From: Clair Bell, Cabinet Member for Community and Regulatory Services

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To: Growth, Economic Development and Communities Cabinet Committee – 6 November 2024

Subject: Introduction of the National Medical Examiner Process - impact on Kent Coroners and Registration services

Key/non-key decision – this report is for information

Classification: Unrestricted

Electoral Division: All

Summary: Dame Janet Smith's Inquiry into the murders by Harold Shipman was announced on the 1st February 2000, the first report was published on the 19th July 2002. The sixth, and final, version of the report was published on the 27th January 2005

The inquiry identified weaknesses in the system of Death certification in the UK, principally because a single doctor could certify a death as being to natural causes, without challenge. Her report pointed out that this weakness had first been identified in the report of a parliamentary select committee in 1893 but over a century later it had still not been corrected.

The implementation of the statutory Medical Examiner system, and the related rationalisation and reform of the death certification system, took effect on 9 September 2024. The reforms have an impact on coroners' responsibilities and ways of working and the way in which information flows through the death registration process. These changes represent the greatest change to the Coroner Service for 50 years.

The principle underlying the reformed system is that, where a death is natural and did not occur in custody or state detention, scrutiny should be provided by the Medical Examiner. Where the death is violent or unnatural, where the cause of death is unknown or where the death occurred in custody or state detention, scrutiny continues to be provided by the coroner. There is therefore a clear delineation between medical and judicial certification of death.

The process has taken some years to refine, to complete Pilots and explore their outcomes, carry out impact assessments, including financial, apply scrutiny and make necessary adjustments.

Recommendation

The Cabinet Committee is asked to

(i)	note the changes in relation to the death management pathway and the impacts on the Coroner and Registration Services; and
(ii)	comment upon the suggestion to link the Coroner Service KPI to the Chief Coroner guidance in relation to inquest timescales.

1. Introduction

1.1 Legislation

1.2 The underpinning primary legislation is the Coroners and Justice Act 2009

1.3 In October 2023 the Health and Care Act 2022 amended the Coroners and Justice Act to introduce the role of Medical Examiner on a non-compulsory basis. Medical Examiners are appointed by NHS bodies in England and Wales.

1.4 On 9th September this year, the three sets of regulations below, made under the Coroners and Justice Act, placed the role of Medical Examiner on a statutory footing and set out a clear pathway for certification and oversight of non-coronial investigation deaths.

- The Medical Certificate of Cause of Death Regulations 2024
- The Medical Examiner s (England) Regulations 2024
- The National Medical Examiner (Additional Functions) Regulations 2024

2 The New System - roles and functions

2.1. Medical certificate of cause of death (MCCD)

2.1.1 From the 9th of September 2024, a new MCCD will replace the existing certificate to reflect the introduction of the statutory Medical Examiner service, which will scrutinise the proposed cause of death. The intended benefits of doing so are to improve:

- efficiency in the death certification system
- mortality data for use at a local level and nationally

2.1.2 There will continue to be a statutory form to be used when a death occurs after 28 days of life, and a separate form to be used when a child dies within the first 28 days of life. The new MCCD will include details of the Attending Practitioner who certified the cause of death to the best of their knowledge and belief (as at present).

2.1.3 In addition, the new MCCD will include the following new information:

a. details of the Medical Examiner who scrutinised the cause of death
b. ethnicity, as self-declared by the patient on the medical record. This builds on learning from the COVID-19 pandemic. If the patient medical record does not

include this information, then the Attending Practitioner can complete it as 'unknown' on the MCCD

c. regarding maternal deaths, there are two new questions regarding the pregnancy status of the deceased:
    - was the deceased person pregnant within the year prior to their death?
    - if the deceased person was pregnant within the year prior to their death, did the pregnancy contribute to their death?

d. The addition of a new line for the cause of death - bringing the MCCD in line with international standards

e. medical devices and implants will be recorded on the MCCD by the Attending Practitioner, and this will be transferred to the certificate for burial or cremation - completed by the registrar in order to inform relevant authorities of the presence of any devices or implants

2.2 Medical Practitioner

2.2.1 As part of the reforms introduced in September 2024, a Medical Practitioner will be eligible to be an Attending Practitioner and complete an MCCD, if they have attended the deceased in the deceased's lifetime. The Attending Practitioner will propose a cause of death, if they can do so, to the best of their knowledge and belief. The introduction of Medical Examiners will see routine independent scrutiny of the cause of death proposed by an Attending Practitioner. This represents a simplification of the current rules that enable medical practitioners to be an Attending Practitioner, to complete an MCCD, if they had attended the patient during their last illness but required referral of the case to a Coroner for review if they had not done so within the 28 days prior to death or had not seen in person the patient after death.

