The Royal College of Pathologists
Pathology: the science behind the cure

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

The Royal College of Pathologists' written submission

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What is your name and role?
Dr Suzy Lishman, President, The Royal College of Pathologists (professional body).

Question 1: Do you agree that an individual should be prescribed in legislation as being responsible to pay, or to arrange to have paid, the medical examiner fee?

Question 2: Should the person prescribed be the individual that collects the MCCD from the medical examiner, or the death registration informant?

Question 3: Should the regulations exempt an official or employee who acts as an informant, from being responsible to pay, or to arrange to have paid the medical examiner fee?

Question 4: Should there be a 28 day or three month period for payment of the medical examiner fee?
Questions relating to the funding mechanism for the implementation of the role of medical examiner is outside the remit of the The Royal College of Pathologists.

Our core concern is that funding should be at a level sufficient to deliver a high quality service and that the mechanism of funding should be as efficient and cost-effective as possible.

In particular, funding should be sufficient for effective set up costs of the medical examiner system.

We would be concerned if it was proposed that the person collecting the MCCD or registering the death would be expected to pay the fee at that point, as such an arrangement might inhibit the proper registration of deaths.

Question 5: As a local funeral service would you be willing to collect the medical examiner fee on behalf of a local authority, for a small administrative charge? The bereaved would see the fee itemised in the funeral director's bill. YES/NO
Not applicable.

Question 6: Do you believe the provision of "administrative and clinical information" set out in schedule 1 is necessary and sufficient for all deaths, either for a medical examiner's scrutiny or for a coroner's investigation? If not, what would you add or delete and why?

Yes. It will be helpful if the information required by both systems is identical.

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

Yes, subject to oversight by the National Medical Examiner (NME) to ensure that this option is not used excessively.

The RCPath suggests that thought needs to be given to providing a mechanism by which any medical examiner found to be over-using this option can be persuaded to comply with national guidance, as the NME has no obvious powers to ensure compliance.

Question 8: In your view, are there sufficient safeguards if a person without a medical qualification but with suitable expertise and sufficient independence carries out a non-forensic external examination of the body on behalf of the medical examiner?

Yes.

Question 9: Under regulation 26, do you agree that the medical examiner process should be suspended during a period of emergency?

Yes.

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

Yes.

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

The RCPath has no recommendations for improving the certificates, other than noting that it will be important to be able to complete, transmit and store the documents electronically. It should therefore be acceptable to reproduce the content of the documents on-screen, rather than requiring the use of approved paper documents.

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

The RCPath believes that nothing further is needed on defining levels of performance, because this is left to the discretion of the NME, and results will presumably be published in his/her Annual Reports. However, there needs to be a robust mechanism by which the NME can obtain information on local compliance with the standards.

We are not convinced that the proposed duty on medical examiners to supply information on request to the NME is sufficient. There is also a need for a mechanism to ensure that corrective action takes place, if a problem is identified. At present this appears to be limited to informing the local authority, informing the Secretary of State for Health, and the publication of reports. We are not convinced that this gives the NME sufficient authority to ensure that problems are corrected.

Question13: Do you agree with the estimates of costs and benefits of the death certification reforms set out in the consultation impact assessment?

We have concerns that the figure in the impact assessment of an increase of 20,378 coroner post-mortems/inquests was an over-estimate.

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

Yes and see Question 15.

Question 15: Do you believe there is sufficient understanding between members of the medical and coronial professions as to the meaning of "unnatural" and that further definition is not required? If not, we would be grateful for suggestions as to what the guidance may include.

The definition of 'natural' in this context is complex, subjective and likely to change over time. We therefore believe that legislation should allow the Chief Coroner, in consultation with the NME, to draft updated guidance on this point as and when it is necessary.

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

Poisoning is clearly an unnatural cause of death so its inclusion is arguably a duplication, but the added clarity probably justifies this duplication.

Question 17: Do you believe that "poisoning, the use of a controlled drug, medicinal product or toxic chemical" sufficiently covers all such circumstances of death? If not, should the guidance be broadened?

