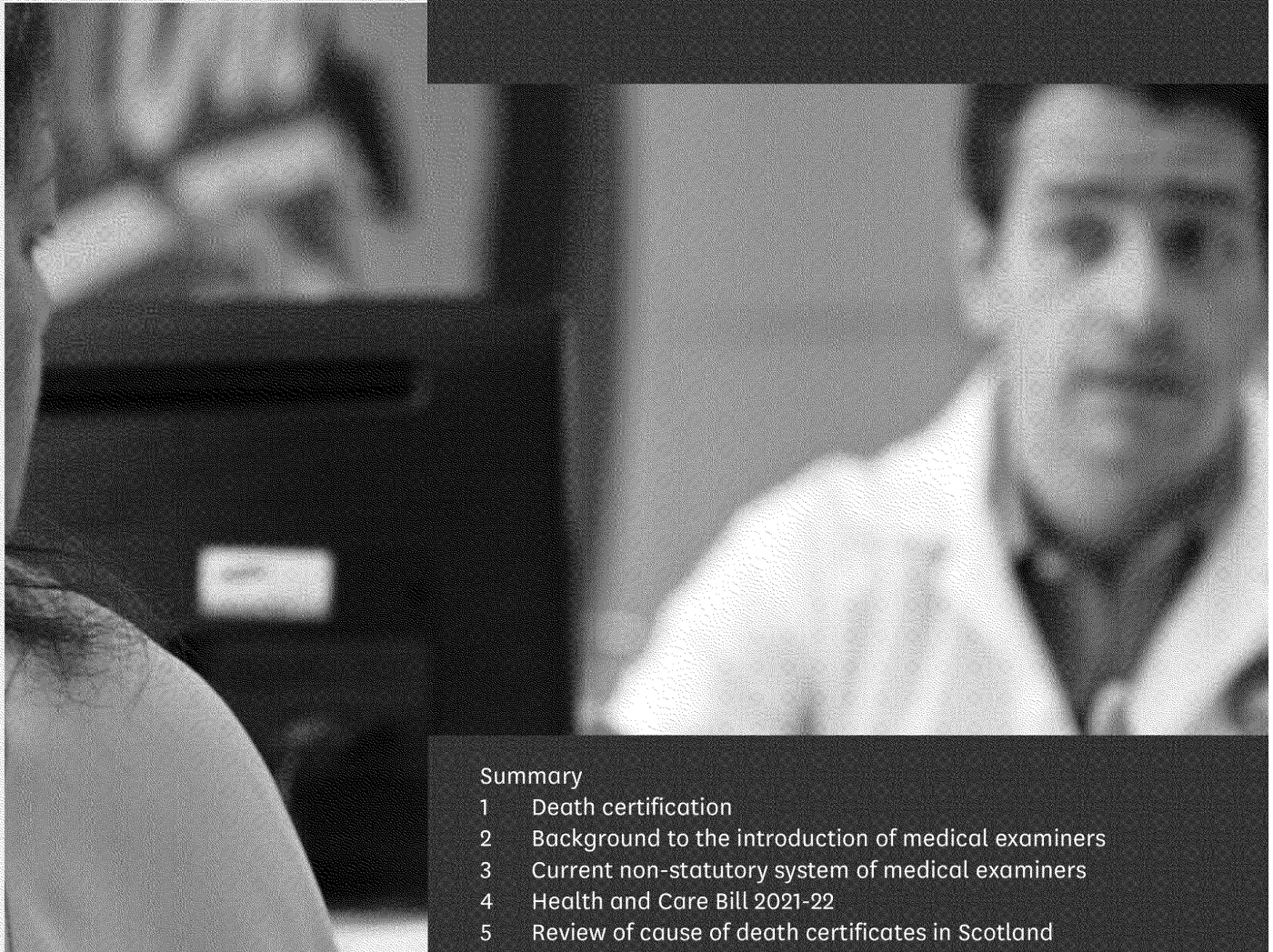


By Catherine Fairbairn

3 November 2021

## Death certification and medical examiners



### Summary

- 1 Death certification
- 2 Background to the introduction of medical examiners
- 3 Current non-statutory system of medical examiners
- 4 Health and Care Bill 2021-22
- 5 Review of cause of death certificates in Scotland



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## Summary

The Health and Care Bill 2021-22 (the Bill) was introduced in the House of Commons on 6 July 2021 as [Bill 140 of 2021-22](#). It had its Second Reading on 14 July 2021 and has been considered by a Public Bill Committee. The Bill, as amended in Public Bill Committee, has been republished as [Bill 183 of 2021-22](#). This briefing paper deals with Clause 124 (now Clause 128 in the Bill, as amended), “Medical examiners”, which was not amended at Public Bill Committee stage. Separate Library briefing papers deal with other parts of the Bill and can be accessed from the Commons Library webpage, [Health and Care Bill 2021-22](#).

This paper deals mainly with the position in England and Wales except where otherwise stated. Section 5 sets out information about the system in Scotland.

### Death certification

The present system of death certification in England and Wales requires certification of the cause of death by a registered medical practitioner, to the best of their knowledge and belief. Alternatively, the death must have been reported to the coroner and the appropriate certificate provided by them.

Temporary changes introduced by the Coronavirus Act 2020 are currently in place, including the suspension of the requirement for a confirmatory certificate from a second registered medical practitioner before a body may be cremated.

### Medical examiners

A new medical examiner system is being rolled out across England and Wales to provide greater scrutiny of deaths.

The [Coroners and Justice Act 2009](#) provides for a system of death certification under which all deaths in England and Wales that do not require investigation by a coroner will be subject to scrutiny by independent medical examiners. The statutory scheme (as amended) provides for local authorities in England and Local Health Boards in Wales to appoint the medical examiners. The legislative provisions are not yet fully implemented.

The Government now intends that the system will be within the NHS. In 2018, the Government announced that it would amend the Coroners and Justice Act 2009, when an opportunity arose, and that, meanwhile, a non-statutory medical examiner system would be introduced. The [stated purpose](#) of the medical examiner system is to:



- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.

The introduction of a system of medical examiners follows a long period of policy development, including pilot schemes, which originated, at least in part, as a response to Harold Shipman's murder of his patients. For many years, Shipman managed to escape detection by certifying patients he murdered as having died from natural causes, avoiding scrutiny by a coroner. In 2003, the Shipman Inquiry, chaired by Dame Janet Smith, proposed that there should be an effective cross-check of the account of events given by the doctor who treated the deceased and who claimed to be able to identify the cause of death, regardless of whether the death was followed by burial or cremation. Similar recommendations have also been made by others.

## **The Health and Care Bill 2021-22**

Clause 124 (now Clause 128) of the Bill would amend the Coroners and Justice Act 2009 to introduce a statutory medical examiner system within the NHS rather than local authorities in England, for the purpose of scrutinising all deaths which do not involve a coroner. It would require the Secretary of State to ensure that enough medical examiners are appointed in the healthcare system in England, that enough funds and resources are made available to medical examiners to enable them to carry out their functions of scrutiny, and to ensure that their performance is monitored.

The Explanatory Notes to the Bill state:

“Medical examiners will introduce an additional level of scrutiny to those deaths not reviewed by a coroner, improve engagement with the bereaved in the process of death certification and offer them an opportunity to raise any concerns as well as improving the quality and accuracy of Medical Certificates of Cause of Death. Independent scrutiny of deaths will reduce the potential for malpractice by doctors to go unchecked. The level of scrutiny will be proportionate so as not to impose undue delays on the bereaved or undue burdens on medical practitioners and others involved in the process”.

