REPORT OF THE HOME OFFICE REVIEW OF DEATH CERTIFICATION

2001

HOME OFFICE

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EXECUTIVE SUMMARY AND RECOMMENDATIONS

1. The existing arrangements for the certification of deaths suffer from lack of consistency and the absence of clear responsibility to account for the causes of all deaths. **We therefore recommend** that the concept of a 'medical examiner' system, as outlined in Option 3, should be clarified and developed (Paragraph 11.2.8)

2. A number of measures to improve existing arrangements were identified during the review which could be considered in advance of reaching conclusions about or implementing the 'medical examiner' system. **We therefore recommend** that Options 1 and 2 should also be revisited to see whether they offer the possibility of incremental change during the evolution of a medical examiner system (Paragraph 11.1.4)

3. Although medical practitioners have traditionally been required to confirm the fact of death, such a restriction can cause difficulty and delay, and many respondents saw no reason not to regard others as perfectly competent to confirm that death had occurred. **We therefore recommend** that the possibility of permitting health professionals other than doctors to confirm the fact of death should be explored (Paragraph 12.1.5)

4. It was clear from responses received that the quality of death certification by doctors was considered uneven due to lack of training and the low priority given to this duty. **We therefore recommend** that more emphasis should be placed on the training of doctors in death certification procedures (Paragraph 12.2.1)

5. Evidence was taken that the existing systems required ineffective duplication of records without the ability to identify anomalies in the facts recorded. **We therefore recommend** that record-keeping capable of integrating the information available to the medical profession, coroners, registrars, etc should be developed, preferably through use of an electronic platform (Paragraph 12.5.3)

6. Although it is important for death certification processes to be uniform, it is also important that the processes are carried out sensitively and with due regard to the reasonable requirements of the deceased and their friends and families, whatever their cultural or other background. **We therefore recommend** that proper account should be taken of the particular needs of religious and ethnic minority communities (Paragraph 12.6.2)

7. The clinical audit undertaken by Professor Baker into the deaths of Harold Shipman's patients stressed the importance of recording information about the death and the deceased's medical history whatever the manner of disposal of the body. **We**

therefore recommend that in a revised certification system, brief information about the circumstances of death and the patient's clinical history should be recorded both in the case of cremations and burials (Paragraph 12.7.4)

8. The review gave rise to much debate about whether 'old age' could ever be a valid and acceptable cause of death for the purposes of certification, or whether the term was used simply to conceal the fact that the precise cause of death was unknown. **We therefore recommend** that the attribution of 'old age' as a cause of death on a MCCD should be added to the list of circumstances requiring registrars to refer a death to the coroner (Paragraph 12.8.5)

9. For the same reasons, **we recommend** that a small group, including medical professionals and organisations representing elderly people, should review the use of 'old age' (and perhaps other terms) as a cause of death (Paragraph 12.8.6)

10. The proposals for a 'medical examiner', as described in Option 3, raise issues about how such a new arrangement might be resourced and funded. **We therefore recommend** that questions of cost and manpower should be pursued with the Department of Health and other relevant bodies (Paragraph 12.9.5)

11. This review of death certification procedures cannot be considered in isolation. The procedures are closely connected with the arrangements for the registration and investigation of deaths. The proposals for a new office of 'medical examiner' would impinge directly on the existing responsibilities of registrars, medical referees, and coroners. **We therefore recommend** that the results of this Review should be taken into account by the Shipman Inquiry, the Home Office Fundamental Review of the Coroners' System, and any other relevant initiative (Paragraph 14.2.4)

HOME OFFICE
REPORT OF THE REVIEW INTO DEATH CERTIFICATION

1 Introduction

1.1 The Home Office Review of Death Certification was initiated in response to the conviction in January 2000 of the Manchester based general practitioner, Harold Shipman, for the murder of fifteen of his patients. The purpose of the exercise, the results of which are in due course to be made available to the Shipman Inquiry under Dame Janet Smith, was to review the current system for the certification, investigation and registration of deaths and to make recommendations for improvements.

2 Structure of the Report

2.1 The Report commences by stating the Terms of Reference of the Review, and looks at the need for death certification and the recent history of consideration of these issues. The structure of the Review itself, with its two rounds of consultation exercises, is then described. Finally the report focuses on the main findings of the Review, and suggests how the various issues might be taken forward.

3 Terms of Reference

3.1 The Terms of Reference of the Home Office Review of Death Certification were agreed as follows:

- To identify issues of concern regarding the law and practice in relation to the certification and registration of deaths in England and Wales in the light of the recent conviction of Harold Shipman for the murder of fifteen of his patients.
- In the light of such issues, to consider improvements to the processes of confirmation, monitoring and certification of deaths and the authorisation of burial or cremation, while respecting the needs of families, including those of ethnic or religious minorities, to hold the funeral without unreasonable delay.
- To consider whether coroners might have a relevant role in the detection and investigation of deaths not reported to them under existing legislation.
- To make recommendations to the Secretary of State for the Home Department and to the Inquiry into the Issues Raised by the Case of Dr Harold Shipman

3.2 While, therefore, the primary intention of the Review was to identify issues directly relevant to the case involving Harold Shipman, it was also considered appropriate to spread the net more widely in order to address general issues concerning the whole process of death certification.

4 Membership of the Review Team

4.1 The Review was led by a small team representing the various interested parties. It first met on 3 February 2000 under the chairmanship of the head of the Home Office Animals, Byelaws and Coroners Unit. The group included representatives of the Department of Health, the Office for National Statistics, the National Assembly for Wales, and a co-opted coroner.

4.2 Although the Review remit is limited to England and Wales, the issues of death certification obviously cross national boundaries. Accordingly, representatives of the devolved administrations in Northern Ireland and Scotland were also invited to join the team leading the Review.

4.3 The names of the Review Team members are attached to this report at Appendix 1.

5 Purposes of death certification

5.1 One of the first steps for the review was to agree the purposes for which a death needed to be certified. In the course of the review a number of reasons for carrying out this task was offered by contributors, and the list which follows was felt by the Review Team to capture the most essential elements:

- to confirm that death has occurred
- to establish the identity of the deceased person
- to give an indication of the likely cause of death
- to support relatives and others with a valid interest in the medical cause of the death
- to assist in the proper and prompt disposal of the body
- to ensure that unnatural deaths, which require further investigation, are properly investigated prior to disposal of the body
- to record and identify essential details, such as the doctor in attendance during the last illness, in order that an adequate audit trail can be established for the certification process
- to facilitate the recording of every death in the public records
- to provide statistical information about the cause and circumstances of death

5.2 Thus we concluded that the purposes of death certification were much wider than simply recording that a death had occurred. A properly designed system of certification needed to identify unnatural deaths which might require further investigation; to furnish the public record with accurate and relevant data; and to support relatives by allowing the death to be registered promptly and the body released for disposal (wherever possible) with minimum delay.

5.3 An outline of the current procedures for the certification of death is appended to this report (Appendix 2).

6 The Brodrick report [1]

6.1 Death certification practice was previously reviewed by a committee set up by the Home Office and led by Norman Brodrick QC, the report of which was published in 1971. For various reasons many of the committee's recommendations remained on the table. Indeed, a number of respondents to the current Review suggested that these should simply now be implemented. However, in view of the many changes which have taken place in the thirty years since the committee undertook its work, this appeared to be too simplistic a solution.

6.2 For instance, the Brodrick committee report recommended that certification of both the fact and cause of death should be performed by the doctor who had attended the deceased person at least once during the seven days preceding death (paragraph 5.12). The development of general practitioner deputising services and the fact that many deaths now occur within care homes meant that this recommendation would be far less practical today that it might have been some years ago.

6.3 Again, Brodrick recommended (paragraph 24.04) that the forensic pathology service - on whom coroners and others rely for the investigation of apparently suspicious deaths - should be firmly based in the National Health Service. The subsequent report of the Home Office inquiry into forensic pathology services[2] introduced the concept of direct contractual relationships between the practitioners and the police service, and the adoption of this recommendation fundamentally altered the manner in which such services are now provided.

6.4 Yet another section of the report (Chapters 26-27) looked in some detail at the certification procedures where disposal of the body was to be by cremation, a process which has gained considerably in popularity since the Brodrick report was published. This concluded with a clear recommendation that a properly completed certificate (issued, as appropriate, by either a registrar or a coroner) should suffice whatever means of disposal was to be used. This recommendation was not pursued pending an opportunity to amend registration legislation, but has now been developed in one of the options described in this report.

7 The process of the Review

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[1] Report of the Committee on Death Certification and Coroners - 1971 [Cmnd 4810]
[2] Report of the Home Office Working Party on Forensic Pathology - 1989 (HMSO)

7.0.1 The Review Team recognised that death certification had more than one use. As well as recording the fact and circumstances of the death, and thus assisting in the prevention (and investigation) of crime, the collection of mortality data was of considerable epidemiological importance. We agreed that any study of death certification should take account of its current uses and also consider how these might change in the future.

7.0.2 It was also agreed that the Review needed to proceed through wide and effective consultation with interested parties in order to determine the issues regarded as important. The Review was therefore to include two phases of consultation, a preliminary exercise to identify the nature and extent of the problem, followed by a second exercise designed to focus on possible solutions.

7.1 The first consultation exercise

7.1.1 The first of the consultation exercises sought to elicit views on current death certification practices and procedures. This phase of the Review was 'open-ended' in that although consultees were provided with background information and offered some pointers to stimulate thought, in essence they were free to raise any issues which they considered important and wished the Review to consider.

7.1.2 In response to 222 packs of information about the Review sent out, 104 replies were received. Included in the consultation exercise were a wide range of individuals and organisations; these included Government departments, the medical Royal Colleges, other medical bodies (including a 10% sample of individual medical referees), coroners, the burial and cremation industry, and other relevant organisations including those representing a wide variety of ethnic and religious communities. Appendix 3 contains the names of all those consulted in both phases of the consultation.

