchopneumonia
1b Immobilisation after femoral fracture
1c Osteoporosis and fall.

(8) A 75 year old man is admitted to hospital after falling at home and suffering a fractured tibia. X rays on admission showed multiple deposits of tumour within the tibia and other bones. He died suddenly 4 days later. Postmortem examination demonstrated deep venous thrombosis and pulmonary embolus. The tumour was found to be metastatic carcinoma of bronchus.

Cause of death given by the pathologist:
1a Deep vein thrombosis with pulmonary embolus
1b Immobilisation after fracture of the tibia
1c Disseminated bronchial carcinoma and fall.

(9) A 38 year old man dies from hepatitis B virus associated cirrhosis of the liver. He is known to have been an intravenous drug addict in the past and this is believed to be the source of the hepatitis B infection.

Cause of death given by the pathologist:
1a Hepatic cirrhosis
A 50 year old man dies from chronic liver disease due to hepatitis C virus infection. The source of infection is obscure because the patient had not admitted to any of the known risk factors, such as blood transfusion or drug abuse.

Cause of death given by the pathologist:

1a Hepatic cirrhosis
1b Hepatitis C virus infection.

A 36 year old man with AIDS dies with cryptococcal meningitis. He was known to be a promiscuous homosexual and it is assumed he became infected from his boyfriend who died of AIDS 2 years earlier.

Cause of death given by pathologist:

1a Cryptococcal meningitis
1b AIDS
1c HIV infection.

A 29 year old woman with AIDS dies from pneumocystis pneumonia. She was a known heroin addict who injected drugs and this is believed to be the source of infection.

Cause of death given by the pathologist:

1a Pneumocystis pneumonia
1b HIV infection
1c Intravenous drug abuse.

A 15 year old boy dies with Creutzfeldt-Jakob disease. He had received injections of human growth hormone in the past and this is the presumed source of infection.

Cause of death given by the pathologist:

1a Creutzfeldt-Jakob disease
1b Treatment with human growth hormone.

A 65 year old man dies after developing a severe fungal pneumonia. He had been diagnosed as suffering from acute myeloid leukaemia 10 months ago and had been treated with a course of chemotherapy. At the time of death he was in remission but had a low white blood cell count as a result of his treatment. The pathologist makes the comment that without treatment the man would have died earlier from the effects of leukaemia.

Cause of death given by the pathologist:

1a Fungal pneumonia
1b Immunosuppression
1c Chemotherapy for acute myeloid leukaemia.

A 16 year old girl dies from a rapidly progressive dementia, demonstrated at necropsy to be caused by spongiform encephalopathy. There were no known risk factors other than the regular consumption of beefburgers over the previous 10 years.

Cause of death given by the pathologist:

1a New variant Creutzfeldt-Jakob disease

A 72 year old woman dies after developing a severe colitis associated with Escherichia coli 0157 infection. The source of infection was traced to some cooked meat at her local butchers.

Cause of death given by the pathologist:

1a Colitis
1b Escherichia coli 0157 infection.
**Figure 2.** Suggested verdicts from 64 coroners in response to the index cases described in Figure 1. From Roberts et al, “What is a natural cause of death? A study of how coroners in England and Wales approach borderline cases”. *J Clin Pathol* 2000; **53**:367–373. (Reproduced with permission)

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Figure 3. A brief diagrammatic summary of the process of certification of deaths under the new Medical Examiner system.

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

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 from Registrar or Disposal Order from Coroner

Advice
provided by ME to Attending Doctors, Coroner and/or Coroner’s Officers

Reportable Deaths & Enquiries

Initial Assessment
Initial Discussion with a doctor when a death is notified

Talk with Relatives
review medical history & decide if to issue 100A

Investigation
Coroner’s Post Mortem if required

Inquest
Appeal against Coroner’s decision or finding

Confirmation of Disposal

Clinical Governance
data on patterns and trends / issues

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

If new concerns raised during registration of deaths for which ME has issued ME-2

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

Deaths reported as a result of Scrutiny

Form 100B

Disposal Order

The inquest stage of the investigation may be suspended as a result of criminal proceedings, public inquiry or an investigation by another country into a death in their jurisdiction and then either resumed or discontinued

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. 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.