The Secretary of State would have power to issue directions to an NHS body concerning medical examiners.

## **Scotland**

Different arrangements for death certification and registration apply in Scotland. The Death Certification Review Service, which is run by Healthcare



Improvement Scotland, checks on the accuracy of a sample of medical certificates of cause of death (MCCDs) with the aim of improving:

- the quality and accuracy of MCCDs
- public health information about causes of death in Scotland, and
- clinical governance issues identified during the death certification review process.



# 1 Death certification

## 1.1 The purpose of death certification

One of the fundamental purposes of death registration is the protection of human life. A White Paper published in 2002 states:

“Society needs to be confident that no burial or cremation can take place without there having been an opportunity to investigate the death and that there are full and proper procedures for its certification.”<sup>1</sup>

Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales states that prompt and accurate certification of death is essential as it serves a number of functions, including providing information for statistical purposes:

“Information from death certificates is used to measure the relative contributions of different diseases to mortality. Statistical information on deaths by underlying cause is important for monitoring the health of the population, designing and evaluating public health interventions, recognising priorities for medical research and health services, planning health services, and assessing the effectiveness of those services. Death certificate data are extensively used in research into the health effects of exposure to a wide range of risk factors through the environment, work, medical and surgical care, and other sources.”<sup>2</sup>

## 1.2 Who certifies the cause of death?

The present system of death certification in England and Wales requires certification of the cause of death by a registered medical practitioner, to the best of their knowledge and belief;<sup>3</sup> alternatively, the death must have been reported to the coroner and the appropriate certificate provided by them.

<sup>1</sup> Civil Registration: Vital Change, CM 5355, January 2002, paragraph 2.18

<sup>2</sup> Office for National Statistics and HM Passport Office, Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales FOR USE DURING THE EMERGENCY PERIOD ONLY, last updated 1 April 2020, p2 (on Gov.UK website)

<sup>3</sup> Births and Deaths Registration Act 1953 section 22

## 1.3

## Certification of death by medical practitioner

Unless the death is reported to the coroner, it is usually the doctor who attended the deceased during their last illness who has a legal responsibility to complete a medical certificate of cause of death (MCCD), and to arrange for its delivery to the registrar.<sup>4</sup> This enables the registration of the death to take place.

However, the [Coronavirus Act 2020](#) has made some temporary changes to this position:

- a registered medical practitioner (X) who did not attend the deceased during their last illness may sign a MCCD if:
  - the practitioner who attended the deceased is unable to sign the certificate or it is impractical for that practitioner to sign the certificate, and
  - X is able to state to the best of X’s knowledge and belief the cause of death
- in addition, a registered medical practitioner (“P”) may sign an MCCD even for a person who has not been attended by a registered medical practitioner during their last illness, if P is able to state to the best of P’s knowledge and belief the cause of death.<sup>5</sup>

[Guidance for doctors completing MCCDs](#) was updated in April 2020 to take into account the changes brought in by the Coronavirus Act 2020. It provides information about who should certify a death:

“In an emergency period, any doctor can complete the MCCD, when it is impractical for the attending doctor to do so. This may, for example, be when the attending doctor is self-isolating, unwell, or has pressure to attend patients. In these circumstances, it may be practical to allow a medical examiner or recently retired doctor returning to work to complete the MCCD.

There is no clear legal definition of “attended”, but it is generally accepted to mean a doctor who has cared for the patient during the illness that led to death and so is familiar with the patient’s medical history, investigations and treatment. For the purposes of the emergency period, the attendance may be in person, via video/visual consultation, but not audio (e.g. via telephone). The certifying doctor should also have access to relevant medical records and the results

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<sup>4</sup> Ibid

<sup>5</sup> [Coronavirus Act 2020 section 18 and Schedule 13, paragraph 4](#)



of investigations. There is no provision in the emergency period to delegate this statutory duty to any non-medical practitioner.

(...)

In hospital, there may be several doctors in a team caring for the patient. It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Any subsequent enquiries, such as for the results of post-mortem or ante-mortem investigations, will be addressed to the consultant.

In general practice, more than one GP may have been involved in the patient's care and so be able to certify the death. In the emergency period, the same provisions to enable any doctor to certify the death prevail in general practice.”<sup>6</sup>

There is usually a requirement for a confirmatory certificate (for which a fee is payable) from a second registered medical practitioner before a body may be cremated. This requirement has been temporarily suspended by the Coronavirus Act 2020.<sup>7</sup>

NHS England and NHS Improvement have issued guidance, [Coronavirus Act – excess death provisions: information and guidance for medical practitioners](#).<sup>8</sup>

## 1.4

### Deaths reported to the coroner

Registrars and medical practitioners must report some deaths to the coroner. The police will also report deaths in some circumstances and anyone else may report a death if they have concerns about it. When a death is reported, the coroner decides whether to carry out further inquiries.

#### Duty to report

##### Registrars' duty to report

[Regulation 41 of the Registration of Births and Deaths Regulations 1987](#) (as amended) imposes a duty on registrars to report a death to the coroner if:

- the deceased had not been attended during their last illness by a registered medical practitioner, or
- the registrar has been unable to obtain a duly completed MCCD, or

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<sup>6</sup> [Office for National Statistics and HM Passport Office, Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales FOR USE DURING THE EMERGENCY PERIOD ONLY](#), last updated 1 April 2020, pp2-3

<sup>7</sup> [Coronavirus Act 2020 section 19](#)

<sup>8</sup> 31 March 2020

- (usually) the certifying medical practitioner had not seen the deceased either after death or within fourteen days before death – but see below.

The Coronavirus Act 2020 has introduced temporary changes to the rules so that the death need not be reported to the coroner if any medical practitioner has seen the deceased after death or within an extended period of 28 days before death.<sup>9</sup>

The 1987 Regulations also provide that the registrar must report a death if:

- the cause of death appears to be unknown; or
- the registrar has reason to believe it to have been unnatural or to have been caused by violence or neglect or by abortion or to have been attended by suspicious circumstances; or
- it appears to the registrar to have occurred during an operation or before recovery from the effect of an anaesthetic; or
- it appears to the registrar from the contents of any MCCD to have been due to industrial disease or industrial poisoning.

### **Medical practitioners' duty to report**

The [Notification of Deaths Regulations 2019](#) require a registered medical practitioner to notify the relevant senior coroner<sup>10</sup> of a death if one or more of a set of prescribed circumstances apply.<sup>11</sup> Previously there had been no such regulations and the circumstances of reporting deaths by medical practitioners to coroners had varied across coroner areas.<sup>12</sup>

The circumstances in which a death should be notified to the coroner are when the death was due to:

- poisoning, including by an otherwise benign substance
- exposure to, or contact with, a toxic substance
- the use of a medicinal product, the use of a controlled drug or psychoactive substance
- violence
- trauma or injury
- self-harm
- neglect, including self-neglect

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<sup>9</sup> [Coronavirus Act 2020 section 18 and Schedule 13 paragraph 6](#)

<sup>10</sup> The senior coroner is the coroner in charge of the coroner service for his or her coroner area. The Coroners and Justice Act 2009 also provides for the appointment of area coroners and assistant coroners who assist the senior coroner. Further information is provided in [Chief Coroner Guidance No 6. The Appointment of Coroners \(Revised March 2020\)](#) and in the [Chief Coroner's Combined Annual Report 2018-2019 and 2019-2020](#), 5 November 2020, Annex A, paragraphs 8-24

<sup>11</sup> SI 2019/1112

<sup>12</sup> Chief Coroner, [Guidance No. 31. Death referrals and medical examiners](#), 19 September 2019, paragraph 3



- the person undergoing a treatment or procedure of a medical or similar nature or
- an injury or disease attributable to any employment held by the person during the person's lifetime.

