

Summary

In summary, Medical Examiners are supposed to answer the following questions:

- What was the cause of death of the deceased?
- Does the Coroner need to be notified of the death [GPs can still refer directly to the coroner if appropriate, although increasingly Coroners Offices are likely to suggest such referrals are initially discussed with a Medical Examiner]
- Was the care provided to the deceased before death appropriate?

In order to answer these questions, Medical Examiners are supposed to undertake a review of: -

- The pre-existing medical records – in practice a recent sample is likely to be requested
- The information provided by the GP completing the Medical Certificate of Cause of Death together with a discussion with the GP if this would be helpful to either party.
- Any information provided by the bereaved, including offering an opportunity to ask questions and raise concerns.

All GP practices need to know which Medical Examiner (ME) Unit they are supposed to refer deceased patients details to, and how to provide this information.

Unfortunately, although there are guidelines in terms of how the Medical Examiner process should work, there is no consistent England-wide implementation of these, and so as is being reported by LMCs there is considerable variation in this process across England. In part this variation also relates to the IT system used by the practice, and the IT links available between practices and the local Medical Examiner Unit.

All GP practices should therefore, if this link is not yet in place, make contact with their local hospital ME Unit to confirm that there needs to be a link with that practice; the ME Unit should advise how to transfer information, including the proposed MCCD, to the Medical Examiner for scrutiny. GPC England is seeking to ensure this does not represent an additional administrative burden, and both GPC England and local LMCs can be contacted if this is the case. ME Units are responsible for their own timescales, which may be a significant factor for some bereaved faith groups, and interaction with the bereaved, including any concerns or complaints not merely about the care of the deceased, but also about the process. If a Medical Examiner wishes to speak directly with a GP about a deceased patient, the GPC

England suggests this is booked as one of a practices 25 – 35 BMA Safe Working Guidance daily appointments, as GP involvement in the Medical Examiner process is not separately resourced.

Regulations

Alongside the implementation of the Medical Examiner scrutiny outside hospitals, the Medical Certificate of Cause of Death Regulations are also being updated; these have been published in draft [but are unlikely to be amended significantly] alongside an overview of the changes, as below:

The Medical Certificate of Cause of Death Regulations 2024 (draft)

(publishing.service.gov.uk)

An overview of the death certification reforms - GOV.UK (www.gov.uk)

Key issues for GPs

- The responsibility for completing a MCCD remains the “attending practitioner” using information available from a patient’s medical records, any physical examination that has taken place, and any other information thought relevant. There remains no definition of “attending practitioner”, but the term can be considered to mean a GP has attended the deceased before death in a professional capacity.
- If a cause of death cannot be completed, or if the death falls into those categories that require a Coroners oversight, the death must be referred to the Coroner. If the Coroner decides not to investigate, they will advise the attending practitioner who will then be expected to submit an MCCD to a Medical Examiner, as directed by the Coroner. The attending practitioner can then discuss a proposed cause of death on the MCCD with the Medical Examiner. Alternatively, the attending practitioner can discuss a possible referral to the Coroner with a Medical Examiner initially, and it is likely Coroner Offices will increasingly expect this. One concern would be if two time consuming referrals were required to complete this process.
- Once a MCCD has been prepared, this must be passed to a Medical Examiner, together with “the deceased persons relevant health records”; in practice the ME Unit should be requesting a limited, recent sample of the records only, with the summary of active clinical problems and current medication two of the most helpful items of information

None of these processes apply if the coroner has already accepted responsibility for investigating the death or themselves referred the death to a Medical Examiner.

- The attending practitioner must respond to any queries the ME may have [“as far as reasonably practicable”] although there is provision for another attending practitioner to substitute if the first cannot undertake their duties “within a reasonable time”.
- If the Medical Examiner is satisfied, after enquiry, with the submitted MCCD they should sign it, thus confirming the cause of death given.
- In this case, the Medical Examiner should then [“without unreasonable delay”] notify a Registrar that the cause of death has been confirmed.
- If the Medical Examiner believes the submitted MCCD needs to be revised, they must discuss this with the attending practitioner, giving reasons. If no agreement can be reached the matter will be referred to the Coroner.
- The Medical Examiner must also inform a person with whom they have discussed the death (which is in practice likely to be a member of the deceased family) so that the registration of death can be arranged by the informant.

Thus, the main change is that GPs must share the MCCD containing the proposed cause of death with the Medical Examiner, for scrutiny (as above) before this can be submitted to the Registrar. However, Medical Examiners can, in exceptional circumstances, issue a Medical Examiner MCCD, when no attending practitioner can be identified by the Coroner.

New MCCD

A new paper MCCD will be available by April 2024, with an electronic version in preparation.

This will include the following additional details: -

- o Details of the Medical Examiner who scrutinised the cause of death.
- o Ethnicity if and as self-declared by the patient on their medical record. If this is not available, the attending practitioner should complete it as “unknown”, and not ask anyone else for this information
- o Reference to maternal death and a new line 1d, to align with international comparisons.
- o Medical devices and implants to be recorded on the MCCD by the attending practitioner.

The Cremation Form 4 is being abolished; and information about devices and implants will be included within the newly designed MCCD and completed by the attending practitioner. The private Form 4 fee will therefore no longer be payable.

Medical Examiners currently have access to deceased patients records via Section 251 of the NHS Act 2006, following recommendations of the Health Research Authorities Confidentiality Advisory Group; following the introduction of the new Regulations, Medical Examiners will have a right to access medical records under Section 3 of the Access to Health Records Act 1990 as amended by the Coroners and Justice Act 2009.

Based on feedback, GPC England is not assured the Medical Examiner process will work, as indeed it did not in March/April 2023; a number of other LMCs have fed back the same concerns GPC England will be writing to the National Medical Examiner expressing these concerns, which focus on capacity within local ME units, turnaround timescales, and the burden of this process on GP practices.