**Medical Examiners and Death Certification Reform: Still in the Long Grass**

**Dr Peter Ellis**

**7 Bedford Row**

It is almost 20 years since Dr Harold Shipman was arrested. Although he was convicted of murder on the basis of 15 test cases, it is likely that he killed at least 200 other patients[[1]](#footnote-1). He escaped detection for a considerable time, by certifying the deaths of the patients he murdered as being due to ‘natural causes’. Certification by a second doctor was then, and remains now, necessary only in cases where the body is to be cremated.

Beginning in 2003 with the Home Office Luce Review and the Third Shipman Inquiry Report, successive investigations have called for urgent reform of the process of death certification and investigation, in order to close this potentially lethal loophole.

The Third Shipman Inquiry Report highlighted the need for a new Coroner Service to: *‘…seek to meet the needs and expectations of the bereaved. Its procedures should be designed to detect cases of homicide, medical error and neglect. It should provide a thorough and open investigation of all deaths giving rise to public concern…’*[[2]](#footnote-2).

In its introduction the Luce Review observed: *‘…During the last three-quarters of a century, the Government has twice commissioned reviews of these subjects, in 1936 and 1965. Very little happened in response to their reports. The services are showing the consequences of this neglect. We, and those whom we have consulted, hope that the inaction will not continue…’* [[3]](#footnote-3)

A key feature of the new death certification and investigation regime envisaged in 2003 was a statutory medical examiner. This would be a doctor working alongside each coroner. He or she would be responsible for auditing the death certification performed by doctors in the area, dealing with many of the natural cause deaths reported to the coroner, helping the coroner with the medical aspects of their investigations, and acting as a bridge between the coroner service and the worlds of public health, healthcare, and public safety.

They would not be pathologists, but would be registered medical practitioners of at least five years’ standing. It was envisaged that they would mostly be recruited on a part-time basis, performing medical examiner duties along with other clinical work as GP’s or hospital doctors.

The medical examiner would also be the second of two doctors certifying all deaths not reported to the coroner, not just cremation cases. He or she would confirm that the certificate was in order, be available for consultation with the family if they wished, and give authority for the burial or cremation of the body.

In 2006 the Government published a draft Bill: ‘Coroner Reform: Improving death investigation in England and Wales’[[4]](#footnote-4). In the introduction Lord Falconer observed: ‘…we will also be providing coroners with significant new medical expertise to help inform their decision making. There will be a new Chief Medical Adviser to the coroner service to whom the Chief Coroner can look for advice on strategic medical issues, and each coroner will be funded to buy in medical support, in consultation with the local authority, which is best suited to meet local needs. In these ways we will address weaknesses that have become increasingly evident over the last 20 years…’.

In 2007 the Department of Health published: ‘A Consultation on Improving the Process of Death Certification’.

The Coroners and Justice Act 2009 received Royal Assent in 2009. The 2009 Act, as amended by the Health & Social Care Act 2012, provided for local authorities (in England) and local health boards (in Wales) to appoint persons as medical examiners in order to fulfil the role envisaged by the Luce Review. It also provided for regulations to be made for medical examiners to act as the second death certifier, and for the appointment of a National Medical Examiner.

However, the medical examiner provisions never came into force. Instead, from 2008, seven medical examiner pilot schemes funded by the DOH in Sheffield, Gloucester, Powys, Leicester, north London, Brighton and Hove, and Mid Essex, were tasked with scrutinising over 23,000 deaths. These pilot schemes were reported to show numerous clear benefits[[5]](#footnote-5):

* Improved accuracy of death certification. The certification of death is often delegated to junior doctors and is not always accurate. When death certificates were checked by a medical examiner, the underlying cause of death was recorded differently in 22% of cases.
* Helping to avoid unnecessary distress for families, by listening to their concerns and providing reassurance. Bereavement support groups involved in the pilots were universally supportive.
* Providing reassurance to families about the terms used on the death certificate, as families often found the medical terminology difficult to understand.
* Identifying trends in unexpected causes of death, for example clusters of fatal post-operative infections.
* Ensuring that the right deaths were referred to a coroner for investigation, and avoiding unnecessary post mortem examinations. When the certifying doctor was unsure of the need for coronial referral, a discussion with the medical examiner usually clarified the position.
* Establishing close working relations between medical examiners and the local coroner’s office. Coroners welcomed the improved quality of medical information they received.
* Immediate referral of avoidable deaths to the coroner. This resulted in faster coronial investigations and reduced the distress for relatives.
* Helping to foster candour in the NHS. Health professionals who raised concerns felt supported and protected by the authority and independence of the medical examiner.
* Discussing and defusing potential complaints, through better explanation of the cause of death. In one pilot, there was a substantial fall in complaint and litigation costs.