7.1.3 As anticipated, the responses to this preliminary exercise covered a wide range of issues. While some of these issues related specifically to the individual or organisation making the point, there were various themes which ran across many of the responses. It became clear that many believed the process of death certification not to be taken seriously enough and not therefore undertaken with sufficient care and attention. If it were true that a significant proportion of deaths was being recorded inaccurately, we concluded that this could have implications at several levels, for instance in the investigation of crime, the recording of reliable mortality data, and ultimately for the bereaved.

7.2 The second consultation exercise

7.2.1 Bearing in mind that the current system of death certification was said to be working, albeit imperfectly, we were not anxious to propose change unnecessarily. Nevertheless, the responses to the initial consultation demonstrated a considerable degree of dissatisfaction with the current arrangements and there clearly appeared to be scope for revision of the system to make it work better and more consistently.

7.2.2 The wide range of opinions and suggestions offered by respondents to the first stage of the consultation exercise were therefore collated. Three outline 'options for change' were then devised from this information, each differing in the degree of change proposed to the present procedures. These ranged from a simple tidying up of the existing procedures to a radical reassessment of the manner in which death certification was carried out in England and Wales.

7.2.3 The intention was not for the options to be accepted (or rejected) as packages complete in themselves; rather it was hoped that the exercise would provoke comment about the extent of change which respondents considered necessary, desirable, and feasible.

7.2.4 In parallel with the three options, consultees were also asked for their views on a number of other matters, such as who should be able to certify that a death had occurred. This was partly to ensure compliance with the requirements of the terms of reference and partly to pursue matters which had been identified by respondents as being of particular interest in the first consultation exercise.

7.2.5 On 13 October 2000 the material was circulated for comment to substantially the same group of consultees as received the phase one package (see Appendix 3). The 228 packs of information distributed attracted 62 responses, many fewer than were generated by the first phase. However, some of the replies were substantial and extremely detailed.

7.2.5 As the remit of the Review was limited to England and Wales most respondents limited their comment to procedures used within this area. However, those respondents who did offer comment, whether from England and Wales or outwith these boundaries, were keen to ensure that as far as possible the procedures employed for the certification of death should be unified across the United Kingdom.

8 The three options

8.1 Three possible options were offered for consideration in the second phase of the consultation exercise. Although one of these (the most radical option) was overwhelmingly favoured by respondents, all three are summarised in the paragraphs which follow. A copy of the document supplied to consultees in this phase of the exercise ('The way forward - some options') is attached as Appendix 4.

8.2 In general, respondents addressed each option separately. There were, however, some important general comments. In the light of the stimulus for the Review itself, the most significant, expressed by a large number of respondents, was that it would not be possible (or certainly neither practical nor realistic) to introduce a system which would absolutely guarantee that another 'Shipman' type incident could not occur.

8.3 There were also very real concerns that, although a Review of death certification was timely, the introduction of far reaching changes should not be contemplated unless there appeared to be real benefits to be obtained.

9 Option 1: Sharpen up the existing procedures

9.1 The changes proposed under this option were intended to be achievable without amendment to primary legislation or incurring significant additional cost. This option was designed simply to improve death certification by tidying and sharpening up the existing procedures; it was also intended that the measures could be put into effect without undue delay.

9.2 Option 1 proposed changes such as:

- enlarging the information included on the medical certificate of the cause of death
- providing a code of practice which might, for instance, include non-statutory definitions of some of the terms (such as 'last illness') which have proved contentious
- encouraging consultation of medical records before issue of the medical certificate of cause of death
- revising the wording of certain of the certificates, such as Forms A, B and C[3]
- offering training, on a voluntary basis, for those who currently receive no instruction in death certification.

9.3 In the main, respondents accepted that the proposals included in this option could be simple, cheap, achievable, valid and easily put into place. However, although one or two respondents considered that their introduction might be of some value, particularly clarification of the problematic terminology of death certification legislation (eg definitions of 'attended' or 'last illness'), most agreed that they would offer little advance on current practice. The general view was that significant progress could not be achieved without necessitating changes to the primary legislation.

9.4 Whether the proposed measures would necessarily be cheap to implement was also questioned. The changes that could be made to the medical certificate of cause of death without legislation are limited and it was suggested that, in the absence of statutory changes, a significant educational and persuasive effort could be required to bring about the adoption of new practices. Much effort had recently been expended on seeking to improve completion of certificates of the medical cause of death, but the results were by no means uniformly successful.

9.5 In view of the apparent ease and speed of introduction of the package of changes encompassed in Option 1, a number of respondents suggested that such changes might form the first stage to a more fundamental revision of death certification. In particular, the Coroners' Society pointed to these proposals as being of immediate appeal and quick to implement.

10 Option 2: Change and improve procedures within the existing framework

[3] Prescribed for us under the Cremation Regulations, 1930, as amended, for applications and certificates for cremation.

10.1 This option was intended to offer a more fundamental reform of some aspects of death certification. The existing overall certification framework would be retained, although some changes to primary legislation would be required.

10.2 Under this option were to be considered:

- unification of the burial and cremation procedures, with the introduction of a second doctor's confirmation of the death certificate in all cases
- clarification of the circumstances under which deaths must be reported to the coroner
- provision for compulsory training for doctors, coroners and their staff
- introduction of regular monitoring of death statistics by the local director of public health to enable local and doctor-specific trends and variations to be identified and investigated.

10.3 Option 2 found more favour than had the first option. There was general support for the changes proposed; it was considered to be achievable, and with appropriate changes to the primary legislation it was felt that it could do much to set standards across the country and inspire public confidence. There were, however, some dissenting voices; for instance, the Coroners' Society considered that, while benefits could flow from this option, their effect might be to render more difficult the introduction of any further desirable changes at some later stage.

10.4 Respondents expressed particular support for unification of the systems of certification used for burial and cremation, and indeed this was a common theme throughout the Review.

10.5 The minority who favoured retaining separate procedures generally did so on the basis that, whereas burials could be exhumed if necessary, cremation completely removed any chance of carrying out further examination of the body. These respondents believed that this difference, which would also apply to disposals such as burials at sea and export of the body to another country, was sufficient to justify the retention of a separate, more rigorous system.

11 The third option - introducing a radical change to the regulatory arrangements

11.1 Outline of the proposals

11.1.1 A recurring theme to emerge from the various responses received during the preliminary consultation exercise was to look for radical changes in the procedures for death certification and registration, with some respondents offering very detailed suggestions. The individual proposals were not identical, but the Review Team remodelled and reconciled them into a scheme which appeared to have potential.

11.1.2 In this model it was proposed that the existing boundaries of responsibility between the existing players should be redefined to create a much more powerful 'medical referee', a 'medical examiner' or 'medical screener', who would absorb certain functions of the registrar, the existing second doctor (and medical referee) in cremation cases and - to some extent - the coroner.

11.1.3 Such an 'examiner' might have the following functions:

(a) confirmation of the medical cause of death issued by the certifying doctor
(b) authorisation of burial or cremation, burial at sea, or removal of bodies abroad (ie to another country)
(c) exercise of the present powers of the coroner to determine whether a sudden death of unknown cause needed to be the subject of an inquest.

11.1.4 The proposed system might streamline and focus the current rather uncoordinated procedures following a death by ensuring that there was a designated individual, possessing appropriate medical qualifications and training, with a clear responsibility to account for the causes of all deaths. One key feature of this model is that the death would be fully investigated prior to its certification, thus avoiding the current post-registration pressures for the funeral which the Review was told tends to inhibit proper investigation in cremation cases. Most of the suggestions included in Options 1 and 2 would also need to be incorporated within this model, and their introduction might form part of its evolution and development.

11.1.5 The new 'medical examiners' would be medical professionals working either full or part time within a team, providing a 24 hour service to obviate the possibility of delay. In addition to their function to confirm a death and authorise disposal of the body, they would be well placed to monitor and put together a clear overview of all the deaths occurring in their areas if it was decided that this public health function needed to be developed. They might also provide feedback to doctors on standards of death certification and identify training needs.

11.1.6 Where responsibility for the implementation and management of such a system might lie would be for consideration. It has obvious links with public health. However, there is a very logical case for linking the function with that of the coroner and incorporating medical screeners into an enhanced coroner service, where they would be supported in their investigations by suitably trained and skilled coroner's officers, thereby creating a new team with varied functions.

11.1.7 Such integration of the proposed medical screening of all deaths within the existing coroner service would also avoid some of the practical problems that might arise if the two roles were not linked, and an enhanced and seamless system of coroners working together with medical screeners, and supported in their investigations by well trained coroner's officers, would have the potential to build upon the existing and essential service provided to the public. In any event, there would be a need to explore and create new relationships between these post-holders, the coroners, and the registration system.

11.1.8 The proposed new system would aim to provide an effective and rapid service in the investigation of all deaths; a more integrated approach should enable more accurate statistics of cause of death to be compiled, while closer monitoring should allow criminal activity or inadequate medical care to be detected at an earlier stage. Responsibility for the death certification process would become a properly defined job, rather than an extra task imposed on a busy GP or hospital doctor.

11.2 Reactions to the proposals

11.2.1 A very clear majority of respondents considered the proposals possessed considerable merit; accordingly they wished to see them developed and clarified. The underlying view was that this was the nettle which really ought to be grasped if death certification was to be effectively modernised.

11.2.2 The Department of Health, too, supported the proposals strongly, with endorsement from the Chief Medical Officer[4]. The belief was expressed that the eventual introduction of a medical examiner system might bring considerable advantages both for death certification and the wider field of public health statistics. How the costs of such a system would be met, or agreed, would need to be a matter for further discussion within Government.

11.2.3 Having regard to the fact that proposals for changes to the civil registration system were expected to be brought forward in due course by the Office of National Statistics, it was suggested by that organisation that changes of this magnitude might be appropriate to meet the future possibility of online registration.

11.2.4 The industry respondents were also universally in favour of developing this option, as were the interest groups such as Age Concern and the majority of medical referees. Support also came from other sources such as the Royal College of Pathologists and individual doctors.