2.2.2 It is already a statutory requirement for an Attending Practitioner to complete the MCCD.

2.2.3 The main change is that Attending Practitioners must share the MCCD and proposed cause of death with a Medical Examiner, who will scrutinise these before submission to the registrar. This is a change to the current system where the MCCD is sent directly to the registrar by the Attending Practitioner

2.3 Medical Examiner

2.3.1 Under the Medical Examiners regulations, Medical Examiners: -

a) provide independent scrutiny of causes of death
b) give bereaved people an opportunity to ask questions and raise concerns with someone not involved in providing care to the deceased person prior to their death
c) review medical records and work with doctors to complete the MCCD to help ensure this is accurate and to highlight any concerns about the care of the deceased person prior to their death

2.3.2 Medical Examiners have been carrying out independent scrutiny of causes of death since implementation of the non-statutory Medical Examiner system. They will continue to carry out these activities in the same way in the new death certification process, but independent scrutiny by a Medical Examiner prior to the registration of all non-coronial deaths in England and Wales will become a statutory requirement.

2.3.3 Once the relevant Attending Practitioner and the Medical Examiner have completed their declarations of certification and scrutiny, and the cause of death is confirmed, the MCCD will be sent to the registrar by the Medical Examiner rather than the Attending Practitioner. The representative of the deceased will be notified at the same time that they can now contact the registrar to arrange the registration of the death.

2.3.4 In exceptional circumstances where either:

- there is no Attending Practitioner
- an Attending Practitioner is not available within a reasonable time

the death will be referred to the Senior Coroner by a referring medical practitioner (not a Medical Examiner).

In these circumstances only, where the senior coroner decides not to investigate, they will refer the case to the Medical Examiner to certify the death.

2.4 Coronial Process

2.4.1 Coroners will continue to investigate deaths where the death is violent or unnatural, where the cause of death is unknown or where the death occurred in custody or state detention.

2.4.2 While the MCCD regulations mainly provide for completion of the paperwork, in practice they reflect the flow of information between the Attending Practitioner, Medical Examiner, Coroner and Registrar in the new system.

2.4.3 There will be little change in terms of coronial interaction with the Registrar where an investigation is discontinued following a post-mortem examination, and this process will be extended to include the notification of investigations which are discontinued without a post-mortem examination. The process for the Coroner's interaction with the Registrar after inquest will be largely unchanged.

2.5 Death Registration

2.5.1 The preparation for the medical examiner service has taken place over the last year within the Registration Service, guided by the General Register Office (GRO). Using the training provided by GRO and working alongside KCC Learning and Development, training was delivered to all registrars ensuring preparedness for the implementation from the 9th September 2024.

2.5.2 Registrars will continue to have a duty to ensure all deaths that occur in their district are registered. Deaths will be registered according to the paperwork that is received, either from the Medical Examiner or from the Coroner. MCCDs can no longer be accepted directly from attending practitioners which ensures every death has been scrutinised. The causes of death are no longer checked for acceptability by the registration staff, with causes of death deemed acceptable once scrutinised by a Medical Examiner. This should reduce the time spent checking and returning paperwork that is not correct for staff to complete registration appointments.

For informants i.e. friends or family of the deceased, this should reduce the time it takes to complete the death registration process, with the paperwork being received in a timely and accurate manner from the medical examiner service. The paperwork does still require checking for completeness by registration staff.

2.5.3 The changes have provided a number of opportunities. More statistical information is gathered at the time of the registration for the Office for National Statistics. Ethnicity and pregnancy related questions as well as any medical devices and implants that the deceased may have had are now asked. There are also more categories of informants that are acceptable, these now include a partner of the deceased, if they were in an enduring relationship and a representative of the deceased, for example a solicitor.

2.5.4 The implementation of the Medical Examiner Service also provides the opportunity for the key national performance indicator to register a death within five days of date of death to be amended. The process will now within five days of the Medical Examiner signing the paperwork. This should provide the opportunity for the General Register Office key performance indicator of death registered within five days to be improved upon in Kent.

2.6 Medical referees

2.6.1 Medical Referees will remain in post while the statutory Medical Examiner system is embedded. During this transitionary period, the Ministry of Justice will gather evidence to determine the long-term status of Medical Referees

2.6.2 The Medical Referee visits the crematorium to inspect all the official medical certificated documentation regarding the deceased, and if in order, they give written consent that a cremation can take place.

