



*Consultation on Improving the  
Process of Death Certification*



# *Consultation on Improving the Process of Death Certification*

Prepared by:  
Simon Bennett  
Clinical Programmes Directorate  
Room 8E10  
Quarry House  
Quarry Hill  
Leeds  
LS2 7UE

July 2007

**DH INFORMATION READER BOX**

<b>Policy</b> HR/Workforce Management Planning Clinical	Estates Performance IM & T Finance Social Care/Partnership Working
<b>Document purpose</b>	Consultation/Discussion
<b>Gateway reference</b>	8549
<b>Title</b>	Consultation on Improving the Process of Death Certification
<b>Author</b>	DH: Clinical Programmes
<b>Publication date</b>	24 July 2007
<b>Target audience</b>	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Welsh NHS Bodies, Welsh representative organisations, Welsh NHS contractors and individuals/organisations listed at Annex A
<b>Circulation list</b>	
<b>Description</b>	A consultation paper seeking view on proposals to address weaknesses in the current system for certifying death which were identified by the Shipman Inquiry.
<b>Cross reference</b>	N/A
<b>Superseded documents</b>	N/A
<b>Action required</b>	Comment on consultation paper
<b>Timing</b>	<b>Comments to be received by 24 October 2007</b>
<b>Contact details</b>	Simon Bennett Clinical Programmes Directorate Department of Health Room 8/E10 Quarry House, Quarry Hill Leeds LS2 7UE <a href="http://www.dh.gov.uk/consultations">www.dh.gov.uk/consultations</a>
<b>For recipient's use</b>	

# Contents

<b>Foreword</b>	<b>1</b>
<b>Section 1: Introduction</b>	<b>2</b>
<b>Section 2: Overview of the current death certification system in England and Wales</b>	<b>4</b>
<b>Section 3: The case for change</b>	<b>7</b>
<b>Section 4: Shipman Inquiry's conclusions and recommendations</b>	<b>9</b>
<b>Section 5: Proposals for improving the death certification system</b>	<b>11</b>
<b>Section 6: Funding the improved death certification system</b>	<b>16</b>
<b>Section 7: Taking forward these proposals</b>	<b>17</b>
<b>Section 8: How to comment</b>	<b>18</b>
<b>Annex A: List of organisations being consulted</b>	<b>21</b>
<b>Annex B: Current death certification process</b>	<b>24</b>
<b>Annex C: Proposed death certification process</b>	<b>25</b>



# Foreword

Bereaved families need to understand the cause of the death of their relative and to be assured that there was nothing untoward in the circumstances surrounding the death. It is also very important that the administrative processes that are necessary to establish the cause of death and to allow a body to be released for burial or cremation should not add to the distress of the family at what is always a difficult time.



The *Third Report* of the Shipman Inquiry Chaired by Dame Janet Smith drew attention to the difference in the arrangements for death certification between cremations and burials. While a series of checks is made before a body can be released for cremation, a single certificate is required for burial.

The Government considers that these different arrangements are no longer justified and is proposing to introduce a single system for death certification for both cremations and burials. The proposed arrangements are intended to provide a common level of assurance to all bereaved families that there were no suspicious circumstances surrounding the death, while simplifying the administrative process. They will also improve public health surveillance of cause of death. The new arrangements will be overseen by a Medical Examiner attached to a local Primary Care Trust (or an equivalent organisation in Wales).

Before taking these proposals forward it is important to know that they command public support. That is why we are consulting on our proposals. Please let us have your views on this important and sensitive subject.

A handwritten signature in black ink, appearing to be 'Ben Bradshaw'.

Ben Bradshaw MP  
Minister of State for Health Services

# Section 1: Introduction

- 1.1 Each year some 500,000 people die in the United Kingdom. The loss of a close relative is a particularly difficult time for families. At such a time, families need to have confidence in the public services associated with the certification of death and burial or cremation. For most families their experience of the processes surrounding the death of a family member is satisfactory, at least given the circumstances, but there is a possibility of things going wrong. The Harold Shipman case, which was the subject of an inquiry chaired by Dame Janet Smith, showed the thankfully rare but potentially devastating effects of criminal activity relating to death certification.
- 1.2 This consultation paper seeks 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. The proposals, which were outlined in the Government's action programme<sup>1</sup> in response to the recommendations of the Shipman Inquiry, apply to England and Wales only.
- 1.3 The system for death certification in England and Wales has remained largely unchanged for over 50 years. The current arrangements require that for all deaths the doctor who attended the patient in their final illness should complete a Medical Certificate of Cause of Death (MCCD). Additional certification is required before bodies can be released for cremation. Currently around 70% of deaths are followed by cremation.
- 1.4 This means that there is a difference in the safeguards provided to relatives of the deceased as to the cause of death and absence of any malpractice, depending on whether the deceased is cremated or buried. The effect of these different levels of assurance and cost is no longer appropriate in modern Britain. We need to be able to provide all bereaved people with a high level of assurance that the death of their relative has been certified correctly and that there are no grounds for concern.