11.2.5 Reaction to this option, however, was not unanimously positive. There was some concern that it might be too radical to be acceptable, with one or two respondents even wondering whether it was intended to be taken seriously. Because the proposals were in outline only, a number of respondents stressed that they required considerable more work before they could be properly assessed.

11.2.6 The general concerns expressed included:

- the proposals to be thoroughly explored and developed to determine whether they might actually offer significant advances
- the likely expense of implementing such a system
- the difficulty of securing the manpower to undertake the work
- the difficulty of creating an adequate career structure for the doctors involved.

[4] Recommendations 10 and 11 of the Removal, Retention and Use of Human Organs and Tissue from Post-mortem Examination 2001 (Stationery Office)

11.2.7 The Coroners' Society cautioned against abandoning the existing system unless there was confidence that a revised system could be shown to confer significant advantages. Other reservations were expressed by both the BMA and the Royal College of General Practitioners. These reservations reflected concerns about the availability of appropriately qualified doctors and whether death certification could be justified as a full-time job.

11.2.8 In the light of the comments received on all the canvassed options, we concluded that Option 3, with the 'medical examiner' function, offered the most promising basis for an effective, but sensitive, death certification system, although the reservations expressed by some respondents appeared valid and would need to be taken into account.

12 Confirmation of the fact of death and other issues

12.0.1 During the first phase of the Review a wide range of issues were raised by respondents, with a number of similar themes appearing in many of the responses. While these matters are all important constituent elements of death certification, there may be merit in making separate reference to some of them here. These issues will be important whatever the outcome of the present Review.

12.1 Confirmation of the fact of death

12.1.1 The Review's terms of reference included consideration of the diagnosis of the fact of death, as well as its medical cause. Traditionally, a medical practitioner had always been called upon to pronounce life extinct although a certifying doctor is required only to certify the cause of death and not the fact of death and does not need to have examined the body in order to sign the death certificate. We were aware that the growth in the use of general practitioner deputising services for out-of-hours calls had created difficulties in that the doctors involved in such services would very seldom be the attending doctor, and would thus not be able to issue the death certificate. In these circumstances, there was a case to consider whether calling out a doctor to confirm death alone was a necessary or efficient use of resources.

12.1.2 While the majority of deaths now took place in hospital, in other circumstances we invited comments on whether it might prove acceptable for another health professional (eg a nurse or paramedic) to certify the fact of death, or even for this to be left to funeral directors (who would have extensive practical experience, even if no formal medical qualification).

12.1.3 Most respondents were content that the fact of death need not always be certified by a medical practitioner; nurses or paramedics were considered entirely acceptable, at least in appropriately defined circumstances, for instance, where the person was known to be dying from an illness and there were no suspicious circumstances.

12.1.4 This view was expressed by a wide range of respondents, including doctors and some medical colleges. However, it was not a universally held view, with the BMA itself

suggesting that the fact of death should always be confirmed by a registered medical practitioner. As for the function falling to funeral directors, while it was considered that such an arrangement might sometimes prove convenient, there was in practice little support for such a proposal.

12.1.5 We concluded that the possibility of permitting other health professionals the right to confirm the fact of death should be explored further.

12.2 The importance of training and audit in the maintenance of standards

12.2.1 Many respondents commented on the lack of importance placed on death certification during the training of doctors. Forensic medicine as a subject was said to have fallen from favour as other topics have taken its place in the medical curriculum. Aside from the problems this was causing in the specialised field of forensic pathology, these changes had resulted in fewer opportunities for training in the completion of documentation concerned with death. We concurred with those respondents who urged that the provision of training in death certification must be encouraged. This is essential to reduce the grief caused to bereaved relatives when registrars have to reject certificates completed incorrectly by medical practitioners.

12.2.2 It was also suggested that, in order to achieve adequate standards of death certification, it would be necessary to include it in programmes of audit and evaluation, all of which would be required for the regular revalidation of general and other medical practitioners under proposals now being developed by the General Medical Council. Such a move would re-emphasise the importance of including training in death certification procedures in both basic and post-graduate medical education.

12.3 Other mechanisms for investigation

12.3.1 A further possibility proposed was to extend the role of the Health Service Ombudsman to allow investigation into death certification. Alternatively, statutory provision to enable relatives themselves to institute a coroner's inquiry or a post mortem examination, as in Canada, was suggested. It was said that measures such as these could help to increase public confidence in the process.

12.3.2 We felt that such measures could be important whichever of the three options (or, indeed, none) was eventually selected. However, one of the advantages of the third option was the creation of posts whose holders would have death certification as one of their primary responsibilities. Such a person would be the obvious focus for the concerns of relatives and ought to be able to respond constructively and rapidly to any expressions of concern or unease about a death.

12.4 Increasing the autopsy rate

12.4.1 Although modern diagnostic techniques can provide good evidence of disease processes, only the autopsy offers an accurate method of determining the cause of

death. One of the issues for consideration was whether an increased rate of autopsy might assure the quality of death certification. However, we noted that while the need for autopsy in appropriate cases was generally accepted by the public, any general increase in the numbers of autopsies undertaken would not be so acceptable. This would be due to the distress caused to relatives, the concomitant increases in costs and delay, and the lack of qualified pathologists able to undertake such work.

12.4.2 In general, therefore, we accepted that the undoubted need for the audit of the accuracy of the death certification process could not be satisfied through the wider use of autopsy.

12.5 Integrating records

12.5.1 It was agreed by the Review Team that achieving accuracy and completeness in the completion of the medical certificate of the cause of death (the MCCD) and the other documents which form part of the certification procedures would represent a significant step forward. However, there appeared to be further advantages to be gained in the integration of records - for instance, in the prevention of crime, the collection of epidemiological data and death statistics, and in the efficiency of the service provided to relatives.

12.5.2 For example, a patient's death should be recorded on their treatment record by the doctor attending to confirm death; on the MCCD by the doctor who has attended in their final illness; and on the cremation certificates (twice, by different doctors) where bodies are cremated. However, there was currently no facility for these recording activities progressively to inform one another, nor for their respective contents to be archived in a common summary record. Integration of this data would improve consistency and help identify anomalies. Recent IT proposals from the Department of Health[5] and the Office for National Statistics[6], if implemented, could allow the recorded circumstances of the death to be transmitted by electronic means between the various parties, thus improving the quality of the records without sacrificing time.

12.5.3 Implementation of such an integrated information transfer system would depend on the universal availability of a suitable electronic platform. We understand, however, that installation of such a platform is likely to be a piecemeal process. Nevertheless, reform of death certification is so important that we concluded that it should not be delayed by lack of suitable IT facilities; rather it should proceed, if necessary, through a dual paper and electronic basis.

12.6 Religious and ethnic minority issues

12.6.1 England and Wales are not homogenous communities, and the Review Team was anxious to ensure that the views of all elements of the community should be heard. In general, support for the Review was extremely positive. The over-riding theme was that the certification and registration process should permit disposal of the body without delay. Within that theme individual groups stated their own positions; for

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5 Information for Health (NHSE 1998)

6 Registration: Modernising a Vital Service (Registrar General 1999)

example, the Hindu body must in most circumstances be cremated, whereas the Baha'i community requires burial. Again, it is accepted within the Jewish and Muslim communities that burial should, if at all possible, be undertaken within 24 hours of the death.

12.6.2 The Review Team considered that it would be important to promote dialogue with these, and other, groups in order that their interests may be properly considered during the development of any new procedures for the certification of death.

12.7 Preventing another 'Shipman' type incident

12.7.1 One of the primary reasons for the failure to detect the activities of Harold Shipman at an earlier stage of his career is said to have been the inability of current systems to integrate data and thus to highlight anomalies in recorded deaths. That is a matter for consideration by the Shipman Inquiry. However, the general view of respondents was that even the radical changes proposed here would not necessarily prevent another similar incident (although we were satisfied that such activities would be more likely to be detected at an earlier stage).

12.7.2 The reason for this was said to be that, although a new system might be designed without difficulty to enable the statistical investigation of individual doctor mortality rates, within any one doctor's practice death remains a relatively infrequent occurrence and year-on-year variability is high[7]. Accordingly, it is only where concealed homicide is very frequent and continuing over a considerable period that the difference in death rates is likely to be sufficient for statistical tests to trigger medico-legal inquiry.

12.7.3 Professor Richard Baker, who conducted the clinical audit into Dr Shipman's practice referred to in the footnote, made the following recommendation:

> ***11.4 Death certification procedures***
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> *In a revised certification system, brief information about the circumstances of death and the patient's clinical history should be recorded both in the case of cremations and burials.*

12.7.4 The Review Team endorsed this recommendation, which reflects the proposed arrangements described in both Options 1 and 2.

12.8 'Old age' as a cause of death

12.8.1 One of the issues which arose in the course of the Review was the attribution of 'old age' as a cause of death. From the commencement, it was clear that there was a diversity of opinion about the acceptability of this diagnosis as a cause of death. Most

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[7] Harold Shipman's clinical practice 1974-1998: A clinical audit commissioned by the Chief Medical Officer(The 'Baker Report' - Dept of Health 2001)

of those responding to the Review expressed their dislike of such an imprecise term even where there was no reason to suppose the death was not natural. Some respondents, such as Age Concern, considered the use of such term completely unacceptable.

12.8.2 Nevertheless, respondents generally made the point that the actual cause of death in the elderly was likely to be multifactorial. Concern was expressed that prohibition of 'old age' would simply encourage the use of other poorly defined terms as a substitute, rather than promote a thorough investigation to identify the causes of death which, if it entailed post mortem examinations, histology and delay, relatives and, ultimately, society as a whole might not consider acceptable.

12.8.3 One view was that recording a death due to old age might remain acceptable in a restricted range of circumstances. For instance, it might be practicable to define the age at which such a cause might be accepted. There might also be circumstances in which such a cause would not be acceptable - for instance, where the death took place in hospital and it might be necessary to ensure that the medical treatment received by the deceased was not a factor.