There is also a duty to notify the coroner if:

- the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the above circumstances
- the registered medical practitioner is an attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person but, despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown
- the registered medical practitioner suspects that the person died while in custody or otherwise in state detention<sup>13</sup>
- the registered practitioner reasonably believes that there is no attending registered medical practitioner who is required to sign a MCCD in relation to the deceased person, and there is no other registered medical practitioner who may sign the certificate within a reasonable time
- the registered medical practitioner reasonably believes that neither the attending medical practitioner, nor any other medical practitioner able to sign the MCCD, is available within a reasonable time of the person's death to sign the certificate of cause of death<sup>14</sup>
- the registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so.

The Coronavirus Act 2020 has made temporary changes to some requirements.<sup>15</sup> Further information is provided on the Gov.UK website:

“The changes relate to the duty to notify a death to the coroner where the deceased had no attending doctor or where the attending doctor is unable to complete a medical certificate cause of death (MCCD). The changes mean the duty only applies where there is no other doctor who may sign an MCCD.”<sup>16</sup>

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<sup>13</sup> See [Coroners and Justice Act 2009, section 48](#) (as amended) for definition of “state detention”

<sup>14</sup> Ministry of Justice, [Revised guidance for registered medical practitioners on the Notification of Deaths Regulations](#), March 2020, p9 states “It is ultimately for the discretion of a medical practitioner to determine what would be a ‘reasonable time’ based on the individual circumstances of the case. It is recommended that where there is a doctor able to complete the MCCD, they should be completing an MCCD as soon as possible. It should be noted that a death must legally be registered within 5 days from the date of death, and the MCCD is needed for this registration to be made within this time limit. Therefore, completion of the MCCD should not exceed this time limit.”

<sup>15</sup> [Coronavirus Act 2020 section 18 and Schedule 13 paragraph 7](#)

<sup>16</sup> Gov.UK, [Notification of Deaths Regulations 2019 guidance](#), updated 3 April 2020 [accessed 3 November 2021]

In the emergency period, if no doctor has attended the deceased within 28 days of death (including video/visual consultation) or the deceased was not seen after death by a doctor, the death must be referred to the coroner.<sup>17</sup>

In April 2020, the Ministry of Justice published revised [guidance](#) for registered medical practitioners on the Notification of Deaths Regulations,<sup>18</sup> to reflect the temporary changes made by the Coronavirus Act 2020. This includes the following about Covid-19:

“Whilst Covid-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010, a death caused by Covid-19 virus is not reason of its own to notify the death to the coroner.”<sup>19</sup>

Covid-19 is an acceptable direct or underlying cause of death.”<sup>20</sup>

## What happens when a death is reported to the coroner?

When a death is reported to the coroner, they may make preliminary inquiries and, if satisfied as to the nature of the death, the coroner may decide that there is no need to carry out a post-mortem examination or to hold an investigation. In that case the registered medical practitioner would sign a medical certificate.

Alternatively, the coroner may decide to carry out a post-mortem examination and, on the basis of the results, decide to discontinue any investigation (in which case there would not be an inquest). If the body is released without an inquest, the coroner will send a form to the registrar stating the cause of death, and a ‘Certificate of Coroner - form Cremation 6’ if the body is to be cremated.

Finally, the coroner may decide that further investigation is required, and an inquest will be conducted as part of that investigation. After the inquest, the coroner will confirm the cause of death to the registrar.<sup>21</sup>

The coroner may not discontinue the investigation if they suspect that the deceased died a violent or unnatural death or died whilst in custody or state detention.<sup>22</sup>

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<sup>17</sup> [Office for National Statistics and HM Passport Office, Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales FOR USE DURING THE EMERGENCY PERIOD ONLY](#), last updated 1 April 2020, p4

<sup>18</sup> Ministry of Justice, [Revised guidance for registered medical practitioners on the Notification of Deaths Regulations](#), March 2020

<sup>19</sup> Registered medical practitioners have a statutory duty to notify the ‘proper officer’ at their local council or local health protection team of suspected cases of certain infectious diseases, referred to as “notifiable diseases”. Public Health England guidance is available on the Gov.UK website, [Notifiable diseases and causative organisms: how to report](#), last updated 9 June 2021

<sup>20</sup> Ministry of Justice, [Revised guidance for registered medical practitioners on the Notification of Deaths Regulations](#), March 2020, p3

<sup>21</sup> Gov.UK, [When a death is reported to a coroner](#) [accessed 3 November 2021]

<sup>22</sup> [Coroners and Justice Act 2009 section 4](#)



The [guidance for doctors completing MCCDs](#) provides further information:

“When a death is referred, it is up to the coroner to decide whether or not it should be investigated further. It is very important that the coroner is given all of the facts relevant to this decision. The doctor should discuss the case with the coroner before issuing an MCCD if at all uncertain whether he or she should certify the death. This allows the coroner to make enquiries and decide whether or not any further investigation is needed, before the family tries to register the death. The coroner may decide that the death can be registered from the doctor's MCCD. ... Omitting to mention on the certificate conditions or events that contributed to the death in order to avoid referral to the coroner is unacceptable and a breach of the doctor's legal obligations. If these come to light when the family registers the death, the registrar will be obliged to refer it to the coroner. If the fact emerges after the death is registered, an inquest may still be held.”<sup>23</sup>

## Coroners duty to investigate

[Section 1](#) of the [Coroners and Justice Act 2009](#) imposes a duty on a senior coroner to investigate a death where (s)he is made aware that the body is within that coroner's area and (s)he has reason to suspect that:

- the deceased died a violent or unnatural death,
- the cause of the death is unknown, or
- the deceased died while in custody or state detention.

At the request of the senior coroner, or at the direction of the Chief Coroner, the investigation may be carried out by a different coroner than one in whose area the body is lying.<sup>24</sup>

The purpose of an investigation is to ascertain:

- who the deceased was;
- how, when and where the deceased came by his or her death;
- the particulars (if any) required to register the death.<sup>25</sup>

An inquest held as part of an investigation is not a trial: the purpose of the inquest is to find facts, and not to attribute blame or liability.

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<sup>23</sup> [Office for National Statistics and HM Passport Office, Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales FOR USE DURING THE EMERGENCY PERIOD ONLY](#), last updated 1 April 2020, p4

<sup>24</sup> [Coroners and Justice Act 2009 sections 2 and 3](#)

<sup>25</sup> [Coroners and Justice Act 2009 section 5](#)

Another Library briefing paper provides information about the coroner's duty to investigate some deaths, Coroners' investigations and inquests.<sup>26</sup>

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<sup>26</sup> Number 03981, 19 February 2021



## 2

# Background to the introduction of medical examiners

The introduction of a statutory system of medical examiners in England and Wales has been under consideration for a long time. This section of this briefing paper sets out milestones (not exhaustive) in the process of policy development. Section 3 of this briefing paper sets out information about the current, non-statutory, system of medical examiners and section 4 deals with provisions in the Health and Care Bill intended to implement a statutory system.