---

<sup>1</sup> Learning from tragedy, keeping patients safe (TSO, February 2007)

- 1.5 In the current certification system there is also some inconsistency in determining which cases are referred to Coroners by doctors completing MCCDs. There is also currently no statutory obligation on a doctor to refer a case at all to the Coroner, although the Ministry of Justice is consulting on proposals to address this (see paragraph 5.18).
- 1.6 In its *Third Report*<sup>2</sup>, the Shipman Inquiry proposed a radical overhaul both of the Coroners' system and of the arrangements for death certification with a common approach to certification and a consistent level of scrutiny, regardless of whether a body was to be buried or cremated. The draft Coroners' Bill<sup>3</sup> published by the Department for Constitutional Affairs (now Ministry of Justice) in June 2006 set out the Government's proposals for improving the Coroners' system.
- 1.7 This consultation paper sets out proposals to address the weaknesses identified by the Shipman Inquiry in the current system for certifying death. We believe these proposals represent a more transparent, proportionate, consistent and affordable response that will provide greater protection for the public, improve the quality and accuracy of death certification, improve public health surveillance and remove current inequalities in the way burials and cremations are dealt with.
- 1.8 The consultation paper invites views on various aspects of death certification and responses to a number of specific questions.
- 1.9 It is recognised that there may be considerable public interest in this proposal. A Partial Impact Assessment indicates that these proposals are unlikely to lead to significant additional costs or savings for businesses, charities or the voluntary sector, or the public sector. **We wish to confirm that assumption by asking about potential economic impact as part of this consultation.** Copies of the Partial Impact Assessment, along with an Initial Equality Impact Assessment, are available on the Department of Health's website at [www.dh.gov.uk/consultations](http://www.dh.gov.uk/consultations).
- 1.10 Copies of this consultation paper are being sent to the organisations listed at Annex A and published on the Department of Health's website (at the address given above).

---

2 Shipman Inquiry *Death certification and the investigation of deaths by Coroners* (TSO, July 2003)

3 Coroner Reform: The Government's Draft Bill *Improving death investigation in England and Wales*

## Section 2: Overview of the current death certification system in England and Wales

- 2.1 Currently, medical practitioners have a duty under the Births and Deaths Registration Act 1953 to complete a Medical Certificate of Cause of Death (MCCD) if they attended the deceased during their last illness. The contents of the MCCD comply with World Health Organisation (WHO) recommendations to ensure comparability for epidemiological purposes. The information recorded on the MCCD includes the name of the deceased, the date and place of death, when they were last seen alive by the certifying doctor, the cause of death and whether it may have been contributed to by the employment of the deceased at some time, and whether the certified cause of death takes account of post-mortem findings.
- 2.2 The MCCD is delivered by the “informant” (usually the next of kin) to the Registrar of Births and Deaths who issues the death certificate. Only the Registrar is under a statutory duty to refer certain cases to the Coroner.
- 2.3 The Registrar has a duty to refer deaths to the Coroner if:
  - the deceased had not been seen by the doctor within 14 days of the death, or
  - the certifying doctor had not seen the body after death.

Registrars are also required to refer deaths to Coroners where:

- the cause of death is unknown;
- the death was violent or unnatural or suspicious;
- the death may be due to an accident (whenever it occurred);
- the death may be due to self-neglect or neglect by others;
- the death may be due to an industrial disease or related to the deceased’s employment;
- the death may be due to an abortion;
- the death occurred during an operation or before recovery from the effects of an anaesthetic;
- the death may be a suicide;
- the death occurred during or shortly after detention in police or prison custody.