12.8.4 While there was some logic in the use of this term, in that where a genuinely old person came to the end of their natural life there might be little to be gained in undertaking detailed and sometimes inconclusive investigations into the precise cause of the death, there was concern that such an approach might also result in unnatural deaths (perhaps as a result of inadequate care) being missed.

12.8.5 We therefore concluded that the attribution of 'old age' as a cause of death on a MCCD ought to be added to the list of circumstances requiring registrars to refer a death to the coroner.

12.8.6 This would not solve the problem, of course. We therefore felt that the way forward might be for a small group, including medical practitioners and organisations representing elderly people, to review the use of 'old age' (and perhaps other terms) as a cause of death, and to make appropriate recommendations.

12.9 Payment for services

12.9.1 At present, there is no charge for confirming the fact of death, for issuing the medical certificate of death, or for registering a death (although there is a charge for a copy of the death registration certificate). The death certification process therefore gives rise to no additional costs to the estate of the deceased if the mode of disposal is burial. If, however, cremation is chosen, both the certifying and confirming doctors charge a fee. There is also a fee payable to the medical referee.

12.9.2 Respondents were asked to consider whether the certification of death should remain an integral part of the care offered by a medical practitioner under the NHS, and consequently not attract extra payment. There was general consent that it should remain an integral part of NHS care.

12.9.3 Historically, the case for paying a fee for the additional certification required by the cremation regulations could be justified where the work involved was additional to that normally required of the treating or attending doctors, and when cremation was a matter of minority choice.

12.9.4 The case for such charges is less evident now that cremation is the majority option for disposal. Moreover, there is no evidence that there is any link between the need to pay a charge and the standard of service provided. While recognising that, under the present arrangements, doctors who complete the cremation certificates are undertaking additional work, it was a matter of concern to us that there was no discernible relationship between the level of charge and the level of service. There was also no ready way for the family of the deceased to determine whether they have received value for money.

12.9.5 Unification of burial and cremation certification procedures would eliminate the charge distinction, but how to meet the cost of any new service (the medical examiner) would still need to be considered. This would either require a fee to be paid (as now, but in all cases), or else be a charge on public funds. It was beyond the remit of the Review to make recommendations on this issue, but it will be an important aspect to address in any more detailed consideration of the proposals.

12.10 Certification of infant deaths

12.10.1 Particular issues may arise in the context of the unexpected deaths of infants and children. The Foundation for the Study of Infant Deaths argued persuasively for enhanced procedures for the investigation of sudden infant deaths, drawing on the expertise of relevant health professionals and paediatric pathologists whenever such deaths were reported. However, after careful consideration, we concluded that assessment of the proposals were outside the remit of the present review, especially as the suggested scheme would need to be reconsidered and possibly reworked in the light of the recommended 'medical examiner' function and possible changes to the coroner arrangements.

13 The Review Team's conclusions

13.1 The Review Team, informed by extensive consultation, has identified a number of issues of concern regarding the law and practice relating to the certification and registration of death. While these issues did not suggest that the system was in crisis, there were firm indications that the current procedures were not as effective as they might be, or ought to be.

13.2 We went on to explore ways in which the procedures might be improved. These ranged from some relatively simple fine-tuning of the system currently in place to a much more radical and fundamental change in the way in which death certification and registration is carried out in England and Wales.

13.3 After considerable deliberation, we concluded that our own concerns, and those expressed by the many respondents to the consultation exercise, could only be

satisfactorily addressed by proposing a radical change to the procedures. In particular, we found that some form of medical examiner system, as outlined in the third option presented in the report (possibly within an enhanced coroner service), appeared to offer the best chance of ensuring that the certification and registration of death met the purposes defined earlier and were carried out to the highest standards.

13.4 The Review's endorsement of fundamental change should not be seen automatically to exclude any further consideration of the other possibilities. We believed that it would also be useful to look again at the proposals included in the first two options, perhaps with a view to incremental change over a period of time.

13.5 We did not consider that the introduction of a medical examiner system would be easy. The proposals now need to be clarified and developed. It was not possible to undertake this task within the confines of the current - necessarily short-term - Review. There have also been other initiatives which will impact on the proposals and on which, in turn, this report will have its own effect. These initiatives are briefly considered later in this report. For all of these reasons it would not be realistic for this Review to do more than suggest a way in which these issues might be pursued.

14 The way forward

14.0.1 Following two rounds of public consultation, we have identified the bare bones of a model for a new system of death certification which seems likely to be more effective by providing a more coherent and focussed effort to determine the medical cause of death. The next task, which was beyond the resources or remit of this Review, would be to develop the model to assess its practicality and affordability.

14.1 Manpower

14.1.1 The need to provide ready access to the examiner may in itself raises question about the practical feasibility of the proposals. It appears probable that a 24 hour/365 day service would be required, with all the costs and logistic problems which that would involve. The numbers of doctors required would almost certainly have to be in excess of, for example, the current number of medical referees and their deputies and, unlike them, many might need to be full time appointments. This might necessitate the creation of a new sub-speciality, perhaps within some aspect of Public Health.

14.1.2 It is recommended that the manpower question is pursued with the Department of Health and other interested bodies such as the medical Royal Colleges.

14.2 Relationship with other initiatives

14.2.1 When this Review was commenced, it was planned that it would report to the Department of Health inquiry into the issues raised by the conviction of Harold Shipman (the Laming Inquiry). That Inquiry was subject to a legal challenge, and it has since been decided to conduct a new inquiry into the various issues raised by the Shipman case. This Inquiry, established in accordance with the provisions of the

Tribunals of Inquiry (Evidence) Act 1921, has now been set up under the chairmanship of Dame Jane Smith, and is expected to report in Spring 2003. It is hoped that this report will contribute to that Inquiry. The recommendations in this report will also need to be considered against the emerging findings of the Shipman Inquiry.

14.2.2 In January 2001, the Chief Medical Officer, when issuing his advice on the retention of organs and tissue taken at post-mortem examinations[8], anticipated the findings of this report and recommended that further consideration be given to the medical examiner option. At the same time, the Home Office announced a fundamental review of the coroners' system (the terms of reference for which are annexed at Appendix 5).

14.2.3 It is axiomatic that the creation of a medical examiner with the functions described here would impact on the role of the coroner, and that any changes to the role of the coroner would have implications for determining the extent of responsibilities of the medical examiner. The two functions need to be considered jointly – and that is what the coroners' review has been asked to do.

14.2.4 Finally, the way in which the medical examiner would be integrated into the work of the registrar also requires careful examination. The future modernisation of the civil registration system has recently been the subject of a public consultation exercise and it would therefore seem timely if the death certification arrangements can be considered at the same time.

14.3 Costs

14.3.1 A critical aspect to any proposed changes is its cost, both in start up and revenue expenditure. It was not possible to identify costings during the course of this review because the precise role and functions of the medical examiner could not be settled. All the Review Team was able to do was to determine, in general terms, that existing fees payable by the public for the cremation certificate could be saved. These would not give rise to savings to the public purse, however, and consideration would need to be given to whether any new system should be paid for by the taxpayer, or by the consumer. This was outside the remit of the present review.

15 Conclusion

15.1 The Review believes the present system of death certification is not well designed to achieve the task required of it. A number of practical ways to improve procedures have been identified, but the preferred solution, subject to further assessment as to costs and practicality, would be the creation of a new post of medical examiner to confirm the medical cause of death irrespective of the proposed manner of disposal of the body.

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[8] The Removal, Retention and Use of Human Organs and Tissue from Post-mortem Examination (Dept of Health 2001)

[9] Deaths reported to coroners: Home Office Statistical Bulletin – 27 April 2001

15.2 The Review Team's recommendations are summarised at the end of this Report.

Appendix 1

HOME OFFICE
REVIEW OF DEATH CERTIFICATION

MEMBERSHIP OF REVIEW TEAM

Mr R Evans *replaced by* Mr T Cobley, June 2000	Head of Home Office Animals, Byelaws and Coroners Unit
Mr R J Clifford	Home Office
Dr P J Dean	HM Coroner, South East Essex and Greater Suffolk
Dr P Goldblatt	Office for National Statistics
Miss C Lloyd	Office for National Statistics
Dr M McGovern	Department of Health
Dr J Wilkinson	National Assembly for Wales
Dr S Cole	Consultant to Scottish Executive
Mr A Clotworthy	Northern Ireland Office
Dr T J Rothwell	Secretary to Review

Appendix 2

THE CURRENT PROCEDURES FOR THE REGISTRATION OF DEATH AND DISPOSAL OF THE BODY

There are three main groups of professionals involved in the certification process. Death is required by law to be certified by a *medical practitioner*. It is then recorded by a *registrar* who, while a local authority appointee, works to guidelines issued by the Registrar General. The *coroner*, a local independent judicial officer, has a duty to investigate deaths which appear to be unnatural or due to violence. Other *medical practitioners* will be involved where disposal of the body is to be by cremation because of the need for a confirmatory medical certificate (by a practitioner other than the one who certified the death), and the need for authorisation by the *medical referee* at the crematorium. There is also the *informant*, who is the person responsible for registering the death; typically, of course, this will be a relative of the deceased. Each of these individuals has their statutory or other responsibilities. They will also have their own particular concerns.

Burial

The regulations governing disposal of a body by burial are relatively straightforward.

Under the terms of the Births and Deaths Registration Act of 1926, the doctor who signs the medical certificate of the cause of death (the MCCD) should pass it directly to the registrar. The doctor also gives the informant a statutory notice of certification which the informant must then give to the registrar.

Disposal of the body by burial can take place once the registrar has issued the appropriate certificate.

In practice, the prescribed arrangements are normally short-circuited with the doctor handing both documents to the informant, with the informant asked to take the registrar's document to the registrar when registering the death. Simplifying the arrangements in this way does not appear to have led to drawbacks or loss of effectiveness.

Most of the practical arrangements for disposal, whether by burial or cremation, are handled by the funeral director. This has the advantage of ensuring that all the necessary procedures are completed, while releasing a burden from the relatives of the deceased. However, it results in the funeral director taking control of the disposal timetable.

