CONSULTATION RESPONSE

INTRODUCTION OF MEDICAL EXAMINERS AND REFORMS TO DEATH CERTIFICATION IN ENGLAND AND WALES

Our details

Name: Action Against Medical Accidents (AvMA)

Email address: director@avma.org.uk

Role: Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice. For over thirty years AvMA has championed the need to improve patient safety and the way patients and families are dealt with following a medical accident (patient safety incident).

In September 2009 AvMA committed resources to providing a specialist pro bono inquest service in England and Wales. The service was officially launched in July 2010. The service aims to find representation for people who have been affected by the death of a loved one where the death occurred in a medical setting. Currently AvMA has at least four members of staff who are committed to undertaking inquest work, along with other duties. All staff involved in the inquest work are highly trained and are qualified as either doctors, solicitors or barristers.

The pro bono inquest service has developed so that it now provides advice to between 80-100 families each year, including at least 15 inquest hearings as well as pre-inquest reviews (PIR). Some of the cases are referred to solicitors, especially if there is a potential civil claim. Through our work, we have developed considerable expertise in providing assistance and representation to members of the public at inquests where the death arose in a healthcare setting.

We would be happy for you to contact us to speak about our answers to this consultation.

Consultation Questions

Question		
1. Do you agree that an individual should be prescribed in legislation as being responsible to pay, or to arrange to have paid, the medical examiner fee?	✓	**Yes**
		No
		Not sure
Comments: We agree that it would be helpful to have a designated person set out in the legislation. However, we consider that there should be scope for one or more alternative people to pay or arrange payment, in case the designated person is unable to carry out this task, for example because they are elderly, unwell or otherwise vulnerable. We also agree that financial assistance should be available for people who are not in a position to pay the fee due to financial hardship.		
2. Should the person prescribed be the individual that collects the MCCD from the medical examiner, or the death registration informant?		**Yes**
		No
		Not sure

	Comments: We do not have strong views on this question but would suggest that the informant would be the most appropriate person. We would emphasise the importance of the process being made as clear and simple as possible, as the people following the procedure will usually be bereaved and dealing with other administrative tasks arising out of the death.		
3.	**Should the regulations exempt an official or employee who acts as an informant, from being responsible to pay, or to arrange to have paid the medical examiner fee?**		**Yes**
		✓	**No**
			Not sure
	Comments: We would submit that, if registering the death forms part of the official or employee's functions, providing they are in funds to do so, this should include paying the fee, or arranging its payment.		
4.	**Should there be a 28 day or three month period for payment on the medical examiner fee?**		**Yes**
			No
			Not sure
	Comments: We agree with the proposal that the time limit should be three months, in order to allow relatives sufficient time to deal with the deceased's financial affairs and other tasks arising out of the death. We would also suggest that there be provision for the time to be extended, particularly in cases of financial hardship when payment is to be made out of the deceased's estate but administration of the estate has not yet been completed, for example due to awaiting probate or other complexity.		
5.	**As a local funeral service would you be willing to collect the medical examiner fee on behalf of a local authority, for a small administrative charge? The bereaved would see the fee itemised in the funeral director's bill.**		**Yes**
			No
			Not sure
	Comments: Not applicable		
6.	**Do you believe the provision of "administrative and clinical information" set out in schedule 1 is necessary and sufficient for all deaths, either for a medical examiner's scrutiny or for a Coroner's investigation? If not, what would you add or delete and why?**		**Yes**
		✓	**No**
			Not sure
	Comments: We would suggest adding a provision for any concerns raised by the family about the deceased's death to be included (for example any complaints made to a healthcare provider), so that the medical examiner is aware of these before scrutinising the medical records and carrying out any external examination.		
7.	**Do you agree that the medical examiner should have discretion about whether an independent non-forensic external examination of the body is necessary?**	✓	**Yes**
			No
			Not sure
	Comments: We accept that an examination of the body may not be necessary in some cases, for example where the death was expected following an established disease process that had been conclusively diagnosed. However, we submit that the discretion to decide that an examination is not required should be subject to the agreement of the family. If the family do not agree that an examination is unnecessary, we submit that one should be performed. We consider it important to ensure that the deaths of vulnerable people, for example in residential care, who may be isolated and not have family members or other sources of support, receive sufficient scrutiny in order to identify any signs giving rise to concern. We therefore submit that the threshold for requiring an external examination should be low enough to encompass situations such as these.		