- 2.4 In practice, medical practitioners themselves tend to refer cases directly to the Coroner where there is uncertainty about the cause of death or reason to believe the death was suspicious, or if the death might fall into one of the categories reportable under the registration legislation. The guidance notes on the MCCD remind medical practitioners of the above categories.
- 2.5 In cases of burial, assuming neither the doctor nor the Registrar refers the case to the Coroner, the Registrar issues a death certificate and the family can proceed with the burial.
- 2.6 For cremation, the arrangements for completion of the MCCD by the doctor attending the patient in their final illness also apply, with the MCCD being delivered to the Registrar, as for burial. Separately, application is made to the crematorium on the statutory Application for Cremation (known as Form A) – usually by the deceased’s executor or the next of kin. Details include relationship to the deceased, place, time and date of death, whether there may be any reason to suspect violence, poison or neglect, whether there is any reason to think an examination of the remains is desirable, and details of the patient’s general medical practitioner (GP). This form is passed to the relevant crematorium.
- 2.7 There is also a requirement for a Certificate of Medical Attendant (Form B) which is completed by a medical practitioner. This medical practitioner can be the same one that completed the MCCD (and in practice often is). Questions on this form include: how long the doctor attended the deceased, when the deceased was last seen alive, when the body was seen, what if any examination was made of the body, details of the cause and mode of death, details of any surgical interventions within a year before death, any reason to suspect poison, violence or neglect, and any reason to suppose that a further examination is necessary. This form is then passed to another medical practitioner who will complete the confirmatory certificate described below (Form C).
- 2.8 The Confirmatory Medical Certificate (Form C) must be completed by a different medical practitioner, who must not be a relative of the deceased or a relative or partner of the doctor who completed the Certificate of Medical Attendant (Form B) and who has been registered with the General Medical Council (GMC) for at least five years. The Confirmatory Medical Certificate asks:
- have you seen the body of the deceased?;
  - have you carefully examined the body externally?;
  - have you seen and questioned the medical practitioner who gave the above certificate (i.e. Form B)?;

- have you seen and questioned any other medical practitioner who attended the deceased (if so, give details)?;
- have you seen and questioned any person who nursed the deceased during the last illness, or who was present at the death (give details and say if seen alone)?;
- have you seen and questioned any other person (give details and state if seen alone)?

2.9 The declaration confirms that the doctor knows of no reasonable cause to suspect that the deceased died either a violent or unnatural or sudden death of which the cause is unknown, or died in such a place or circumstances as to require an inquest. The form is sent to a Medical Referee (another doctor, attached to the cremation authority, and appointed by the Ministry of Justice).

2.10 The Authority to Cremate (Form F) is completed by the Medical Referee, authorising the superintendent of the crematorium to cremate the remains. The Medical Referee may make enquiries of other signatories and may refuse cremation (but must give a reason for refusal). The Medical Referee has the power to request a post-mortem examination be carried out, but must seek permission from the next of kin.

2.11 A process map providing more information on the current death certification system in England and Wales is at Annex B.

## Section 3: The case for change

- 3.1 There are a number of weaknesses and anomalies in the current arrangements, particularly the difference in the level of certification required for cremation rather than burial.
- There is no additional medical scrutiny for burial cases (30% of all funerals) once the Medical Certificate of Cause of Death (MCCD) has been completed. The Registrar does an administrative check on all MCCDs, and has a legal duty to refer to the Coroner in certain circumstances. However, the Registrar is not medically qualified and does not have access to supporting information such as medical notes. The Registrar is therefore not in a position to make effective judgements about the reliability of the cause of death recorded on the MCCD.
  - In contrast, cremation cases are subject to a series of checks involving three different doctors (completing Forms B, C and F). However, the scrutiny is not always sufficiently independent of the doctor signing the MCCD and is not subject to effective quality assurance.
  - There is no routine system for analysis for local clinical governance<sup>4</sup> purposes of the information on MCCDs or on the additional forms completed for cremations, and no explicit link to clinical governance processes in either Primary Care Trusts or hospitals.
- 3.2 The absence of a link with the clinical governance framework means best use may not be being made locally, of data about deaths to identify concerns, and there is no real oversight of quality and accuracy.
- 3.3 Fees associated with medical certification for cremation are usually paid by the family of the deceased as part of funeral expenses. Most of the fees for cremation certification go to the doctors who carry out the examinations. The higher cost of certification associated with cremations as opposed to burials is potentially discriminatory.

---

<sup>4</sup> Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.