Cremation certification procedures

Cremation destroys the body in a manner which simple burial does not, allowing no further opportunity to ascertain the cause of death. In broad terms, therefore, the regulations which control the granting of permission for cremation are more demanding than those governing burial in order to make sure that the cause of death has been properly and accurately certified.

Under the Cremation Regulations 1930 an application for cremation of a body must be made on a prescribed form (Form A). This will normally be completed by a relative of the deceased or an executor of the deceased's estate.

As well as completing the MCCD, the doctor confirming death must also complete another prescribed form (Form B) which requires additional information about the death. A second doctor is then required to complete a further prescribed form (Form C). This confirmatory certificate is intended to provide an opinion independent of the doctor who signed the MCCD, and consequently the two doctors should not be related, nor share a professional practice. If the death has been subject to investigation by the coroner, the coroner may issue a certificate which replaces the Form B and C certificates.

All applications for cremation at any particular crematorium must be scrutinised by the Medical Referee attached to that establishment. Medical referees are experienced medical practitioners, nominated by the cremation authority but appointed by the Home Secretary on a part-time basis. They receive a small fee for each application completed.

The medical referee is the final arbiter on the application for cremation; if he or she decides that further inquiry is required into the cause of death then the cremation will not be authorised until such inquiries have been made. They have the power to authorise a post mortem examination, but in practice tend to refer to the coroner any cases in which such an examination seems required.

The review team was advised that the complex arrangements for multiple medical certification set out in the cremation regulations have atrophied into formalised documentary transactions which simply do not meet their intended purpose. In particular, medical referees report that the current framework actively discourages any form of open-ended inquiry as to the circumstances of death. Since the death will have already been certified and registered, all the remaining elements of the system are under pressure to complete any further enquiries in accordance with the timetable for the funeral.

Perversely, therefore, some of the statutory safeguards built into the system, such as the second doctor procedure, appear to have made it more difficult to conduct an effective medical inquiry into the death since all the attention is focussed on the completion of the process.

Although the cremation regulations specify that cause of death should be known with a higher standard of certainty before a body may be disposed of by cremation, it would appear that this standard has been steadily eroded as cremation has become overwhelmingly the more popular means of disposal. For example, the Review was told that it is widely accepted that the body may be cremated in any death whose cause has been ascertained sufficiently for the coroner not to need to assume jurisdiction. That, however, is not what the cremation regulations actually require.

Recent research into the quality of cremation certification eg James DS An examination of the medical aspects of cremation certification: are the medical certificates required under the Cremation Act effective or necessary? *Medical Law International 1995* confirms that inadequate precision in completing forms and perfunctory forms of inquiry are unfortunately very much the standard. That the cremation certification procedure is perceived as a process rather than an inquiry tends to be confirmed by the inclusion on the cremation forms of

redundant questions such as 'were you the ordinary medical attendant?', and 'what was the mode of death?', which do little to encourage the process to be taken seriously.

The chief problem, however, may not be the content of the form but its scheduling; as mentioned above, at the time the cremation forms are being completed, the MCCD will already have been issued and the death registered, and hence a timetable for disposal has been established. This approach is in the wrong order; in a properly designed system, the Review Team considered that any necessary inquiries should precede the registration of the death to allow scope for its medical review to be effective.

Reporting to the coroner

Where the cause of death appears to be unnatural, sudden and of unknown cause, or due to violence, the death should be reported to the coroner for investigation. The legal position is that cases apparently falling within the jurisdiction of the coroner will be identified and referred by the registrar, on the basis of their interview with the informant. In practice, however, it is the certifying or attending doctor who reports such deaths to the coroner (in certain cases, the death will be reported by the police).

In recent years there has been a steady increase in the proportion of deaths reported to the coroner, rising from about 30% of all deaths to 37% during the last twenty years.[9] This trend is probably due to the growing use of deputising services by general practitioners. In these cases, the doctor attending at or after death cannot legally issue a MCCD (since he or she will not have attended the deceased "during the last illness").

Only a minority of deaths reported to the coroner will result in an inquest.[10] The majority are reported because they are sudden and of unknown cause in the absence of a medical practitioner available to issue a medical certificate of cause of death. In many such cases, the coroner will be able to satisfy himself, from reference to the deceased's GP or otherwise, that the death was entirely natural and that no further enquiry is required. In rather more cases, the coroner will decide that a post mortem examination is necessary to enable a cause of death to be identified. Either way, once the coroner is satisfied that the death is neither unnatural nor due to violence, he will notify the registrar and arrangements can be made for the death to be registered and the body buried or cremated.

If the death needs to be subject to an inquest, the coroner may give authority for the body to be buried (by means of a burial order) or cremated (by means of a cremation certificate) at any time after he is satisfied that the body is no longer required for his purposes. There is no need to await the outcome of the inquest (which may take some weeks or even months to arrange and take place).

Copies of the various certificates used in connection with these procedures are attached at Appendix 6.

[10] 12% - see Home Office Statistical Bulletin: Deaths reported to Coroners (April 2001)

Appendix
3

HOME OFFICE
REVIEW OF DEATH CERTIFICATION

LIST OF CONSULTEES (PHASES 1 AND 2)

Government departments

Audit Commission

Attorney General

Benefits Agency
- Security Branch
- Director of Field Operations
- Benefit Fraud Inspectorate

Cabinet Office
- Modernising Public Services Group
- CITU
- Economic and Domestic Secretariat
- Bereavement SAT

Court Service
- Civil and Family Business Branch
- Family and Probate Service Secretariat
- Civil and Family Business Branch

Crown Prosecution Service
- Policy Directorate

Dept of the Environment, Transport and the Regions
- Local Government Sponsorship Division
- Local Government Division

Department of Health
- Information Management Group
- NHS Executive
- Medical Statistics Branch
- Dept of Health Drug Strategy Team

Dept of Social Security
- Technical Support Group
- Overseas Division - Pensions and Overseas Directorate

Personal Account Security
Child Support Policy
Contributions Agency
NI Integrity Progamme
War Pensions Agency

10 Downing St

Policy Unit

Home Office

Constitutional and Community Policy Directorate
Constitutional Unit
Freedom of Information Unit
Family Policy Unit
Justice and Victims Unit
Immigration and Nationality Policy Directorate
Liquor, Gambling and Data Protection Unit
Statistician ICU
Disclosure of Information Unit
Race Equality Unit
Home Office Policy Advisory Board for Forensic Pathology

Inland Revenue

National Intelligence Unit

Local Government

Head of Environmental Health, Consumer Protection and Building Control
Local Government Association

Lord Chancellor's Department

Family Policy Division

UK Passports Agency

HM Treasury

Family Policy Unit
TA Team

Treasury Solicitor

Wales

National Assembly for Wales
Local Government Policy and Finance Division
Welsh Health Common Services Authority

Scotland

Courts Group
Civil Justice and International Division
Policy Group
Crown Office
General Register Office for Scotland
Home and Social Division
Scottish Executive Health Department
Directorate of Primary Care

Public Health Policy Unit

Northern Ireland

Primary Care Directorate
Dept of Health, Social Security and Public Safety
Northern Ireland Court Service
Personnel Services Division, Northern Ireland Office
Dept of the Environment (NI), Local Government Division

Eire

Assistant Registrar General

Medical

General Medical Council
British Medical Association

Medical Royal Colleges

Academy of Medical Royal Colleges
Royal College of Pathologists

Individual pathologists

Prof S Lucas, London
Professor M A Green, Leeds
Prof J Crane, Belfast
Prof P Vanezis, Glasgow
Dr S Leadbeatter, Cardiff

Royal College of Ophthalmologists
Faculty of Occupational Medicine
Royal College of Paediatrics and Child Health
Royal College of Radiologists
Royal College of Anaethetists
Royal College of Psychiatrists
Faculty of Public Health Medicine
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of General Practitioners
Royal College of Surgeons of England
Faculty of Dental Surgery
Royal College of Physicians
Royal College of Physicians of Edinburgh
Royal College of Physicians and Surgeons of Glasgow
Royal College of Surgeons of Edinburgh
Royal College of Surgeons of Ireland
Royal College of Physicians of Ireland
UK Central Council for Nursing, Midwives and Health Visitors
Royal College of Nursing
The Royal College of Midwives Trust
National Perinatal Epidemiology Unit

Individual doctors

Dr Rick Jones, Leeds
Dr Mike Murphy, Imperial Cancer Research Fund, Oxford
Dr Gillian Maudsley, Liverpool
Dr J Knox, Hull

Professional bodies

National Association of GP Co-operatives
Association of Clinical Pathologists

British Association in Forensic Medicine
Association of Police Surgeons

Medical referees

Dr A J Rigg Milner, London
Dr A P Nash, Bristol
K Marshall, Ipswich
Dr Gordon Pledger, Morpeth, Northumberland
Dr K Carnegie Smith, Scarborough, North Yorkshire
Dr Rosin, Darlington Crematorium
Dr L P Grime, Accrington, Lancashire
Dr J F Bostock, Wickham, Hampshire
Dr B H Burne, Amersham
Medical Referee, Mortlake Crematorium, Richmond, Surrey
Medical Referee, Plymouth (Weston Mill) Crematorium, Plymouth
Medical Referee, Emstrey Crematorium, Shrewsbury
Dr Dorothy Wright, Burials & Cremation Office, Swansea
Medical Referee, Distington Hall Crematorium, Workington
Dr Alun Wyn, Wilford Hill Crematorium, Nottingham
Medical Referee, Rotherham Crematorium
Dr H V Duggal, Stafford Crematorium
Dr Lauren G Bloch, Putney Vale (Wandsworth) Crematorium
Medical Referee, York City Crematorium
Medical Referee, Accrington Crematorium

