Department of Health

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

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PURPOSE

- Overview of proposed introduction of Medical Examiners and reforms to the process of Death Certification in England and Wales.
- The SofS indicated the reforms would be introduced from April 2018. The Strategic Programme Board is reviewing timing of implementation in light of consultation responses.
- Recent consultation has provided direction in preparing for implementation.

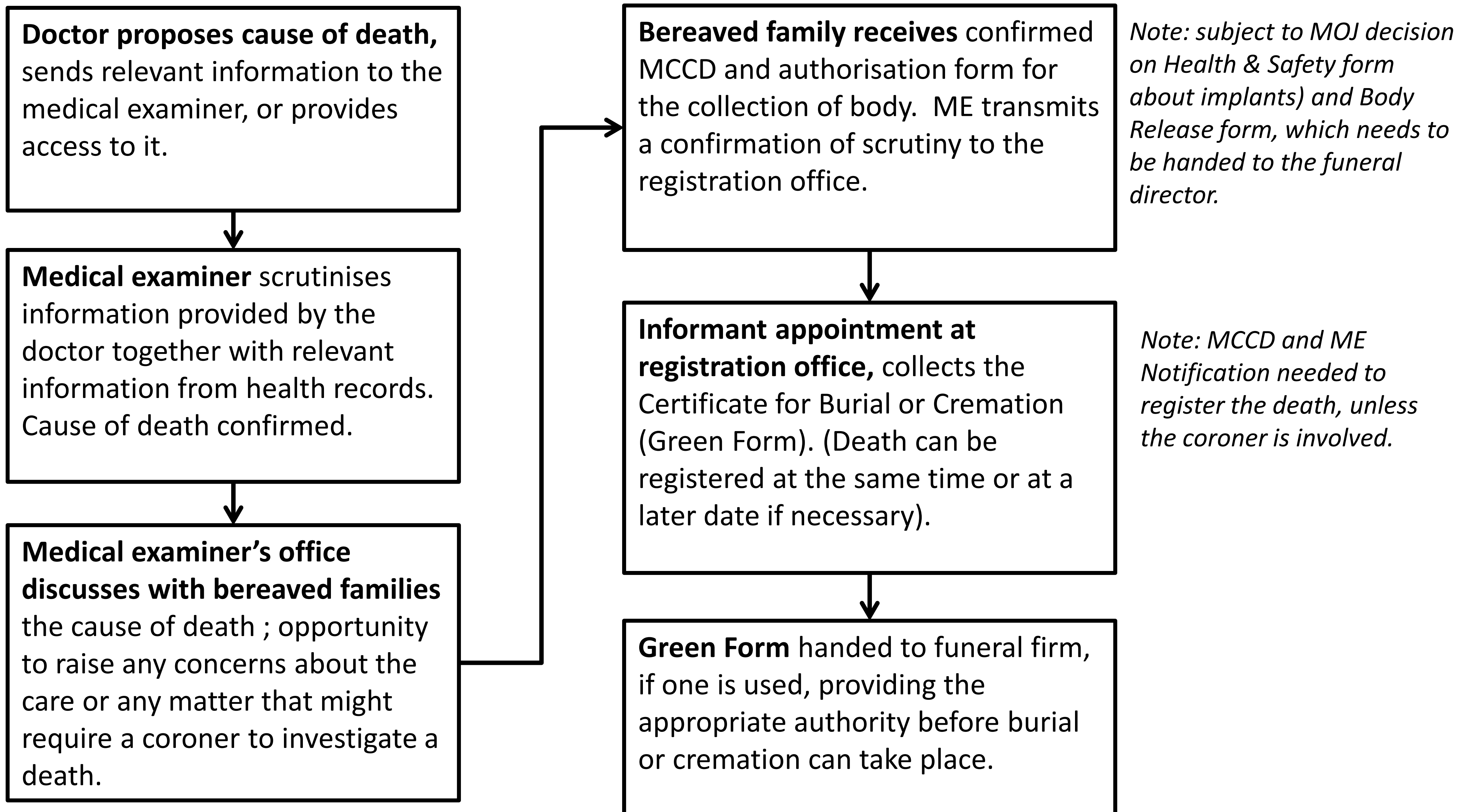
BACKGROUND CONTEXT

- **SHIPMAN INQUIRY 2003 -** existing arrangements for death certification are confusing and provide inadequate safeguards.
- **CONSULTATION 2007 -** Outlined the design, piloting and implementation of a medical examiner system of death certification.
- **CORONERS AND JUSTICE ACT 2009 -** enable reforms to introduce medical examiner system.
- **FRANCIS INQUIRY 2013 –** renewed calls for introduction of medical examiners.
- **LEARNING NOT BLAMING –** Secretary of State for Health Jeremy Hunt announcement of a suite of policies to make the NHS the largest learning organisation in the world.

The vision …

- **A common, simpler approach**.
- **Robust, proportionate, independent and consistent scrutiny**.
- **A transparent process.**
- **Focus on speed and convenience.**
- **Reduced delays and distress.**
- **Improved quality of information on cause of death**.
- **Learning from errors and poor practise.**
- **Focus for implementation is bereaved people and doing what's best for them.**

Flow chart - the medical examiner’s role in death certification



Establishing the system and recruitment

- **Legislation** - every death scrutinised by a medical examiner or investigated by a coroner.