## 2.1

# Early proposals for reform

At least in part, the proposals for a system of medical examiners originated as a response to Harold Shipman's murder of his patients. For many years, Shipman managed to escape detection by certifying patients he murdered as having died from natural causes, avoiding scrutiny by a coroner:

“Dr Harold Shipman was able to conceal his wilful malpractice and kill many patients because he relied on others having no reason to question or suspect malpractice when he certified the causes of death. For cremations other doctors, whose role was to independently certify the cause of death, trusted Dr Shipman as a respected colleague and confirmed his dishonest account. For burials Dr Shipman did not need to consult anyone else and relied on the lack of medical knowledge of registrars for his causes of death to be accepted. The system depends on the integrity of a doctor and there is no independent oversight.”<sup>27</sup>

The subsequent Shipman Inquiry's terms of reference included a requirement to recommend what steps should be taken to protect patients in future.

In its [third report](#),<sup>28</sup> published in 2003, the Shipman Inquiry, chaired by Dame Janet Smith, recommended that there should be an effective cross-check of the account of events given by the doctor who treated the deceased and who claimed to be able to identify the cause of death. The report said that this was needed, “not only to deter a doctor such as

<sup>27</sup> Department of Health and Social Care Guidance, [An overview of the death certification reforms](#), 26 May 2016 [accessed 3 November 2021]

<sup>28</sup> [Third Report of the Shipman Inquiry, Death Certification and the Investigation of Deaths by Coroners](#), Cm 5854, July 2003

Shipman, but also to deter any doctor who might be tempted to conceal activity less serious than murder, such as an error or neglect by him/herself or a colleague”.<sup>29</sup>

A 2006 Report by the previous House of Commons Constitutional Affairs Committee,<sup>30</sup> [Reform of the coroners’ system and death certification](#), summarised the reforms proposed by the Shipman Inquiry and others.<sup>31</sup>

## 2.2

## 2007 Government consultation

The Labour Government accepted the Shipman Inquiry’s conclusion that existing arrangements for scrutinising the Medical Certificate of Cause of Death (MCCD) were “confusing and inadequate”.<sup>32</sup> In July 2007, the Department of Health<sup>33</sup> published a [consultation on improving the process of death certification](#). This sought views on proposals to address the Shipman Inquiry’s recommendations “that there should be one system of death certification with effective scrutiny applicable to all deaths, whether the death is to be followed by burial or cremation, and that public health surveillance of causes of death should be improved”.<sup>34</sup> The consultation outlined a programme of work “to design, pilot and implement a rigorous and unified system of death certification for both burials and cremations in England and Wales”.<sup>35</sup>

Among other things, the consultation paper proposed that all MCCDs, with the exception of cases referred directly to the coroner by the certifying doctor, would be subject to scrutiny by an independent medical examiner appointed by a Primary Care Trust<sup>36</sup> (or an equivalent organisation in Wales) and with strong links to NHS clinical governance teams.<sup>37</sup>

A [summary of responses](#) to the consultation was published in May 2008. This stated that the vast majority of respondents supported the proposed introduction of a process of secondary certification of deaths not referred to the coroner, and for this scrutiny to be undertaken by appropriately qualified medical examiners. The main concerns raised by respondents were over ensuring that the scrutiny process did not cause significant delays to funerals

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<sup>29</sup> [Ibid. paragraph 5.67](#)

<sup>30</sup> Now the Justice Committee

<sup>31</sup> House of Commons Constitutional Affairs Committee, [Reform of the coroners’ system and death certification](#), HC 902, 1 August 2006, paragraphs 53 to 55

<sup>32</sup> Department of Health, [Consultation on Improving the Process of Death Certification](#), July 2007, paragraph 5.1

<sup>33</sup> As it was then, now the Department of Health and Social Care

<sup>34</sup> Department of Health, [Consultation on Improving the Process of Death Certification](#), July 2007, paragraph 1.2

<sup>35</sup> Department of Health and Social Care, [An overview of the death certification reforms](#), 26 May 2016

<sup>36</sup> Primary Care Trusts were abolished by the Health and Social Care Act 2012

<sup>37</sup> As summarised in Department of Health, [Summary of Responses to the Consultation on Improving the Process of Death Certification](#), May 2008, p1



and ensuring that medical examiners were able to carry out their duties with the necessary degree of independence from NHS and other public authorities.<sup>38</sup>

## 2.3

### Coroners and Justice Act 2009

The Coroners and Justice Act 2009, (as amended by the Health and Social Care Act 2012), provides for a new system of death certification under which all deaths in England and Wales not requiring investigation by a coroner will be subject to scrutiny by independent medical examiners. This would cover both burials and cremations.

The Explanatory Notes published with the Act set out detailed information about the proposed operation of the system.<sup>39</sup> In short:

“[Section 19] relates to the appointment of, and functions to be carried out by, medical examiners. It also enables regulations to be made by the Secretary of State for Health (in relation to England) and the relevant Welsh Ministers (in relation to Wales) about the appointment, payment and training of, and functions to be carried out by, medical examiners....

[Section 20] enables the Secretary of State for Health to make regulations about the preparation, scrutiny and confirmation of MCCDs and about the way the confirmed MCCD is notified and given to a registrar or about how the death is referred to a senior coroner. The section also enables regulations to be made about the payment of a fee for the service provided by a medical examiner.

The independent scrutiny and confirmation of MCCDs is part of a wider process that starts with the preparation of the certificate by a registered medical practitioner who attended the deceased and ends with the certificate being returned to the medical examiner after it has been used by the registrar to register the death. The new unified process is intended to be simpler and more transparent than the previous one and requires specification of activities, responsibilities and alternative scenarios that are more suited to regulations than to provisions on the face of the Act. Subsection (1) provides the power to make the necessary regulations...”<sup>40</sup>

Sections 19 and 20 are not yet in force.

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<sup>38</sup> Department of Health, Summary of Responses to the Consultation on Improving the Process of Death Certification, May 2008, p5

<sup>39</sup> Coroners and Justice Act 2009 Explanatory Notes, Chapter 2: Notification, certification and registration of deaths

<sup>40</sup> Ibid, paragraphs 148-162

The Department of Health has also provided this summary:

“The Act provides the framework for a new system of medical examiner scrutiny of the cause(s) of death proposed by a certifying doctor soon after a death occurs; and a medical examiner’s confirmation would enable a death to be registered. The primary role of medical examiners is therefore to confirm cause(s) of death, and in doing so, medical examiners must offer the bereaved family an opportunity to raise any concerns and to act on those concerns. Where the concerns may warrant an investigation by a coroner, the medical examiner must notify a death to the coroner.”<sup>41</sup>

It was originally intended that Primary Care Trusts would appoint the independent medical examiners in England. Provisions in the Health and Social Care Act 2012 transferred this responsibility to local authorities, “with the intention of providing medical examiners with independence from major healthcare providers”.<sup>42</sup> In Wales, Local Health Boards would make the appointments.

Gov.UK, [Improving the process of death certification](#) (2011) has an overview of the reforms as at that date and an update on work to prepare for implementation – at that time anticipated to be from April 2013. The Government proposed to fund the system on a cost-recovery basis through a statutory fee chargeable for all deaths not investigated by a coroner. A Department of Health document, [Death Certification Reforms: New Duty on Local Authorities](#),<sup>43</sup> acknowledged that concerns had been raised about the requirement for the proposed statutory fee and stated that these concerns would be kept under review. Page 4 of the document sets out more detailed information.