Medical Referee, Blackpool Crematorium
Dr J F Skone, Medical Referee - Cardiff Crematorium
Medical Referee, Dewsbury Moor Crematorium
Medical Referee, Forest of Dean Crematorium
Medical Referee, Chanterlands Crematorium, Hull
Medical Referee, Lewisham Crematorium
Dr Simon Lenton, Medical Referee, Bridgend Crematorium
Medical Referee, Colchester Crematorium
Medical Referee, Eastbourne Crematorium
Medical Referee, Guildford Crematorium
Medical Referee, Kettering Crematorium
Dr Harold Newton Gatoff, Manchester (Blackley) Crematorium

Registration

Society of Registration Officers
Institute of Population Registration
Public Record Office
Deputy Registrar General
GRO Scotland

Burial & Cremation

The Funeral Ombudsman
Association of Burial Authorities Ltd (ABA)
The Cremation Society of Great Britain
Resurgam Editorial Office
The Federation of British Cremation Authorities
The National Society of Allied and Independent Funeral Directors
Institute of Burial and Cremation Administration
Confederation of Burial Authorities
The Crematorium Company
British Institute of Funeral Directors
Federation of British Cremation Authorities
Co-operative Funeral Services
National Association of Funeral Directors
Funeral Standards Council
British Institute of Embalmers
Proprietary Crematoria Association

Official bodies

Coroners

Coroners Society

Individual coroners

Dr P Dean, Essex
Dr J D Bruce, Bodmin
Dr W F G Dolman, Hornsea Coroner's Court, London

Coroners' Officers Association
Law Society
Association of Chief Police Officers
Association of Chief Police Officers in Scotland
Emergency Planning Society

Organisations

Victim Support
Victims of Crime Trust
Support after Murder and Manslaughter
Victims' Voice
Marchioness Action Group
Foundation for the Study of Infant Deaths
INQUEST
Road Peace
National Association of Citizens Advice Bureau
CRUSE
SANDS (Stillbirths and neonatal death society)
Patients Association
Relatives and Residents Association
National Association of Bereavement Services
Compassionate Friends
Age Concern / Age Concern Cymru
The Terence Higgins Trust

Religious bodies and ethnic minority community interests

Churches Group on Funeral Services at Cemeteries and Crematoria
Confederation of Indian Organisations
Inner Cities Religious Council
Board of Deputies of British Jews
Union of Muslim Organisations
Muslim Burial Council of Leicestershire

Interfaith Network

Interfaith Network
Network of Buddhist Organisations (UK)
Buddhist Society
CYTUN, Swansea
Churches Together in England
National Council of Hindu Temples
Hindu Council (UK)
Vishwa Hindu Parishad
Jain Samaj Europe
Institute of Jainology
Muslim Council of Britain
Imams and Mosques Council (UK)
Network of Sikh Organisations (UK)
Zoroastrian Trust Funds of Europe

Other correspondents

Mr S White, Radyr, Cardiff
Hampshire Care Association, Chandlers Ford, Eastleigh
Director - Environmental Services, Birmingham City Council
Dr P G Roads, Aylesbury

Malcolm Charlesworth, Spalding
Mrs M P Burns, Manchester
Mrs A M Rowles, Wymondham, Norfolk
Mrs L H Lewy, London

HOME OFFICE
REVIEW INTO DEATH CERTIFICATION

THE WAY FORWARD - SOME OPTIONS

1 The Home Office Review of Death Certification was introduced in response to the conviction of Harold Shipman for the murder of fifteen of his patients. The purpose of the exercise, the results of which were to feed into the Department of Health Inquiry led by Lord Laming[11], is to review the current system for the registration of deaths and, where possible, to make recommendations for improvements. Its terms of reference are as follows:

- To identify issues of concern regarding the law and practice in relation to the certification and registration of deaths in England and Wales in the light of the recent conviction of Harold Shipman for the murder of fifteen of his patients.

- In the light of such issues, to consider improvements to the processes of confirmation, monitoring and certification of deaths and the authorisation of burial or cremation, while respecting the needs of families, including those of ethnic or religious minorities, to hold the funeral without unreasonable delay.

- To consider whether coroners might have a relevant role in the detection and investigation of deaths not reported to them under existing legislation.

- To make recommendations to the Secretary of State for the Home Department and to the Inquiry into the Issues Raised by the Case of Dr Harold Shipman

2 While, therefore, the primary intention of the review was to identify issues directly relevant to the case involving Harold Shipman, it was also considered legitimate to spread the net more widely in order to pick up general issues concerning the whole process of death certification.

3 In the first stage of the review a large number of individuals and organisations were invited to offer their views on the manner in which such certification is currently undertaken. Out of 222 packs of information about the review sent out, 104 replies were received. Included in the exercise were a wide range of consultees, including

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[11] The Department of Health has announced that a full public inquiry into the events is now to be held

Government departments, the medical Royal Colleges, other medical bodies (including a sample of individual medical referees), coroners, the burial and cremation industry, and other relevant organisations including those representing a wide variety of ethnic and religious communities.

The Brodrick report [12]

4 Death certification practice was previously reviewed by a committee set up by the Home Office and led by Norman Brodrick QC, the report of which was published in 1971. For various reasons many of the committee's recommendations remain on the table and a number of respondents to the current review suggested that these should now be implemented. However, in view of the many changes which have taken place in the thirty years since the committee undertook its work this appeared to be too simplistic a solution.

5 For instance, the Brodrick committee report recommended that certification of both the fact and cause of death should be performed by the doctor who had attended the deceased person at least once during the seven days preceding death (para 5.12). The development of general practitioner deputising services and the fact that many deaths now occur within care homes may mean that this recommendation needs to be looked at in a different light.

6 Again, Brodrick recommended (para 24.04) that the forensic pathology service - on whom coroners and others rely for the investigation of deaths which may appear to be suspicious - should be firmly based in the National Health Service. The subsequent report of the Home Office inquiry into forensic pathology services[13] introduced the concept of direct contractual relationships between the practitioners and the police service, and the adoption of this recommendation has fundamentally altered the manner in which such services are now provided.

7 Yet another section of the report (Chaps 26-27) looked in some detail at the certification procedures then existing where disposal of the body was to be by cremation, a process which has gained considerably in popularity since the Brodrick report was published. There was a clear recommendation that a properly completed certificate (issued, as appropriate, by either a registrar or a coroner) should suffice whatever means of disposal was to be used. This recommendation has been developed in one of the options described in this paper.

Response to consultation

8 The thrust of all the responses gave the very clear message that no regulatory arrangements (or at least none likely to be acceptable to the general public) could be certain to prevent another incident like those involving Harold Shipman. Within that

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[12] Report of the Committee on Death Certification and Coroners - 1971 [Cmnd 4810]
[13] Report of the Home Office Working Party on Forensic Pathology - 1989 (HMSO)

constraint, however, respondents identified weaknesses in the present arrangements and suggested measures which might be expected to improve the regulatory process. Details are set out in the attached analysis of responses.

9 Various themes, differing in the radical nature of their approach, could be drawn from the responses. These have been developed into three broad 'options' offering different degrees of change. Details are discussed in paragraphs 13 to 25 below.

Purposes of death certification

10 The possible efficacy of the various options will need to be assessed against both the terms of reference and the purposes of death certification. Having regard to comments and suggestions made by respondents, the review concluded that the primary purposes of this process might be said to be:

- to confirm that death has occurred
- to give an indication of the likely cause of death
- to support relatives and others interested in the reasons for the death
- to ensure that sudden and / or unexpected deaths, where the question of criminal causes may arise, are investigated prior to disposal of the body
- to provide statistical information about the cause of death.

Views are invited on the purposes of death certification as set out here, and the order of priority in which they are given.

Effectiveness of the current arrangement

11 In general terms, the responses indicated that most of the purposes of certification were in fact met through the current arrangements most of the time. Existing processes were believed to be adequate provided they were applied conscientiously and the areas of doubt clarified, although that is not to say that they could not be completed more effectively or with greater accuracy of the factual information.

12 Respondents expressed concern, however, that the existing processes could not be regarded as completely reliable in diagnosing the cause of death with accuracy. Furthermore, many of the procedures were thought to be bureaucratic and expensive and that, due to lack of training, low priority, and ineffective responsibility or accountability, those involved could not be relied upon to identify with certainty the determined killer, the unexpected cause of death, or negligent treatment. In particular,

the Shipman case demonstrated that the investigation of crime may not be adequately addressed at present, although no respondents indicated there was cause for undue alarm.

13 A significant minority of respondents felt that the weaknesses were more systematic and a system change, or at least a substantial revision, would be required if the processes were to achieve their intended aims.

14 All respondents recognised that effective controls were likely to increase the delay between the time of death and the disposal of the body, although this might be mitigated through the use of electronic communications. It was evident that, out of consideration for the relatives of the deceased, of whatever religious persuasion or cultural background, it would be most important to strike an appropriate balance.

15 The options which have now been identified are not mutually exclusive; for example it might be possible to combine elements from Option 1 with those from Option 2 if that were considered to offer a potentially useful combination of changes. In broad terms, however, Options 1 to 3 offer a progressively more radical approach.

Option 1: Sharpen up the existing procedures

16 The changes proposed under this option are designed to be achieved without amendment to primary legislation or significant additional costs (although it has not yet been possible to make a realistic cost assessment). This option is designed simply to improve death certification by tidying up the existing procedures. For instance, it would be useful to:

(a) add, on a non-statutory basis, to the medical certificate of cause of death a narrative account of the circumstances in which the death occurred, plus some reasoning for the diagnosis;[14]

(b) encourage, on a non-statutory basis, medical records to be consulted before issue of a medical certificate of the cause of death (with the death to be reported to the coroner if the medical records are not available);

(c) provide non-statutory definitions of 'attended' and 'last illness' for the purpose of achieving consistency in practice and understanding;[15]

(d) revise the questions posed in cremation Forms A, B and C to ensure that they are relevant, clear and unambiguous;[16]

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[14] The current medical certificate of cause of death requires merely that the cause is given to the best of the certifying doctor's knowledge or belief. Respondents believed that more information provided at this stage would make the certificate more robust and enable any queries to be followed up more effectively.