3. Financial Implications

3.1 The implementation date of the statutory Medical Examiner provision began on the 9th of September 2024, we are yet to understand what financial implications are likely, if any. As there is no quantifiable impact at this stage, there have been no legislative growth pressures included in the Medium Term Financial Plan until we have a better understanding of the situation.

3.2 We are ensuring that our processes are measurable so that we can quantify any impact going forward

3.3 For context, the annual budget of the Coroner Service is £6.89m. The service is responsible for delivery across Kent and Medway. Medway Council contribute 15% of the cost of the service.

3.4 In 2023, 6436 deaths were reported to The Coroner in Kent and Medway. Of those, 3369 required a postmortem examination. 1200 inquests were opened in that period.

4 Legal implications

4.1 The primary legislation that underpins the new statutory Medical Examiner system is the Coroners and Justice Act 2009. Since its passage, the act has been amended (most recently by the Health and Care Act 2022) to reflect changes to the health system.

4.2 There are no additional legal implications beyond the direct changes made as set out in this report.

5 Equalities implications

5.1 These changes are statutory changes which do not impact on the existing EQIAs, which have been reviewed in the light of these changes.

6 Data Protection Implications

6.1 For the purposes of the Coroner Service, the two Senior Coroners are the data controllers. The General Data Protection Regulations (GDPR) do not apply to deceased persons, but information is collected during the course of Coroner Officer enquires that relates to the living. This includes details about next of kin, for example name, address, and telephone number. Sometimes this information is shared with other organisations for the specific purposes of the Coroner's investigation, for example with the NHS for the purpose of conducting a postmortem. The contract contains a data sharing agreement that places a specific obligations on the provider to always comply with the requirements of the GDPR for the data they hold relating to next of kin. In addition, the service has published a privacy notice which explains what personal information it holds about service users, how it collects it, how it uses it and how it might share information

7 Other corporate implications

7.1 Impact of the changes, including in relation to Key Performance Indicator COR1

Whilst it is early days, from shadow implementation of the ME process, we anticipate the introduction of the statutory ME process the Coroners Service will be positive, as:

a) a high percentage of the hospital and community referrals will come from the ME office and will include much of the information required by the Coroners.
b) additionally, the period of scrutiny will have occurred prior to the ME's office referring to us
c) if a GP can offer a cause of death and there is no need for the Coroner to investigate, the referral will not come to us
d) if a GP cannot offer a cause of death and the referral comes to us, the Coroner will be able to open an investigation and, if required, request a Postmortem or open an inquest as they should have all of the information required in the referral and will have no requirement for further information.

7.2 With the changes implemented in September, it is likely that the case type coming to the Coroner Service will alter to become more complex, with more straightforward cases being dealt with by the Medical Examiner. As such there will be a greater proportion of investigations and inquests following Postmortem.

7.3 As a result of these significant changes, it is unlikely that the current KPI will be an effective measure for the performance of the service. Proposals will be put forward to be included in consideration for next year's KPIs with a view to aligning the KPI with the guidance issued by the Chief Coroner in relation to the timescale within which an inquest has been heard**.**

7.4 Any delay in paperwork being received by the Registration or Coroners Service from the Medical Examiner Service could impact a customer being able to complete the death registration process. If customers are unable to register a death due to a delay, this could impact funeral arrangements, leading to customer dissatisfaction.

8 Governance

8.1 The process changes implemented from the 9th of September 2024 will be robustly reviewed by the Service and Senior Coroners at regular intervals to ensure that we understand risks as they arise. Communication and guidance from the Chief Coroner's office will steer further changes to ensure that governance is maintained and risks are managed.

9 Conclusions

9.1 Kent and Medway Coroners Service - it is likely that there will be some benefits to the residents of Kent and Medway - these are likely to result in some further changes to our current service delivery model.

9.2 Registration - Customers should have the reassurance that the cause of death has had an additional layer of scrutiny by another medical professional. When customers attend the registration appointment, they will be less likely to experience delay to the appointment, because any concerns over the cause of death would have already been discussed with the Medical Examiner Service. Registrars should be more confident proceeding with the registration without being required to scrutinise the cause and death and need to refer deaths to the Coroner.

Recommendation:

The Cabinet Committee is asked to

(i) note the changes in relation to the death management pathway and the impacts on the Coroner and Registration Services; and

(ii) comment upon the suggestion to link the Coroner Service KPI to the Chief Coroner guidance in relation to inquest timescales.

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