Subsequently the Francis Inquiry report[[6]](#footnote-6), published in 2013, also made a number of recommendations about death certification and inquests relating to medical examiners and hospital deaths:

* Independent medical examiners should be independent of the organisation whose patients’ deaths are being scrutinised.
* Sufficient numbers of independent medical examiners need to be appointed and resourced to ensure that they can give proper attention to the workload.
* Death certification national guidance should set out standard methodologies for approaching the certification of the cause of death to ensure, so far as possible, that similar approaches are universal.
* It should be a routine part of an independent medical examiners’s role to seek out and consider any serious untoward incidents or adverse incident reports relating to the deceased, to ensure that all circumstances are taken into account, whether or not referred to in the medical records.
* So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient’s case or treatment.
* Appropriate and sensitive contact with bereaved families. Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.

Similar conclusions were reached in the Inquiry Report into the care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust, published in 2015[[7]](#footnote-7): *‘…Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer…’*.

Notwithstanding the accumulated evidence that reform was required urgently, and that there were substantial potential benefits, it was not until March 2016 that the DOH published a fresh consultation: *‘Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Consultation on Policy and Draft Regulations’*[[8]](#footnote-8).

This latest in a long line of consultations, inquiries and reviews, set a timetable for independent medical examiners to start work across England & Wales by April 2018. Now, less than one year before that unambitious target was due to be met, the starting date has been put back again until April 2019: *‘…to allow for more time for preparation to ensure that the benefits of the new system were realised…’*[[9]](#footnote-9).

No doubt frustrated by the glacial progress in implementing reforms he had first proposed in 2002, when interviewed by the BBC in early 2015, former Home Office Review Chairman Tom Luce remarked[[10]](#footnote-10): *‘…Seven million deaths have been dealt with through a system known for at least a dozen years to be unsafe, and it is scarcely believable that this is to continue…*’.

It now seems that in 2019, we will look back once more with incredulity, and ask why nine million deaths were dealt with through a system known for at least 16 years to be unsafe.

1. First Shipman Inquiry Report (July 2002), Chapter 14, ‘The Numbers’. Available from: <http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/reports.asp> [↑](#footnote-ref-1)
2. Third Shipman Inquiry Report (July 2003), ‘Death Certification & the Investigation of Deaths by Coroners’, Chapter 19, ‘Proposals for Change’. Available from: <http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/tr_page.asp?id=56> [↑](#footnote-ref-2)
3. ‘Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review’. Available from:

   <http://webarchive.nationalarchives.gov.uk/20131205100653/http:/www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf> [↑](#footnote-ref-3)
4. Available from: <http://webarchive.nationalarchives.gov.uk/+/http:/www.justice.gov.uk/docs/coroners_draft.pdf> [↑](#footnote-ref-4)
5. ‘Reforming death certification: Introducing scrutiny by Medical Examiners. Lessons from the pilots of the reforms set out in the Coroners and Justice Act 2009. Available from: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/521226/Death_certificate_reforms_pilots_-_report_A.pdf> [↑](#footnote-ref-5)
6. Francis R. ‘Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry’. ‘Executive Summary – Table of Recommendations’. Available from: <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf> [↑](#footnote-ref-6)
7. Kirkup B. ‘Report of the Morecambe Bay Investigation’ (2015), chapter 8, ‘Recommendations’. Available from: <http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf> [↑](#footnote-ref-7)
8. Available from: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/517184/DCR_Consultion_Document.pdf> [↑](#footnote-ref-8)
9. <http://www.health-and-care-update.co.uk/2017/04/medical-examiners-scheme-delayed-until-april-2019.html> [↑](#footnote-ref-9)
10. <http://www.bbc.co.uk/news/uk-30909270> [↑](#footnote-ref-10)