[15] Under the Births and Deaths Registration Act 1953, the death of a person not 'attended' during his last 'illness' must be reported to the coroner, but there is inconsistency in interpretation of the circumstances in which this requirement applies.

[16] For example, Form A might have a question added about whether there was reason to suppose the cause of death was unnatural; Form B might require the name of the person who

(e) provide, on a non-statutory basis, relevant information in support of the medical certificate of the cause of death such as the doctors' GMC registration numbers and the deceased's NHS number;

(f) make provision for the recording of any inquiries and their results by the doctor completing the Form C cremation certificate and the medical referee completing the Form F cremation certificate;

(g) introduce a non-statutory code of practice for dealing with deaths currently attributed to 'old age';[17]

(h) develop a code of practice/non-statutory definition of 'unnatural' deaths to promote greater consistency in the deaths referred to coroners;[18]

(i) provide training, necessarily on a voluntary basis, for those who currently do not receive any, or only minimal, provision. These will include medical referees and coroners' officers. Training for medical students in the diagnosis of death and completion of the relevant forms would need to be reviewed by the medical schools;[19]

(j) review arrangements for the provision of pathology services for coroners and consider an appropriate accreditation scheme, in line with that applied to forensic pathologists.[20]

17 This option would clearly address a number of issues. It should help to ensure that death certification was carried out more effectively and consistently, with more accurate information recorded (within the constraints of the absence of post mortem examinations); it could not, however, address the more fundamental concerns raised by many respondents such as the different procedures for burial and cremation and the need, or otherwise, for certification of deaths to be countersigned by another medical practitioner.

18 The advantage of this option is that the measures could be put into place relatively quickly because no legislation would be required. The lack of a statutory basis for the measures would, however, also constitute a weakness. Higher costs could arise if

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nursed during the last illness; and Form C could ask whether the medical records had been inspected and whether the countersigning doctor was satisfied with the cause of death given.

[17] Respondents were divided on the age of the deceased at which 'old age' might be acceptable; some felt 'old age' was never acceptable. It might be appropriate to require such deaths, for which the precise cause of death may be unascertained, or unascertainable, to be referred to the coroner.

[18] The absence of a statutory definition of 'unnatural' for the purpose of referral of deaths to coroners is a source of confusion and inconsistent practice. A satisfactory definition would not, however, be easy to achieve. Guidance could nevertheless assist (and might reduce unnecessary referrals) and might also be preferable to a statutory definition which could inadvertently exclude deaths which it would be desirable to investigate.

[19] Training would need to be voluntary under this option since compulsory training would require legislation.

[20] Only Home Office registered forensic pathologists are currently accredited for providing services to the police and coroners in cases of suspected homicide. Although there is no evidence that standards of post mortem examinations for coroners have given rise to problems or doubts in the certification of deaths, in order to ensure the highest standards of service consideration should be given to an accreditation scheme with auditable standards for all the pathologists used by coroners.

doctors felt that the additional work involved in providing the further information could not be absorbed within the terms of their NHS employment, although it is not possible to predict what this might amount to. It would also be for consideration as to who should pay (eg local or central government, or the estate of the deceased). Training costs for medical referees and coroners' officers have been estimated at £100K per year.[21]

Views are invited on the measures set out under this option, in particular whether they are achievable, whether they would offer prospects for real improvements to the existing arrangements, and whether there might be other low cost and non-statutory measures which should also be taken.

Option 2: Change and improve procedures within the existing framework

19 This option offers a more fundamental reform of some aspects of death certification for which primary legislation might be required, although the existing overall certification framework would be retained. Under this heading should be considered:

(a) make statutory the non-statutory amendments to registration legislation as described in paragraph 13 above;[22]

(b) unification of the burial and cremation procedures;[23]

(c) introduction of a second doctor's confirmation of the death certificate in all cases;[24]

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[21] Assumes £100 per head per year for 400 coroners' officers and 200 medical referees (similar training costs are incurred for coroners and registrars), plus administrative overheads.

[22] In addition, this would enable consideration to be given to vary the existing procedure to allow certifying doctors who need to report a death to the coroner to complete the certificate as far as they are able and send this information to the coroner. In turn, if the coroner did not need to make the death the subject of an inquest, the information provided by the certifying doctor could be passed on to the registrar. Such a procedure would require the information to be processed electronically if delays were to be avoided and legislation would be needed to achieve this.

[23] Although many respondents argued vigorously that, where there was a loss of primary evidence through cremation or other disposal procedures (such as burial at sea or removal of the body abroad), it was essential to have a more thorough process for death certification, the majority concluded that it would be better to have essentially the same processes applied whatever the manner of disposal. This seems justified. Although a body may be exhumed for further examination if it has been buried, it seems wrong to rely on such a process or to apply lower safeguards simply because there is a theoretical opportunity to revisit the evidence.

[24] Such a procedure offers the prospect of greater assurance in both the accuracy of the doctor's diagnosis and in the integrity of their work, especially if the medical certificate of the cause of death contains more detailed information (see paragraph 13(a)). Nevertheless, it would seem essential for the second doctor to have additional training in the responsibilities he was to discharge. There would also be a need to have procedures to ensure that proper

(d) extend to doctors and nurses the duty to report deaths in the circumstances currently prescribed for registrars of births and deaths, and impose a similar duty on funeral directors;[25]

(e) make financial provision for medical referees to arrange post mortem examinations without recourse to the coroner;[26]

(f) provide that where a medical referee refuses application for cremation the matter must be referred to the coroner;[27]

(g) provide that where a body is to be removed out of the country the application must be made to the local coroner and no other;[28]

(h) put on a statutory basis the present procedure whereby deaths reported to the coroner are decided not to require either a post mortem examination or an inquest;[29]

(i) make enabling provision for the meaning of 'unnatural death' (for the purposes of referring deaths to the coroners) to be defined in regulations;[30]

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examination of the body was undertaken and that an adequate number of doctors were available to undertake the tasks.

[25] Respondents were generally in favour of extending to doctors the duty to report to coroners deaths taking place in certain circumstances, and it would seem sensible to impose the same duty on nursing staff. In some cases funeral directors, rather than medical staff, will be the first to attend the deceased on the report of a death and it would also seem prudent to extend the requirement to them. However, it has not yet been possible to determine the full range of circumstances in which funeral directors should report cases to coroners. It is envisaged that the requirement would apply in a narrower range of circumstances and where it might be important to avoid, for example, removal of the body until the scene of the death had been inspected.

[26] Although medical referees currently have the power to order their own post mortem examinations, there are no effective arrangements to meet their costs. In practice, such cases are referred to the coroner, or otherwise the applicant is required to meet the cost directly. Now that cremation is the majority choice of disposal, it seems difficult to justify imposing additional costs on applicants. Funding would need to be arranged through local authorities (probably even where applicants had applied to private crematoria) since it would appear right to regard the arrangements as a public health or criminal justice measure.

[27] At present, cremation legislation is silent on what should happen if a medical referee refuses an application. In such rare cases, it would be appropriate to take steps to ensure that the death was fully investigated and the applicants not allowed to make application to another medical referee, bury the body, or, for example, take it abroad.

[28] The present legislation does not clearly prescribe this. Although the risk of abuse seems low, it would seem sensible to remove this possibility.

[29] If a death is reported to the coroner, he or she may be satisfied that the death is not one which needs to be subject to an inquest. If that decision is reached without a post mortem examination, the coroner may issue the so-called Pink Form A to the registrar of births and deaths to advise him that he may proceed with the registration of the death. However, there is no statutory basis for this procedure. Moreover, it is common for doctors to discuss deaths informally with coroners to ascertain whether the death needs to be reported. Practice varies, but there is often no formal notice of the decision taken in some cases, and there is no clear distinction between deaths which merit completion of a Pink Form A and those which do not. Although there is no evidence that deaths are not properly investigated in these cases, consistency and good audit practice suggest that <u>all</u> cases should be recorded and a decision notified.

(j) clarify the roles and functions of coroners' officers and responsibility for their provision so that they can provide a high quality front line service to both professionals and the public;[31]

(k) provide for compulsory training for the second doctor, the medical referee, the coroners' officer and the coroner;[32]

(l) enable readier access to the cause of death by the family of the deceased;[33]

(m) introduce regular monitoring of death statistics by the local director of public health to enable local and doctor-specific trends and abnormalities to be identified and, where appropriate, investigated.[34]

20 It has not yet been possible to assess the costs of the above measures, either individually or collectively. The need for confirmation of a death by a second doctor in all cases could be expected to increase the costs to those making arrangements for a burial by about £40, but this may be offset in part if the revised and expanded medical certificate of cause of death is issued without charge and replaces, to a great extent, the existing cremation Form B.

21 Compulsory training will also increase the costs estimated in paragraph 18 above since both the initial demand and the ongoing requirements are likely to be higher. The costs of training countersigning doctors will be particularly difficult to determine. The costs associated with the introduction of any changes to coroners' officers arrangements cannot at present be forecast, nor can the costs for the introduction of local or regional monitoring of death statistics and the investigation of apparent problems.

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[30] The case for non-statutory guidance was made under Option 1, but legislative provision might also be made if it seemed likely to achieve greater certainty without the disadvantage of lack of flexibility.

[31] Coroners' officers play a critical role in the initial investigation of reported deaths, but there are wide variations between different jurisdictions as to the duties they are required to undertake. This creates uncertainty and inefficiencies. Moreover, it has been suggested that the absence of uniform arrangements for the provision of such officers, and the current arrangements in the majority of counties whereby the officers are provided for coroners by the police as civilian officers, but carry out their duties under the direction of the coroner, can lead to loss of proper accountability and hinder the delivery of an efficient service.

[32] There is no compulsory relevant training for these groups at present.

[33] Families do not normally have access to the certified medical cause of death until after the death has been registered. Nor do they normally have access to the information recorded in connection with applications for cremation. If the details were known to families, and at an early stage, any concerns or challenges could be made and considered without delay. The disadvantage would be that the doctors completing the documents might feel inhibited in their comments especially where the cause of death, although natural, was sensitive. One possibility would be to insert the medical cause of death on the notice explaining how to register the death.