- 3.4 The argument for more stringent procedures for cremation was that once a body has been cremated there is no possibility of further examination should there need to be further investigation of the cause of death. Exhumation is a possibility where a body has been buried. However, the system was introduced at a time when cremation was a rarity, and it could be argued that it was justifiable to charge bereaved people for a service that was over and above the norm. Nowadays, the vast majority of people opt for cremation. We also live in a multi-cultural society in which for some people the method of disposing of a body is not a matter of personal choice but of cultural or religious practice.
- 3.5 Families opting for burial, also deserve the same degree of reassurance that all is well before the burial takes place as those opting for cremation. Any necessary investigations should take place before burial, with all steps being taken to minimise the need for possible exhumations which are both distressing for families and less likely to reveal useful information than investigations carried out before burial.
- 3.6 There is also some inconsistency in determining which cases are referred to Coroners by doctors completing MCCDs. About half the deaths reported to Coroners require neither post mortem nor inquest, and these cases have been increasing in recent years – from 39% in 1995 to 51% in 2006<sup>5</sup>. Currently, many cases are referred to the Coroner because the deceased person has not seen their doctor in the 14 days preceding death, and the doctor has not seen the body after death. This inevitably causes delay and distress for bereaved families.

---

5 Source: Ministry of Justice

# Section 4:

## Shipman Inquiry's conclusions and recommendations

- 4.1 In its *Third Report*, the Shipman Inquiry examined the processes for death certification and the Coroners' system, and asked whether more clues about Shipman's actions could have been found through better scrutiny either of individual deaths or of the pattern of deaths in Shipman's patients.
- 4.2 The Shipman Inquiry concluded that the current system of death certification was confusing and provided inadequate safeguards, particularly against the very unlikely (but sadly not unthinkable) possibility that the doctor completing the Medical Certificate of Cause of Death (MCCD) was himself responsible for the patient's death. The Inquiry proposed a radical overhaul both of the Coroners' system and of the arrangements for death certification, in which:
- a national system of legally-qualified Coroners under a Chief Coroner would replace the current system of local Coroners appointed and funded by local authorities;
  - a single system of death certification would apply, regardless of whether the deceased is to be buried or cremated;
  - the certifying doctor would provide a description of chain of events leading to death and opinion of the cause of death and refer *all* deaths to the Coroners' service;
  - a new Coroners' service at arm's length from Government would be established. This would be responsible for the final certification of death and for deciding whether further investigation was necessary in ALL deaths. It would include a "Medical Coroner" who would be responsible for establishing the medical cause of death, as well as "Judicial Coroners" who would investigate where necessary (e.g. suspicious deaths);
- 4.3 A fundamental review<sup>6</sup> chaired by Tom Luce and presented to the Home Office in June 2003 came to broadly similar conclusions about the shortcomings of the current arrangements, although it proposed different solutions.

---

6 Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review (TSO, June 2003)

- 4.4 The draft Coroners' Bill published by the Department for Constitutional Affairs (now the Ministry of Justice) in June 2006 set out the Government's proposals for improving the Coroners' system. The main proposals are:
- new national leadership, through a Chief Coroner and Coronial Advisory Council. The Chief Coroner will, among other things, set national standards, hear appeals against Coroner decisions, arrange and monitor Coroner training;
  - a move towards whole-time Coroners (mostly a part-time role at present), working within a local authority framework of accountability and service delivery;
  - improved powers for Coroners to receive information so they are able to more easily obtain information to help with their investigations;
  - removal of unwieldy boundary restrictions, so the system as a whole is better able to respond to surges in workload, including incidents leading to mass fatalities;
  - an improved focus on the needs of bereaved people, with a national charter setting out their opportunities to contribute to investigations and to receive information
- 4.5 The Bill is part of the Government's draft legislative programme, announced on 10 July 2007, for the Parliamentary session beginning in November 2007.

## Section 5:

# Proposals for improving the death certification system

- 5.1 The Government accepted the Shipman Inquiry's conclusion that existing arrangements for scrutinising the Medical Certificate of Cause of Death (MCCD) are confusing and inadequate. The Government's action programme in response to the recommendations of the Shipman Inquiry proposed a variant of the Shipman Inquiry's key recommendations in order to create a rigorous, unified system covering both burials and cremations.
- 5.2 Ensuring that the new death certification system is sensitive to the needs of the bereaved and can provide them with reassurance at an inevitably difficult time is central to the Government's proposals, which are described in more detail below.