## Pilot schemes

The scheme set out in the 2009 Act was piloted in a number of areas. The report, [Reforming death certification: Introducing scrutiny by Medical Examiners](#), reviewed the pilot schemes.<sup>44</sup> It included the recommendation that, “On the basis of this experience those involved in the pilots believe that these reforms should be implemented as was envisaged by Parliament”.<sup>45</sup>

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<sup>41</sup> Department of Health, [Learning not blaming](#), Cm 9113, 16 July 2015, paragraph 46, p58

<sup>42</sup> Department of Health, [Reforming death certification: Introducing scrutiny by Medical Examiners](#), May 2016, Paragraph 1.4, p6

<sup>43</sup> August 2011

<sup>44</sup> May 2016

<sup>45</sup> Department of Health, [Reforming death certification: Introducing scrutiny by Medical Examiners Lessons from the pilots of the reforms set out in the Coroners and Justice Act 2009](#), May 2016, p5



## 2.4

## Further recommendations for reform

Recommendations relating to medical examiners were also made by the [Mid-Staffordshire NHS Foundation Trust Public Inquiry Report](#) (2013), the [Morecambe Bay Investigation Report](#) (2015) and the [Review of Forensic Pathology](#) (2015).

The Department of Health's 2015 report, [Learning not blaming](#),<sup>46</sup> set out the Government's response to:

- the [Freedom to Speak Up review](#) by Sir Robert Francis QC
- the Public Administration Select Committee report, [Investigating clinical incidents in the NHS](#)
- Dr Bill Kirkup's [Report of the Morecambe Bay Investigation](#).

The Department of Health reiterated its intention to reform the current system of death certification:

"The medical examiners system has been trialled successfully in a number of areas across the country. The work of the two flagship sites in Gloucestershire and Sheffield has been extended to operate a medical examiner service on a city and countywide basis at a scale that will be required for implementation by local authorities when legislation is introduced. We will soon be publishing a report from the interim National Medical Examiner setting out the lessons learned from the pilot sites.

The Government remain committed to the planned reform of the death certification system. Further progress will be informed by a reconsideration of the operation of the new system in the light of other positive developments on patient safety since 2010 and by a subsequent public consultation exercise on regulations required to introduce a medical examiner system nationally in England."<sup>47</sup>

## 2.5

## Consultation on implementation of death certification reforms

In 2016, the UK Government [consulted](#) on the introduction of the death certification reforms.<sup>48</sup> At that time, the Government expected that the reforms would be introduced from April 2018 and that the statutory fee in England, which was to replace the existing fee charged by doctors for the

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<sup>46</sup> Department of Health, [Learning not blaming](#), Cm 9113, 16 July 2015

<sup>47</sup> Ibid, paragraphs 47 and 48, p59

<sup>48</sup> Department of Health, [Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Policy and Draft Regulations](#), March 2016

completion of cremation forms and would be collected locally, would be around £80 to £100.<sup>49</sup>

The Department of Health and Social Care published an [overview](#) of what was proposed.<sup>50</sup> This stated:

“The new system will introduce independent safeguards and checks to highlight patterns, both through a review of relevant medical records and by making sure that the family has the chance to raise any concerns. This independent review will make the identifying malpractice easier, provide opportunities for the NHS to learn and address system failures earlier.”

The Department of Health and Social Care published its response to the consultation in June 2018.<sup>51</sup> This set out the Government’s intention to proceed, at first, with a non-statutory system within the NHS, to be introduced by April 2019:

“The response to the consultation demonstrates that there is widespread support for the aims of the reforms and for the introduction of medical examiners but there were concerns about some aspects of the proposals. In particular, concerns were raised about how the proposed model, to be based in local authorities, would work in practice and about the proposed timeframes for implementing the system. Feedback on a proposed funding model was also received. Since the Government consulted on the package of Death Certification reforms events have moved on. New information on how medical examiners could be introduced across England within the NHS has been generated by our pilot sites and NHS Trusts that have adopted a medical examiner model to support their work on the Learning from Deaths process, which has been in place since March 2017. Going forward section 21 and 18 of the Coroners and Justice Act 2009 will be commenced, this will provide for the appointment of a National Medical Examiner and a power to introduce regulations that would require medical practitioners to report deaths to the coroner for which the coroner has a duty to investigate. We will progress with the introduction of the medical examiners by April 2019 and, in parallel, explore the option to amend the 2009 Act to make the requirement for medical examiners statutory. The revised plans are designed to respond to the issues raised in consultation, to reflect developments within the NHS and to build on elements of the process that have been shown to deliver real improvements, in particular, for the bereaved.”<sup>52</sup>

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<sup>49</sup> Ibid, p21

<sup>50</sup> Department of Health and Social Care, [An overview of the death certification reforms](#), 26 May 2016

<sup>51</sup> Department of Health and Social Care, [Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Government response to consultation](#), June 2018

<sup>52</sup> Ibid, paragraph 1.5

The Government said that it would amend the Coroners and Justice Act 2009 “when an opportunity arises, to put the medical examiner system on a statutory footing and further consider legislative requirements post April 2019”.<sup>53</sup>

In an accompanying written Ministerial statement, Lord O'Shaughnessy, who was then junior Health Minister, said that there would be two stages to funding the medical examiner system “to enable its introduction while legislation is in progress”:

“Initially, medical examiners will be funded through the existing fee for completing medical cremation forms, in combination with central government funding for medical examiner work not covered by those fees. Following this interim period and when Parliamentary time allows for the system to move to a statutory footing, the funding of the system will need to be revisited. The existing medical cremation forms and fees payable associated with those forms will continue to apply for the interim period.

The Government has proposed that all child deaths (up to age 18) be exempt from the cost associated with the Medical Examiner system. This aligns with the broader purpose of the Government’s recent announcement about steps to ensure that no bereaved family will have to pay for the essential costs of burying or cremating their child.”<sup>54</sup>

## 2.6

## Welsh Government consultation and response

The Welsh Government consulted separately on aspects of the new system.<sup>55</sup> Its 2017 consultation paper included information about the scope of the Welsh Ministers’ powers in this area and of the consultation itself:

“It is important to state that death certification is not a subject which is currently devolved to the National Assembly for Wales. However, Welsh Ministers are responsible for the practical implementation of the system in Wales. As such, they can make regulations in two distinct areas, namely:

- the appointment and remuneration of medical examiners and
- the fees to be charged for the medical examiner’s confirmation of the cause of death stated on the attending

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<sup>53</sup> Ibid, Section 8, Conclusions and next steps, p26

<sup>54</sup> [HLWS725 \[on Introduction of Medical Examiners and Reforms to Death certification in England and Wales\], 11 June 2018](#)

<sup>55</sup> Welsh Government, [Introduction of the medical examiner role and reforms to death certification](#). The consultation ran from 7 November 2016 to 13 January 2017



practitioner's certificate or the issue of a medical examiner's certificate.

Given the limited scope of the Welsh Ministers' powers in this area, this document does not repeat in detail the information set out in the DH's document relating to the system or the role of medical examiners, or the impacts on doctors, coroners, bereavement services, registrars, funeral directors and crematoria. This is because the death certification process and the medical examiner role will essentially be the same in England and Wales. For more information on these areas please see the DH consultation document at the above link. Individuals and organisations in Wales were encouraged to respond to the DH consultation and the Welsh Government has seen their responses. As far as possible, and in the context of the Welsh Ministers' remit, the Welsh Government has taken into account those views."<sup>56</sup>

The purpose of the consultation was to seek views on the proposed operational arrangements and draft regulations for Wales.<sup>57</sup>

In June 2018, The Welsh Government published a [response](#) to the consultation.<sup>58</sup> This noted the UK Government's revised approach and set out the Welsh Government's next steps:

"It is vital now to set up the Implementation Board for Wales and its working groups as referred to throughout this response report. This will enable all the helpful comments and suggestions received to inform the operational arrangements for putting this new system into place. The Implementation Board will be led by the NHS and it is hoped that all stakeholders will continue to play a constructive role in working together in introducing the new Medical Examiner service for the benefit of the people of Wales.