We consider that, where the medical examiner (or the family) considers that an external non-forensic examination is required, they should have discretion to decide whether they are the appropriate individual to carry it out or whether, for example, someone in another medical specialty would be more suitable. We would submit that, in order to promote confidence in the service, the threshold for seeking a more specialised examination should be low. In order to promote confidence in the service, all reasonable steps should be taken to avoid any potential perception of lack of independence or subjectivity.

Question		
8. In your view, are there sufficient safeguards if a person without a medical qualification but with suitable expertise and sufficient independence carries out a non-forensic external examination of the body on behalf of the medical examiner?		**Yes**
	✓	**No**
		Not sure

Comments: We would submit that it would be inappropriate for anyone other than a qualified doctor to carry out any examination, again in the interests of maintaining confidence in the quality of the examinations. If consideration is given to permitting individuals without medical qualifications to conduct examinations, we would recommend that the family be given the right to 'veto' this decision, in which case only a doctor would be able to perform the examination. In some cases, concerns regarding the death come to light only after disposal of the body and can lead to a coronial investigation. In cases such as this, it is possible that the external examiner could be required to give evidence at an inquest. If the decision is made for someone without a medical qualification to carry out the examination, the person conducting the examination should be capable of giving authoritative evidence and undergoing examination at an inquest.

Question		
9. Under regulation 26, do you agree that the medical examiner process should be suspended during a period of emergency?		**Yes**
	✓	**No**
		Not sure

Comments: We appreciate the importance of deploying medical staff to treat patients at times of emergency such as epidemics, or large-scale accidents. Howeverwe would submit that, where a patient receives medical treatment during a period of emergency, there is increased potential for family members to be concerned about the circumstances of their relative's death. This includes the care that their relative received due to the level of demand on healthcare providers. We see this already where, for example, patients are managed in the Emergency Department at a time of high demand and there may be delays or errors due to inadequate staffing. Therefore, we submit that the medical examiner process should continue during periods of emergency. However, if consideration is given to suspending the process at such times, we would submit that other individuals with suitable expertise (as suggested in question 8 above) should conduct an examination.

Question		
10. Do you agree that during a period of emergency any registered medical practitioner could certify the cause of death in the absence of a qualified attending practitioner?		**Yes**
	✓	**No**
		Not sure

Comments: For the reasons set out in response to question 9 above, we consider that, in light of the potential for concerns to arise about causes and circumstances of death in times of emergency, the requirement for a qualified attending practitioner should continue.

Question		
11. Are the proposed certificates and medical examiner forms set out in schedules 2-7 fit for purpose? If not, please say why.	✓	**Yes**
		No
		Not sure

Comments:

12. In relation to regulation 5 of the NME regulations, what other aspects should standards cover for monitoring medical examiners' levels of performance?

We do not have specific comments on this point would emphasise the importance of individuals appointed as medical examiners having suitable qualifications and experience to fulfil the requirements of the position. but wonder whether there is scope for interaction with the General Medical Council's revalidation process, whereby medical examiners could be required to demonstrate additional standards.

13. There does not appear to be a question 13 on the consultation paper.

Question		
14. Do you agree that a death should be notifiable if it is "otherwise unnatural"?	✓	**Yes**
		No
		Not sure

Comments: We agree that a category of 'otherwise unnatural' deaths should be notifiable for those deaths which do not fall clearly into one of the other categories but which the qualified attending practitioner and/or medical examiner considers should be reported to a Coroner.

Question		
15. Do you believe there is sufficient understanding between members of the medical and coronial professions as to the meaning of "unnatural" and that further definition is not required? If not, we would be grateful for suggestions as to what the guidance may include.		**Yes**
		No
	✓	**Not sure**

Comments: It is unclear whether there is any specific lack of understanding between the professions as to the definition of "unnatural" but would suggest that further guidance is helpful in order to promote consistency and understanding. We note that the guidance refers to deaths which may result from culpable human failure in relation to neglect but does not refer to them in relation to the definition of "natural" and "unnatural" The case of *R v HM Coroner for Inner London North ex parte Touche* [2001] sets out that culpable human failure is capable of rendering an otherwise natural death unnatural for coronial purposes. We submit that it should be clear to practitioners that a death from progression of a natural disease process does not necessarily constitute a natural death for the purposes of death certification. For example, a delay in diagnosis and/or treatment could require reporting to a Coroner for potential investigation.