### Independent scrutiny of MCCDs by a Medical Examiner

- 5.3 The Medical Certificate of Cause of Death (MCCD) should be completed by the medical practitioner responsible for the deceased person's care, as now. After completion, the MCCD should be passed to a Medical Examiner attached to the clinical governance team of a Primary Care Trust (or an equivalent organisation in Wales). If the medical practitioner is unable to complete an MCCD, or for example if the death is violent or unnatural or suspicious, the death should be reported to the Coroner. Further information on the relationship between Coroners and Medical Examiners, including a number of consultation questions, is provided below.
- 5.4 The Medical Examiner will scrutinise the MCCD and investigate as necessary. This stage needs to be completed as speedily as possible to ensure minimum distress for families and to allow cremation or burial to take place as quickly as possible. It will include for example, looking at the deceased's medical records and the results of investigations, discussing the circumstances of the death with the doctor signing the MCCD and other clinicians involved in the deceased's care and, where necessary, with the family of the deceased.
- 5.5 If the Medical Examiner is satisfied that all is in order, he or she will issue an authorisation to the family of the deceased to enable them to register the death and proceed to burial or cremation (this will remove the existing responsibility for authorising burial from Registrars and abolish the present Cremation Form system).

**Q1 To avoid unnecessary delays, and upon receipt of authorisation from the Medical Examiner, would it be desirable to allow the deceased to be buried or cremated before the death is registered (as is the case now when the Coroner issues a cremation certificate or burial order)?**

- 5.6 If not satisfied, the Medical Examiner will have a duty to refer the case to the Coroner for further investigation and to inform the family that he or she has done so. In this situation, the Medical Examiner should provide a recommendation on whether or not a post-mortem examination is likely to provide relevant information beyond that which is available from other sources (although the final decision to order a post-mortem will continue to remain with the Coroner). In this way, unnecessary post-mortem examinations should be avoided. In such cases authorisation to release the body for burial or cremation will come from the Coroner.
- 5.7 Registrars will still have a duty to report deaths to the Coroner, particularly where issues are raised by the family member registering the death.
- 5.8 A process map illustrating the proposed death certification system is at Annex C.

### The role of the Medical Examiner

- 5.9 Medical Examiners will be medical practitioners with at least five years' full registration with the General Medical Council (GMC) who have received special training in the role. Medical Examiners will be appointed by Primary Care Trusts (or an equivalent organisation in Wales) which have responsibility for the health of populations. Appointments could be either full-time or part-time. Each Medical Examiner will need to work closely with clinical governance teams in both the Primary Care Trust (or an equivalent organisation in Wales) and local hospital trusts.

**Q2 In order to attract medical practitioners with the right level of expertise and experience, and also to maximise the flexibility of the service to minimise any delays to funeral arrangements, would it be desirable to appoint Medical Examiners on a part-time basis?**

- 5.10 The details of the role of the Medical Examiner, including guidance on the appropriate level of scrutiny, appointment arrangements, training and continuing professional development needs and information requirements, still need to be developed with stakeholders and piloted. However, we envisage the main responsibilities of a Medical Examiner to be as follows:
- to speak to the doctor signing the MCCD, the deceased's family, carers and any other persons who may provide information relevant to the death;
  - to obtain and consider medical records provided by the deceased's GP, hospital, nursing home or private treatment provider. In addition, other records, e.g. from Social Services, may also need to be considered;
  - to authorise burial or cremation or refer the case to the Coroner;
  - to work closely with the clinical governance team in the Primary Care Trust (or equivalent organisation in Wales), and similar teams in local hospital trusts, to collate key information from MCCDs and use this to analyse trends and identify unusual patterns and support the development of a Primary Care Trust/local authority Joint Strategic Needs Assessment (in Wales this is likely to feed into the Local Health Board Needs Assessments process);
  - to support the training of junior doctors in completion of MCCDs and provide feedback on accuracy of certification locally.
- 5.11 Each Medical Examiner will be assisted in their role by a Medical Examiner Support Officer who will have a key responsibility for gathering information from different sources and preparing cases for scrutiny. The detailed specification for this role will be developed and piloted alongside that of the Medical Examiner.

## Relationship to the Coroner

- 5.12 It will be important for Medical Examiners to work closely with the Coroner to ensure the proposed arrangements set out in this consultation paper work efficiently and effectively. Medical Examiners can also provide an important link, and promote greater co-operation, between the Coroner and clinical governance and public health teams in the NHS in order to better understand wider health trends.
- 5.13 The need to share information and refer individual cases between Medical Examiners and the Coroner means that, although appointed by a Primary Care Trust (or an equivalent organisation in Wales), it might be desirable to co-locate Medical Examiners with Coroners. Clearly, such arrangements would need to be agreed locally and would need to take account of the need for Medical Examiners to work closely with NHS clinical governance teams.