In Wales, the new arrangements will be introduced in tandem with England, beginning in April 2019."<sup>59</sup>

## 2.7 Health Service Safety Investigations Bill [HL] 2019

The [Health Service Safety Investigations Bill \[HL\] 2019](#) included an amendment to the Coroners and Justice Act 2009 which was intended to

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<sup>56</sup> Ibid, paragraphs 4-5

<sup>57</sup> Welsh Government, [Introduction of Medical Examiners in Wales Consultation Response Report](#), June 2018, Introduction

<sup>58</sup> Welsh Government, [Introduction of Medical Examiners in Wales Consultation Response Report](#), June 2018

<sup>59</sup> Ibid, p10

introduce a statutory scheme of Medical Examiners within the NHS rather than local authorities in England.<sup>60</sup>

At Lords Second Reading, Baroness Blackwood of North Oxford, who was then a junior Minister at the Department of Health and Social Care, said:

“This will underpin the system that is already being rolled out successfully across the country. Medical examiners will ensure that every death in England and Wales is scrutinised, either by a coroner or a medical examiner, to strengthen safeguards for the public. It will provide support to doctors by being able to provide expert advice, in turn improving the quality of the death certification process. It will also be able to provide a service for anyone who has just lost a loved one, by increasing transparency, by offering an opportunity to raise concerns, and ultimately, by avoiding unnecessary distress for the bereaved.

Overall, the medical examiner system is a key element of the NHS safety system and will ensure that any clinical issues and learning are quickly identified to improve patient safety.”<sup>61</sup>

At that time, Baroness Blackwood said that the Government expected the medical examiner system to be operational from April 2021, subject to the passage of the Bill through Parliament.<sup>62</sup>

The Bill did not complete its passage through Parliament due to the dissolution of Parliament for the General Election.

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<sup>60</sup> HL Bill 4, Clause 34

<sup>61</sup> [HL Deb 29 October 2019 c889](#)

<sup>62</sup> [HL Deb 29 October 2019 c942](#) See also the Government’s [factsheet on the medical examiner provisions of the Bill](#) (October 2019)

## 3 Current non-statutory system of medical examiners

A non-statutory medical examiner system is being rolled out across England and Wales to provide greater scrutiny of deaths.

In March 2019, Dr Alan Fletcher was appointed as National Medical Examiner for England and Wales. His role is “to provide professional and strategic leadership to regional and trust-based medical examiners”.<sup>63</sup>

### 3.1 The purpose of the system

“The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.”<sup>64</sup>

### 3.2 The role of medical examiner offices

Medical examiner offices in England are hosted by acute trusts (and a small number of specialist trusts). They are staffed by a team of medical examiners, supported by medical examiner officers.<sup>65</sup> NHS England, [The national medical examiner system](#), provides information about medical examiners, including:

“Medical examiners are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner

<sup>63</sup> NHS England, [The national medical examiner system](#) [accessed 3 November 2021]

<sup>64</sup> NHS England, [The national medical examiner system](#) [accessed 3 November 2021]

<sup>65</sup> Ibid



duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes”.

The role of medical examiner offices is to examine deaths to:

- “agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it
- discuss the cause of death with the next of kin/informant and establish if they have questions or any concerns with care before death
- act as a medical advice resource for the local coroner
- inform the selection of cases for further review under local mortality arrangements and contribute to other clinical governance procedures.”<sup>66</sup>

The NHS envisages that medical examiner scrutiny will be extended to all deaths which do not involve the coroner:

“During 2021/22, the services provided by medical examiner offices will start to be extended beyond acute trusts to provide independent scrutiny of all non-coronial deaths, wherever they occur. Implementation of this next phase will happen incrementally, to allow time for capacity and processes to be put in place.

Each medical examiner office will lead work to establish arrangements with local health and care providers in their area, supported by regional medical examiners where needed.

On 8 June 2021 we sent a [system wide letter](#) setting out what local health systems now need to do to implement the national medical examiner system for scrutiny of non-coronial deaths across all health settings. We have also created an additional webpage providing [specific information for colleagues working in primary care](#)”.<sup>67</sup>

### 3.3

## Good practice guidelines

In January 2020, NHS England and NHS Improvement published [National Medical Examiner’s good practice guidelines](#), on behalf of the National Medical Examiner for England and Wales, setting out how the National Medical Examiner expects medical examiner offices to operate during the

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<sup>66</sup> Ibid

<sup>67</sup> Ibid

current non-statutory phase of the programme.<sup>68</sup> The document sets out good practice from the National Medical Examiner and learning from pilot sites and early adopters.<sup>69</sup>

The guidelines set out what a medical examiner does:

“Medical examiner offices review medical records and interact with qualified attending practitioners and the bereaved to address three key questions:

- What did the person die from? (ensuring accuracy of the medical certificate of cause of death)
- Does the death need to be reported to a coroner? (ensuring timely and accurate referral – there are [national requirements](#))
- Are there any clinical governance concerns? (ensuring the relevant notification is made where appropriate).”<sup>70</sup>

## 3.4 Medical Examiner Service in Wales

The Medical Examiner Service in Wales is hosted by NHS Wales Shared Services Partnership (NWSSP).<sup>71</sup> [NHS Wales](#) provides a range of information about the service.

## 3.5 Chief Coroner guidance

The Chief Coroner has issued guidance which encourages coroners to form good collaborative working relationships with medical examiners:

“It is the firm view of the Chief Coroner that coroners (and in particular, senior coroners) should forge good collaborative working relationships with Medical Examiners in their area in much the same way as they have with Registrars. Medical Examiners are now part of the wider death oversight and investigation system in England and Wales. Their duties are different to coroners but they are the counterpart for coroners and coroners and their staff should work in

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<sup>68</sup> NHS England and NHS Improvement, [Implementing the medical examiner system: National Medical Examiner's good practice guidelines](#), January 2020

<sup>69</sup> NHS England, [The national medical examiner system](#) [accessed 3 November 2021]

<sup>70</sup> NHS England and NHS Improvement, [Implementing the medical examiner system: National Medical Examiner's good practice guidelines](#), January 2020, p7

<sup>71</sup> NHS Wales, [Medical Examiner Service](#) [accessed 3 November 2021]

a spirit of partnership and mutual respect with the Medical Examiner”.<sup>72</sup>

## 3.6 Further information

The NHS publishes regular [National medical examiner updates](#), “providing useful information and news to support medical examiner offices”.<sup>73</sup> It also provides further information including about:

- funding for medical examiners and
- regional support.