- **Responsibility** - Local Authorities in England, Local Health Boards in Wales.

- **Experienced doctors** - recruited as medical examiners, assisted by medical examiners' officers.

- **LA and LHB Set-Up costs** – funded by DH.

- **Running costs** – largely financed by a single public fee. DH will cover the ME costs associated with those cases that are referred to the coroner by a medical examiner~~s~~.

Changes to current system

- **Cremation Forms** – some will be abolished (forms 4, 5 and 10).
- **Medical referees** – no longer required.
- **Registrars** – no longer need to question medical causes of death.
- **Coroners** – focus on cases that are appropriate.
- **Medical Examiners** – scrutinise every death not requiring a coroner investigation, provide expert advice, confirm the doctor's MCCD ensuring the cause of death is accurate, discuss the cause with the family and address any concerns they may raise, identify patterns.

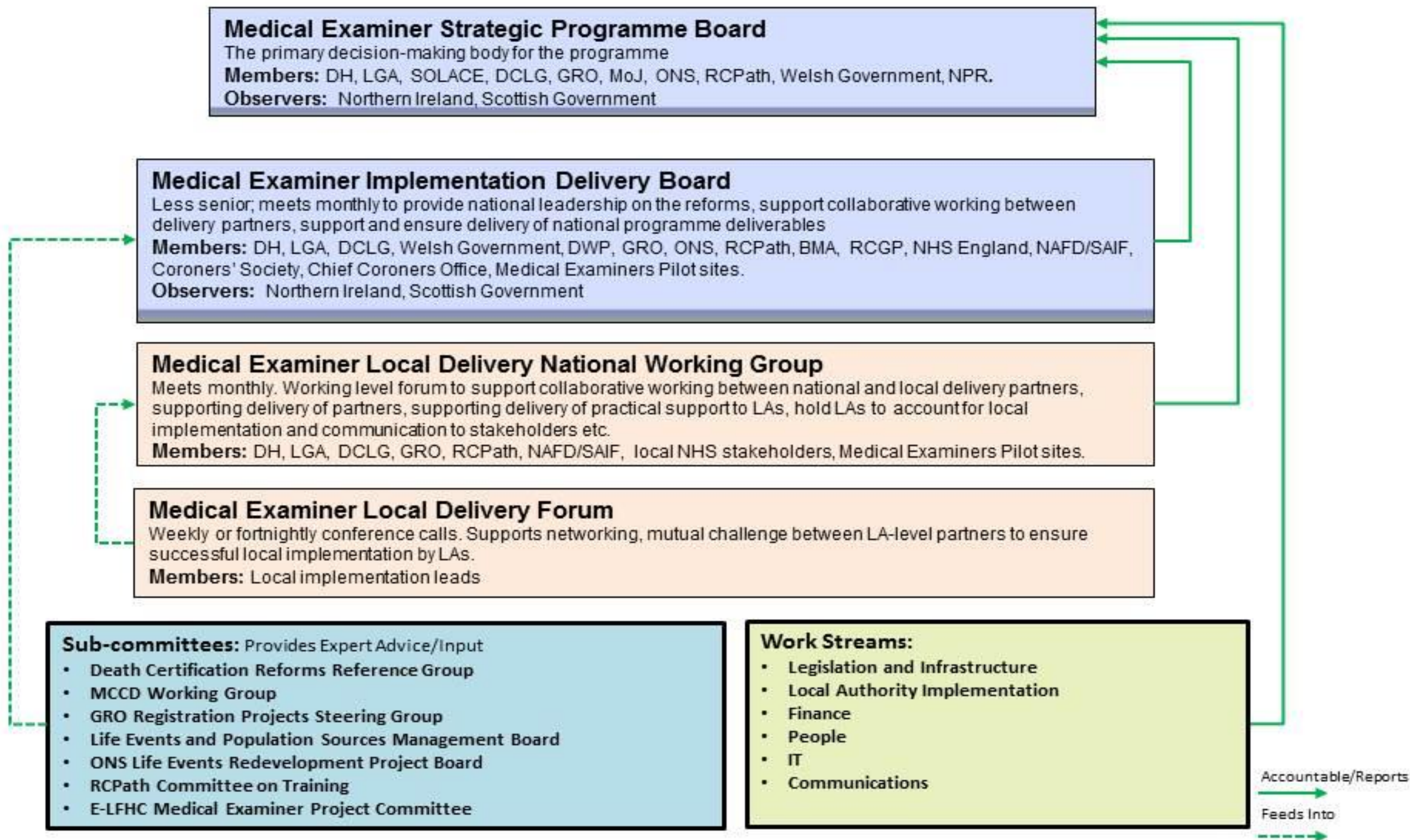
Benefits of the new system

- Bereaved people
  - Consistency
  - Independent
  - Expert
  - Assurance
- Prevention
  - Public Health targeting
  - Clinical governance and feedback
- Improvement
  - Identify patterns and trends
  - Early detection of malpractice
  - Cause of death statistics
  - Certification skills of doctors
  - Coroners’ focus

Next steps

- Updating the Impact Assessment
- Going back to Social Reform (Home Affairs) sub-Committee
- Implementing the new Governance arrangements
- Wider considerations
  - Digitisation and Information Technology
  - Timing of Implementation

Programme Governance Structure



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