The use of a controlled drug or medicinal product is often justified on medical grounds. In terminal care, the use of controlled drugs in an entirely appropriate manner, to alleviate pain, may risk hastening an inevitable death. The RCPath does not believe that such cases should automatically be investigated by the coroner. Consequently the test should be an ***inappropriate*** use of (or an inappropriate failure to administer) a controlled drug or medicinal product.

The RCPath believes that legislation should allow the Chief Coroner, in consultation with the NME, to draft updated guidance on this point as and when it is necessary.

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

The definition of 'neglect' in this context is complex, subjective and likely to change over time. The RCPath therefore believes that legislation should allow the Chief Coroner, in consultation with the NME, to draft updated guidance on this point as and when it is necessary.

Question 19: Do you agree that regulation 3(2)(e) - "occurred as a result of an injury or disease received during, or attributable to, the course of the deceased person's work" - is clear that it includes any death that has occurred as a result of current or former work undertaken by the deceased, including cases such as mesothelioma or other asbestos related cases? If not, we would be grateful for alternative suggestions.

The RCPath believes that this is sufficiently clear. If problems in interpretation do arise, it should be possible for clarification to be issued by the Chief Coroner, in consultation with the NME.

Question 20: Do you agree that it should be possible to make notifications orally, but that where an oral notification is made the information must be recorded in writing and confirmed?

The RCPath believes that this is acceptable, although it should be explicit that 'in writing' includes electronic communication.

Question 21: Do you agree that regulation 3(6) should prevent duplication of notification? We would be particularly grateful for views on how this would work in a surgical environment.

The RCPath believes that regulation 3(6) is reasonable and proportionate, although clearly it is preferable to balance the system towards duplicate notifications rather than risk a failure of notification.

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

The RCPath has no further comments other than noting that implementation of these reforms is long overdue and any further delays should be strenuously resisted. The pilots of the reforms have demonstrated conclusively that the benefits far outweigh the costs.

Question 23: In relation to the guidance, do you agree with the examples used under each category of death? If not, we should be grateful for further examples or suggestions for definitions.

The RCPath is concerned that the condition for referral: *'The death is related to any treatment or procedure of a medical or similar nature'* is too vague. 'Related' could even be interpreted as 'related in time', in which case all deaths would be referred. The examples clarify this to some extent, but may still be interpreted in a way which results in a large number of unnecessary coronial investigations.

Question 24: Also in relation to the guidance, do you agree that no specific reference is needed as to whether certain deaths will be subject to jury inquests or not (such as those that have occurred under state detention)?

The RCPath does not wish to respond to this question.

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

The RCPath has no further comments other than noting that implementation of these reforms is long overdue and any further delays should be strenuously resisted. The pilots of the reforms have demonstrated conclusively that the benefits far outweigh the costs.

Question 26: After the changes are brought in, there will be no provision for medical examiners to be involved in the certification of the cremation of body parts. Do you agree that the requirement to complete a statutory application form and provide a registration document and a certificate from the hospital trust or other authority holding the body parts will provide sufficient scrutiny prior to the cremation of body parts? If not, what further scrutiny do you think would be needed, in the absence of medical referees?

The RCPath does not believe that further scrutiny of the cremation of body parts is needed, but accepts that the opinion of other organisations will be of more relevance on this point.

Question 27: Do you agree that this proposal will provide a sufficient level of scrutiny in stillbirth cases? If not, what further scrutiny do you think would be needed, in the absence of medical referees?

The RCPath supports extending the scope of the role of medical examiner to review stillbirths.

It might be appropriate to consider this extension once the medical examiner service has been established and settled in.

Question 28: Do you agree that investigation and clearance for cremation by a coroner provides sufficient assurance for cremation to take place without a further check by a medical referee based at the crematorium? If not, what further scrutiny do you think would be needed, in the absence of medical referees?

The RCPath believes that clearance for cremation by a coroner ought to be sufficient. However, we note that coroners are now obliged to have legal rather than medical qualifications; if this issue is regarded as problematic it might be appropriate to require the coroner to consult a medical examiner about the case. This would of course demand the establishment of appropriate funding to cover the work. We do not at present believe that such a step is necessary.