There is also a [Good Practice Series](#) which is described as:

“a topical collection of focused summary documents, designed to be easily read and digested by medical examiners and other busy front-line staff, with links to further reading, guidance and support...”<sup>74</sup>

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<sup>72</sup> Chief Coroner, [Guidance No. 31. Death referrals and medical examiners](#), 19 September 2019, paragraph 13

<sup>73</sup> NHS England, [The national medical examiner system](#) [accessed 3 November 2021]

<sup>74</sup> NHS England, [The national medical examiner system](#) [accessed 3 November 2021]



## 4

## Health and Care Bill 2021-22

### 4.1

### Government white paper

In February 2021, the Department of Health and Social Care published a white paper, [Integration and Innovation: working together to improve health and social care for all](#).<sup>75</sup> This document set out wide-ranging legislative proposals for a Health and Care Bill. Among other things, the Government said it would establish a statutory medical examiner system within the NHS “for the purpose of scrutinising all deaths which do not involve a coroner and increase transparency for the bereaved”.<sup>76</sup>

The Government said it supported the recommendations of previous inquiries, including the Shipman Inquiry, “to create a new rigorous and unified system of death certification in England”. It intended to amend provisions in the Coroners and Justice Act 2009 to allow for NHS bodies, rather than local authorities, to appoint Medical Examiners.<sup>77</sup>

### 4.2

### The Bill

The [Health and Care Bill 2021-22](#) (the Bill) was introduced in the House of Commons on 6 July 2021 as Bill 140 of 2021-22. It had its Second Reading on 14 July 2021 and has been considered by a Public Bill Committee. The Bill, as amended in Public Bill Committee, has been republished as [Bill 183 of 2021-22](#). Information about the Bill is provided on the [Bill page on the Parliament website](#). The Government has also published [Explanatory Notes](#).<sup>78</sup>

This briefing paper deals with Clause 124, (now Clause 128 in the Bill, as amended), “Medical examiners”.<sup>79</sup> Separate Library briefing papers deal with other parts of the Bill and can be accessed from the Commons Library webpage, [Health and Care Bill 2021-22](#).

<sup>75</sup> Department of Health and Social Care, [Integration and Innovation: working together to improve health and social care for all](#), CP 381, February 2021

<sup>76</sup> Ibid, [paragraph 3.27](#), p29

<sup>77</sup> Department of Health and Social Care, [Integration and Innovation: working together to improve health and social care for all](#), CP 381, February 2021, paragraphs 5.157-5.158

<sup>78</sup> Bill 140-EN

<sup>79</sup> This briefing paper uses the Clause number as in the original Bill

## Clause 124: Medical examiners

Clause 124 would amend sections 19 and 20 of the Coroners and Justice Act 2009 (the 2009 Act) to introduce a statutory medical examiner system within the NHS rather than local authorities in England, for the purpose of scrutinising all deaths which do not involve a coroner. The Explanatory Notes provide an overview of the clause and its purpose:

“The Bill will amend the Coroners and Justice Act 2009 in England to set out a power for English NHS bodies to appoint Medical Examiners and a duty on the Secretary of State to ensure that enough medical examiners are appointed in the healthcare system in England, that enough funds and resources are made available to medical examiners to enable them to carry out their functions of scrutiny to identify and deter poor practice, and to ensure that their performance is monitored.

The purpose of the amendment is to introduce a statutory scheme of medical examiners within the NHS rather than Local Authorities in England. Following a death that is not being referred to a coroner, medical examiners, who will be registered medical practitioners, will scrutinise the cause of death stated by the attending medical practitioner on the Medical Certificate of Cause of Death and hold discussions with families.

Medical examiners will introduce an additional level of scrutiny to those deaths not reviewed by a coroner, improve engagement with the bereaved in the process of death certification and offer them an opportunity to raise any concerns as well as improving the quality and accuracy of Medical Certificates of Cause of Death. Independent scrutiny of deaths will reduce the potential for malpractice by doctors to go unchecked. The level of scrutiny will be proportionate so as not to impose undue delays on the bereaved or undue burdens on medical practitioners and others involved in the process”.<sup>80</sup>

For the purposes of discharging the duty mentioned above, the Secretary of State would have power to give a direction to an English NHS body (as defined):<sup>81</sup>

- requiring the body to appoint or arrange for the appointment of one or more medical examiners;
- about the funds or other resources to be made available to a medical examiner employed by an English NHS body;
- about the steps to be taken by the body to monitor the performance of medical examiners; or

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<sup>80</sup> [Bill 140-EN paragraphs 173-5](#)

<sup>81</sup> Clause 124(6) which would insert new subsection 5(A) into section 19 of the Coroners and Justice Act 2009

- about the steps to be taken by the body to monitor the performance of functions by an English NHS body in relation to medical examiners.

Clause 124 would remove references in section 19 of the 2009 Act to local authorities in England but “leave or clarify the references to Local Health Boards in Wales”.<sup>82</sup>

Subsection (5) would amend section 19(5) of the 2009 Act to replace the reference to a local authority with an English NHS body. The Explanatory Notes provide information about the intent of this provision:

“The effect of this subsection is to make clear that this section and any regulations made under it does not give such English NHS body any role in relation to the way in which medical examiners exercise their professional judgment as medical practitioners”.<sup>83</sup>

Section 20(5) of the 2009 Act enables the appropriate Minister to make regulations to provide for a fee to be payable in respect of a medical examiner's confirmation of the cause of death stated on an attending practitioner's certificate, or the issue of a medical examiner's certificate. Clause 124(8) would amend this provision to require any such fee to be payable to an English NHS body rather than a local authority. The Explanatory Notes state, “The introduction of regulations will be dependent on wider reforms around existing requirements for cremations and will be subject to further parliamentary scrutiny”.<sup>84</sup>

## Delegated powers memorandum

On 6 July 2021, the Department of Health and Social Care published a [memorandum to the Delegated Powers and Regulatory Reform Committee](#). This sets out the Department's justification in respect of the power for the Secretary of State to issue directions to an NHS body concerning medical examiners, and the proposed procedure.

The Memorandum notes that the power for the Secretary of State to issue directions to an NHS body concerning medical examiners would, for example, enable one NHS body to be directed to make funds available to a medical examiner employed by another NHS body, or to be directed to perform oversight functions in relation to another NHS body. The Memorandum adds,

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<sup>82</sup> [Bill 140-EN paragraph 955](#)

<sup>83</sup> [Bill 140-EN paragraph 956](#)

<sup>84</sup> [Bill 140-EN paragraph 958](#). Section 176(5) of the 2009 Act provides that a statutory instrument containing (whether alone or with other provision) regulations under section 20(5) setting a fee for the first time or increasing the fee by more than is necessary to reflect changes in the value of money, is subject to affirmative resolution procedure (requiring the approval of both Houses of Parliament to become law)



“This is because the NHS body to whom a direction is given will not necessarily be the body employing the medical examiner”.<sup>85</sup>

The Memorandum also notes that the direction would normally be given in writing to an NHS body, and would not be subject to any Parliamentary procedure, and sets out the Government’s reasons for this.<sup>86</sup>

## 4.3

## Public Bill Committee consideration of Bill

The Health and Care Bill Public Bill Committee considered Clause 124 at its 17<sup>th</sup> sitting on 26 October 2021.<sup>87</sup>

### Debate on proposed amendment

Shadow Minister for Health and Social Care, Justin Madders, moved amendment 116 which was intended to extend the medical examiner remit to look at stillbirths and maternity cases. He referred to the Government’s consultation, Coronial investigations of stillbirths (which closed in June 2019) and asked for an update on when the Government would publish its response.<sup>88</sup> Justin Madders noted that the Government’s roll-out of medical examiners had not, so far, included investigations into stillbirths and said the purpose of the amendment was “to get underneath the rationale for that and to press for the issue to be reconsidered”.<sup>89</sup>

Health and Social Care Minister, Edward Argar did not consider the amendment was necessary. He said the Government intended that regulations setting out the functions of medical examiners in non-coronial cases would include confirming the cause of death of mothers in childbirth. The Government proposed that information relating to pregnancy at the time of death would be recorded on the medical certificate of cause of death.<sup>90</sup>

Edward Argar said work on analysing the responses to the consultation was delayed during the Covid-19 pandemic, but the Government hoped to publish the response to the consultation as soon as possible, adding:

“At such a time as the response to the consultation on proposals to provide coroners with new powers to investigate term stillbirths is published, it will be appropriate for the position on medical examiners also, potentially, to be considered”.<sup>91</sup>

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<sup>85</sup> Health and Care Bill, Memorandum from the Department of Health and Social Care to the Delegated Powers and Regulatory Reform Committee, paragraph 709

<sup>86</sup> Ibid, paragraph 711

<sup>87</sup> PBC Deb 26 October 2021 cc663-668

<sup>88</sup> PBC Deb 26 October 2021 c663

<sup>89</sup> PBC Deb 26 October 2021 c664

<sup>90</sup> PBC Deb 26 October 2021 c664

<sup>91</sup> Ibid

The Minister reiterated existing processes for investigating stillbirths.