Question		
16. Do you agree that provision needs to be made with regard to poisoning, given that cases of poisoning are rare?	✓	**Yes**
		No
		Not sure

Comment: Although cases of poisoning are rare, such cases that do occur are likely to raise issues of significant concern, whether accidents or deliberate, and we therefore consider that they should retain their own separate category. We submit that deaths due to drug toxicity where the drugs were administered in a medical setting should fall within the category of deaths related to a medical procedure or treatment, in order to keep these cases distinct. However, if a category of "otherwise unnatural" deaths is included, cases of poisoning could be incorporated within this classification.

Question		
17. Do you believe that "poisoning, the use of a controlled drug, medicinal product or toxic chemical" sufficiently covers all such circumstances of death? If not, should the guidance be broadened?		**Yes**
	✓	**No**
		Not sure

Comments: We would suggest that alcohol be included within this aspect of the guidance.

We would reiterate that, as noted above, deaths in which the toxicity occurred as a result of administration/intake in a medical context should be categorised with deaths related to a medical procedure or treatment rather than deaths arising from poisoning.

18. Do you believe there is a sufficient understanding of "neglect"? If not, should this be made clearer in the draft regulations rather than guidance?

	Yes
✓	**No**
	Not sure

Comment: We do not have detailed knowledge as to what doctors understand by the term 'neglect' but consider that guidance should be made available to allow putative deaths relating to neglect to be notified appropriately. 'Neglect' has a specific legal definition, which is distinct from the way in which the word is used colloquially. For coronial purposes, the definition of 'neglect' is set out in the case of *Jamieson*.

We would highlight that, in order to make a finding of neglect, neglect must have contributed to the death but is not required to be the sole causative factor. We would suggest that this be clarified in the regulations.

We would also note that, although the guidance notes that individuals who would be considered vulnerable may be in a dependent position for the purposes of finding of neglect, any patient relying on a clinician or other care providers could be considered dependent if they are relying on that care provider to maintain their health. For example, a patient (particularly a hospital inpatient) is dependent on their doctor to prescribe correct medication or refer them to an appropriate specialist for management, even a generally fit and well patient in a GP or outpatient setting. We would suggest that the guidance be expanded to reflect this.

19. Do you agree that regulation 3(2)(e) – "occurred as a result of an injury or disease received during, or attributable to, the course of the deceased person's work" – is clear that it includes any death that has occurred as a result of current or former work undertaken by the deceased, including cases such as mesothelioma or other asbestos related cases? If not, we would be grateful for alternative suggestions.

	Yes
	No
✓	**Not sure**

Comments: Cases of industrial injury/disease/poisoning fall outside our remit and we do not have specific experience in this regard. However, we would suggest that "work history" might reflect that work includes employment other than that in which the deceased was engaged at the time of the death.

20. Do you agree that it should be possible to make notifications orally, but that where an oral notification is made the information must be recorded in writing and confirmed?

✓	**Yes**
	No
	Not sure

Comments: We agree but would recommend that oral notifications be permitted only in exceptional circumstances, for example where the matter is urgent, and be confirmed in writing at the earliest opportunity. Any discrepancy between the oral and written notifications should be clarified.

21. Do you agree that regulation 3(6) should prevent duplication of notification? We would be particularly grateful for views on how this would work in a surgical environment.

✓	**Yes**
	No
	Not sure

Comments: The WHO Surgical Checklist has been widely implemented in theatres and includes a series of questions to be addressed at the end of the procedure before the patient leaves theatre. We would suggest that, where a patient dies in theatre, agreement be made among the staff as to which member of staff will be responsible for making the notification before leaving the theatre.

Question		Response
22. Do you have any other comments about the draft Regulations?		**Yes**
	✓	**No**
		Not sure
Comments:		
23. In relation to the guidance, do you agree with the examples used under each category of death? If not, we would be grateful for further examples or suggestions for definitions.	✓	**Yes**
		No
		Not sure
Comments:		
24. Also in relation to the guidance, do you agree that no specific reference is needed as to whether certain deaths will be subject to jury inquests or not (such as those that have occurred under state detention)?	✓	**Yes**
		No
		Not sure
Comments: We agree; this is a matter for the Coroner.		
25. Do you have any other comments about the guidance?		**Yes**
	✓	**No**
		Not sure
Comments:		