[34] Although it might be possible to introduce such arrangements without legislation, they would be unlikely to be as effective. In the time available it has not been possible to determine any details as to how the monitoring process might best be put into effect, but respondents were clear that this was a function which would not fit easily or readily with the existing work of the coroner.

Views are invited on the measures set out under this option, in particular whether they are achievable, whether they would offer prospects for real improvements to the existing arrangements, and whether there might be other measures which should also be taken.

Option 3: Radical change to the regulatory arrangements

22 A recurring theme to emerge from the various responses looked for radical changes to be made in the procedures for death certification and registration, with some respondents offering very detailed proposals. This option, therefore, proposes a model in which the boundaries between the existing players are redefined to create a much more powerful 'medical referee' or 'medical examiner' who would absorb certain functions of the registrar, the existing second doctor (and medical referee in cremation cases) and - to some extent - the coroner.

23 Such an 'examiner' might have the following functions:

(a) confirmation of the medical cause of death issued by the certifying doctor;[35]
(b) authorisation of burial or cremation, burial at sea, or removal abroad;[36]
(c) exercise of the present powers of the coroner to determine whether a death needed to be the subject of an inquest.[37]

24 The proposed system might streamline and focus the current rather uncoordinated procedures following a death by ensuring that there was a designated individual, possessing appropriate medical qualifications and training, with a clear responsibility to account for the causes of all deaths. One key feature of this model is that the death could be investigated prior to its registration, thus avoiding the current post-registration pressures for the funeral which may inhibit proper investigation in cremation cases. Most of the suggestions included in Options 1 and 2 would also need to be incorporated within this model.

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[35] The 'examiner' would thus replace the Form C doctor in cremation cases or a countersigning doctor under any other arrangement.

[36] It would be for consideration whether the information currently obtained by the registrar of births and deaths should instead be sought by the 'examiner' to enable an informed decision to be taken about the need for any further inquiries. The function of the registrar, in respect of deaths, might then be reduced to receiving details from the 'examiner' for record purposes and for the issues of a death certificate only. The 'examiner' would replace the current function of the coroner in regulating the removal of bodies abroad (unless the deaths required an inquest).

[37] Only some 14% of deaths reported to coroners currently result in inquests. The proposal would therefore mean that 86% of coroners' current caseload would be dealt with by 'examiners'. This would have a significant impact on the work of the coroner and would require a full assessment of the consequences - which is beyond the remit of the present review.

25 The new 'medical examiners' would be medical professionals working either full or part time within a team, providing a 24 hour service to obviate the possibility of delay. In addition to their function to confirm a death and authorise disposal of the body, they would have a duty to monitor and put together a clear overview of all the deaths occurring in their areas.

26 Responsibility for the implementation and management of such a system might appropriately lie within the area of Public Health. However, there might equally be a case for linking the function more closely with that of the coroner, thereby creating a new team with varied functions. In any event, there would be a need to explore and create new relationships between these post-holders and the coroners, and with the wider registration system.

27 The proposed new system would aim to provide an effective and rapid service in the investigation of all deaths; a more integrated approach should enable more accurate statistics of cause of death to be compiled, while closer monitoring should allow criminal activity or inadequate medical care to be detected at an earlier stage. Responsibility for the death certification process would become a properly defined job, rather than an extra task imposed on a busy GP or hospital doctor.

28 The introduction of a completely new system would have associated costs; for instance, to set the system up, to ensure that electronic communication links were adequate to support the system, and to provide the necessary training. More particularly, the need to provide ready access to the examiner raises questions about the practical feasibility of the proposals. The numbers would almost certainly have to be in excess of the current number of medical referees and their deputies and, unlike them, many might need to be full time appointments.

29 The costs of such an arrangement remain to be quantified. Although the existing functions of the medical referee would be lost, this could not finance the new arrangements since the medical referees, like the Form B and Form C doctors, are funded by those who apply for cremation. There may, however, be some consequent savings from a simplification of the arrangements.

Views are invited on this option, in particular whether the arrangements would be attractive and likely to be effective, and whether there would be disadvantages in changing or removing functions from registrars and coroners.

Confirmation of the fact of death

30 The confirmation of the fact of death appears to raise two separate considerations. The first is who is appropriately qualified to confirm that death has occurred. Professional medical opinion appears to be satisfied that this can be quite properly undertaken by a qualified nurse as much as by a doctor, at least where the person is known to be dying from an illness and there are no suspicious circumstances.

31 The second issue is who should have the authority to remove the body from the place of death. This is important because any suspicious circumstances and relevant evidence might only be detected from a view of the body *in situ*. Accurate

certification, or the need for further investigation, may therefore depend in part on the circumstances in which the body was found.

32 The review considered that questions regarding the ethics of attendance on the deceased by medical professionals and the priority to be attached to such a duty were beyond its remit, as were the concerns as to their liability expressed by some funeral directors. What was clear, however, was that care would be needed before a body was removed from the place of death and that routine removal to hospital, for example, was not necessarily appropriate.

33 The solution might lie in a code of practice, possibly supported by legislation in due course, to prescribe the initial procedures to be followed in the event of a death. Such a code might require:

(a) confirmation to be undertaken by a qualified doctor only, unless
- the deceased was known to be dying from an illness and there were no suspicious circumstances, *or*
- the death was reported to the coroner;

(b) the body not to be removed from the place of death until attended by the certifying doctor (or coroner's officer, or police) unless funeral directors were in attendance and were satisfied that there were no grounds for reporting the death to the coroner.

(c) no embalming of the body to be undertaken until the cause of death had been certified or, where the death has been reported to the coroner, without the consent of the coroner.

Again, adoption of any such code of practice is likely to necessitate training for appropriate individuals.

34 This procedure would need to be complemented by placing a duty on funeral directors to report deaths to the coroner where there appeared to be grounds for so doing. While this might seem an unduly arduous and inappropriate responsibility, it should be remembered that funeral directors probably have more familiarity with death than most medical professionals, and that it would not seem unreasonable both for qualified personnel to confirm death and to judge whether or not the body should be moved.[38]

[38] By contrast, one of the main recommendations of the Brodrick committee was to place an obligation on the relevant doctor to issue a certificate of the fact and cause of death, but this should be seen within the framework arrangements which the committee proposed. This recommendation has not been reassessed by the review, but should not be lost to sight.

Views are invited on the proposals for regulating death confirmation, in particular whether the arrangements would be effective, workable, and place duties on those who could realistically be expected to discharge them.

Payment for services

35 The review found no significant evidence that the payments made for the various services required in connection with certification of death or disposal of the body affected the quality of the service provided. The vast majority of respondents generally held that certification of death was a responsibility which the attending doctor should be expected to discharge under National Health Service arrangements. However, some respondents felt that the remuneration of medical referees was inadequate, while many expressed the view that the fees for doctors for their cremation certificates rarely reflected the work done or the responsibility borne.

36 The review was unable to conclude whether certain procedures would be undertaken more effectively if they were paid for, or if higher payments were made. Equally, it was not possible to form a view as to the effect of removing a power to charge a fee, or whether there was a case for fees to be regulated rather than negotiated. It should, however, be noted that if the arrangements outlined in Option 3 were to be adopted, the need for fees for medical referees and certifying doctors would fall away, although central payments for the new 'examiner' would arise instead.

37 One potential problem noted, however, was that the payment of a fee to a doctor for the completion of a cremation certificate might introduce a conflict of interests if it fell to that same doctor (as it usually would) to notify the coroner that the death ought to be reported. In particular, this situation might occur where the need to refer the case was unclear or arguable. If the coroner accepted jurisdiction, cremation could be approved by the coroner and no fees would then be payable to the doctor concerned. It would seem desirable to avoid such a situation arising, although it is not immediately clear how best to do so.

Notwithstanding the above, views are invited on whether the effectiveness of the arrangements are dependent on the fees paid and whether such fees should be subject to regulation rather than negotiation. Views are also invited as to whether any significant conflict of interests occurs in practice, and to the way in which any such situation might be avoided.

Conclusion

38 This consultation paper considers the responses to the questions which were first raised about how death certification might be made more effective, and has drawn together some measures for improvement which are necessarily tentative. A view has also been taken on death confirmation procedures which suggest that some regulation of practice would be beneficial. Finally, consideration has been given to the existing arrangements for the payment for relevant services.

39 All the options contained in this paper will require further, more detailed, consideration as to their feasibility and completeness. It will also be necessary to determine how they might mesh with any changes to the registration arrangements which may in due course flow from the current review of that service.

40 Nevertheless, views are invited on these options and the measures which appear likely to enable a more effective death certification system to be constructed. **Responses are invited by 20 December 2000.**

Appendix 5

HOME OFFICE
FUNDAMENTAL REVIEW OF THE CORONERS' SYSTEM

TERMS OF REFERENCE

In respect of England, Wales and Northern Ireland:

To consider the most effective arrangements for identifying the deceased and for ascertaining and certifying the medical cause of death for public health and public record purposes, having regard to proposals for a system of medical examiners.

To consider the extent to which the public interest may require deaths to be subject to further independent investigation, having regard to existing criminal and other statutory and non-statutory investigative procedures.

To consider the qualifications and experience required, and the necessary supporting organisations and structures, for those appointed to undertake the duties for ascertaining, certifying and investigating deaths.

To consider arrangements for the provision of post mortem services for the investigation of deaths.

To consider the consequences of any changes arising from the above for the registration service and the role of coroners under the Treasure Act 1996, and to consider where Departmental responsibilities for the arrangements should be located, having regard both to coherence for bereavement services and effective accountability.

CERTIFICATES USED IN CONNECTION WITH THE CERTIFICATION OF DEATH AND DISPOSAL OF THE BODY

1. Medical Certificate of Cause of Death
2. Certificates for Burial or Cremation
3. Certificate of Medical Attendant
4. Confirmatory Medical Certificate
5. Coroner's Certificate
6. Authority to Cremate

} under the Cremation Regulations