Justin Madders withdrew the amendment.<sup>92</sup>

Another Library briefing paper deals with the way stillbirth is investigated at present and the Government's consultation on coronial investigations of stillbirths in England and Wales, [Investigation of stillbirth](#).<sup>93</sup>

## Clause stand part debate

The Public Bill Committee also debated whether Clause 124 should stand part of the Bill.<sup>94</sup> Edward Argar set out the intended benefits of the Government's proposals:

“Appointment of medical examiners by NHS bodies will facilitate their access to patient information in order to scrutinise the proposed cause of death while remaining clinically independent of the case. The medical examiner system will introduce a level of independent scrutiny, improving the quality and accuracy of the medical certificate of cause of death and thereby informing the national data on mortality and patient safety.

The medical examiner system will increase transparency and offer bereaved people the opportunity to raise concerns. It will provide new levels of scrutiny to help identify and deter criminal activity and poor practice. New duties on, and powers for, the Secretary of State to ensure enough medical examiners are appointed by English NHS bodies and are provided with sufficient resources and monitoring will help to facilitate and develop this system. As a result of the introduction of the medical examiner system, all deaths would be scrutinised by either a medical examiner or coroner, irrespective of the decision to bury or cremate, thus bringing the system on to an equal footing”.<sup>95</sup>

Justin Madders said he could support the Government's aims for medical examiners, which he said were “worthy”, but asked how the Government would benchmark the success or otherwise of the system.<sup>96</sup> The Minister said the new system could be a catalyst for a further change if a pattern was identified.

In answer to further questions from the Shadow Minister, Edward Argar provided further information about fees and resources:

“I hesitate to put a figure on exactly how many medical examiners or what level of resource would be needed at this stage, but I will seek

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<sup>92</sup> [PBC Deb 26 October 2021 c665](#)

<sup>93</sup> [CBP 08167, 21 September 2021](#)

<sup>94</sup> [PBC Deb 26 October 2021 cc665-7](#)

<sup>95</sup> [PBC Deb 26 October 2021 cc665-6](#)

<sup>96</sup> [PBC Deb 26 October 2021 c666](#)

to address [the Shadow Minister's] point about fees and resourcing in broader terms. He will know that, in the non-statutory system, medical examiners are funded through the existing fee for completing medical cremation form 5, in combination with central Government funding for medical examiner work not covered by those fees. With the temporary removal of cremation form 5 as a provision of the Coronavirus Act 2020, all costs are currently covered by central Government, but that is temporary. The Coroners and Justice Act 2009 includes provisions for making regulations to introduce a new fee for the service provided by the medical examiner, and any such regulations will be subject to further parliamentary debate and scrutiny before their passage.

On the overall cost, the reality is that our estimated cost will be informed by the impact assessment published in 2018 and the data gathered from the non-statutory medical examiner system introduced in the NHS in 2019. We have seen a slightly atypical year or 18 months, so I hesitate to put an exact figure on this, but we have a broad evidence base from which to extrapolate. It predates the pandemic but it probably still has relevance. I am sorry that I cannot give him more direct data..."<sup>97</sup>

Clause 124 was ordered to stand part of the Bill without a division.

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<sup>97</sup> [PBC Deb 26 October 2021 c667](#)

## 5 Review of cause of death certificates in Scotland

Different arrangements for death certification and registration apply in Scotland. In 2015, the Scottish Government published [statutory guidance on death certification](#).<sup>98</sup>

### 5.1 Death Certification Review Service

The [Certification of Death \(Scotland\) Act 2011](#) introduced a number of changes to the system of death certification in Scotland:

“From 13 May 2015, the Act:

- introduced a new national review system to provide independent checks on the quality and accuracy of MCCDs
- ended additional paperwork and fees for cremations to make the process the same for everyone, and
- meant that all deaths must be registered before either a burial or cremation can take place.”<sup>99</sup>

The 2011 Act also established the roles of Senior Medical Reviewer and Medical Reviewers supported by medical reviewer assistants. Together these roles make up the Death Certification Review Service, part of Healthcare Improvement Scotland.<sup>100</sup>

The review service checks on the accuracy of a sample of MCCDs with the aim of improving the:

- quality and accuracy of Medical Certificates of Cause of Death (MCCD)
- public health information about causes of death in Scotland, and

<sup>98</sup> Scottish Government, [Certification of Death \(Scotland\) Act 2011: statutory guidance](#), 19 August 2015 [accessed 3 November 2021]

<sup>99</sup> Healthcare Improvement Scotland, [Death certification questions and answers](#) [accessed 3 November 2021]

<sup>100</sup> Support Around Death, [Roles and Responsibilities](#) [accessed 3 November 2021]



- clinical governance issues identified during the death.<sup>101</sup>

Healthcare Improvement Scotland publishes a range of information on their “[Death certification in Scotland](#)” webpages, including:

“What we do:

- normally review 12% of randomly selected MCCDs before registration of the death can take place (standard case) along with further possible reviews
- where appropriate, approve requests allowing families to make funeral arrangements whilst the review is still being processed (advance registration)
- help families who believe the cause of death detailed on the MCCD is inaccurate by carrying out a review at their request (interested person review)
- work collaboratively with National Records of Scotland and registrars of births, deaths and marriages to review MCCDs that are not randomly selected for review but where the registrar has concerns the MCCD may not have been completed correctly (registrar referral)
- provide educational support to certifying doctors by reviewing the next 6–10 MCCDs they write (‘for cause’ review), and
- administer and authorise the burial and cremation of people who have died outside the UK and are returned to Scotland for funeral (repatriation).”

The service does not review:

- the quality of care provided to the deceased prior to their death, and
- suspicious deaths or deaths that should be reported to the Procurator Fiscal under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.<sup>102</sup>

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<sup>101</sup> Healthcare Improvement Scotland, [Death certification in Scotland](#) [accessed 3 November 2021]

<sup>102</sup> Ibid

## 5.2

# Temporary changes to the Death Certification Review Service

Section 20 of the Coronavirus Act 2020 introduces Schedule 14, Part 1 of which provides a power, by direction, to suspend the review of medical certificates of cause of death if Scottish Ministers consider that:

- the incidence or transmission of coronavirus constitutes a serious and imminent threat to public health, and
- the exercise of the power would be an effective means of expediting the disposal of bodies and better utilise medical resources.

Before making any such direction, Scottish Ministers are required to consult the Senior Medical Reviewer (or, if unavailable, the medical reviewer who is to perform the Senior Medical Reviewer's functions in such circumstances).

Rather than full suspension, Ministers can choose to reduce the percentage of random reviews to be undertaken, as a temporary measure. This is by agreement and does not require legislative change. Parliament are notified via a letter to the Health and Sport Committee.<sup>103</sup>

Use of the power was revoked by direction on 11 May 2020.<sup>104</sup>

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<sup>103</sup> Scottish Government, Coronavirus Acts: ninth report to Scottish Parliament, October 2021, section 6, Table 1, paragraph 66

<sup>104</sup> Ibid




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