**Q3 Would it be beneficial to co-locate Medical Examiners with Coroners where this was agreed locally? If so, what would be the specific benefits?**

- 5.14 As part of the Government's plans for reform of the Coroners' system, Coroners are to have access to better medical advice at both a national and local level. A National Medical Advisor to the Chief Coroner is to be appointed to contribute to a reformed service on a range of medical aspects, and Coroners will be supported to secure medical advice locally.
- 5.15 With colleagues in the Ministry of Justice, the Health Departments in England and Wales will be considering whether it would be appropriate and practical to establish a line of professional accountability between the National Medical Advisor to the Chief Coroner and Medical Examiners in the NHS. We will also be considering whether, in specified cases, it would be appropriate for Medical Examiners to be contracted to provide local medical advice to Coroners.

**Q4 Would it be appropriate and practical to have a professional line of accountability between the National Medical Advisor to the Chief Coroner and Medical Examiners? What do you consider to be the advantages and disadvantages of this proposal?**

**Q5 Would it be appropriate for Medical Examiners to be contracted to provide medical advice to Coroners in certain cases?**

- 5.16 We are not proposing that the Medical Examiner should act as an intermediary between medical practitioners and the Coroner in the generality of cases. However, as part of piloting the proposed new system, we will consider whether some cases that are currently discussed informally with the Coroner should, more appropriately, be discussed with a Medical Examiner.
- 5.17 It might also be appropriate for Medical Examiners to take over, in some cases, the role of the Coroner in authorising the removal of bodies abroad where the family of the deceased require the body to be repatriated to another country for burial or cremation. These are most likely to be cases where the death would not otherwise require a Coroner to investigate. Similarly, where bodies are repatriated here from other countries, the Medical Examiner would be well placed to authorise their burial or cremation – if the Coroner was satisfied that the death was not one he or she was required to investigate.

**Q6 Are there circumstances where deaths are discussed with the Coroner unnecessarily and should, in the future, more appropriately be discussed with a Medical Examiner?**

### Qualifying period

- 5.18 The Ministry of Justice is issuing a consultation paper<sup>7</sup> proposing that a statutory duty should be placed on certain public personnel (including medical practitioners) to report specific cases to the Coroner when specified circumstances apply. The consultation paper also considers the current requirement that a death should be reported to the Coroner if the deceased was not seen by the certifying doctor within the last 14 days or viewed after death.
- 5.19 The Ministry of Justice believes that the doctor's knowledge about the patient and the death is the key factor determining whether or not they can certify the death. The time elapsed since a doctor has seen the deceased would, in any event, be a factor for them to take into account in deciding whether they had the necessary knowledge of the patient and the death. For these reasons the Ministry of Justice is seeking views on whether a time limit of this kind is appropriate. We will take full account of the plans that emerge from the Ministry of Justice's consultation in developing our proposals for improving the process of death certification

**Q7 Is a qualifying period necessary to achieve the desired aim of ensuring the Coroner investigates appropriate cases?**

---

<sup>7</sup> Statutory Duty for Doctors and other Public Service Personnel to Report Deaths to the Coroner (TSO, July 2007)

## Section 6: Funding the improved death certification system

- 6.1 Under the present system, fees associated with the certification of death are paid by families whose relatives are cremated. The successive medical checks that are required before a cremation can take place currently cost families a total of £148.50 (see Figure 1). The effectiveness of these checks has been criticised by a number of Inquiries, and they are not subject to effective quality assurance.
- 6.2 Our preferred option for funding the proposed new system of death certification is a single fee for certification of all deaths (irrespective of whether death is followed by burial or cremation). Fee levels will be considered carefully and sensitively as part of the proposed pilots, when we will be in a position to more accurately determine the costs associated with scrutiny and analysis by the Medical Examiner. We would welcome views on this funding proposal.

## Section 7: Taking forward these proposals

- 7.1 The proposals outlined in this consultation paper represent a major change to the current death certification system. Responses to the consultation will help us to address the issues highlighted in the paper and identify workable solutions to those issues.
- 7.2 Implementation will inevitably require significant legislative change, e.g. to the Birth and Deaths Registration Act 1953, Cremation Regulations and legislation governing access to health records of the deceased (Access to Health Records Act 1990). Subject to the parliamentary timetable for introducing new legislation, implementation of the proposals for improving the death certification system is likely to broadly mirror that for introducing the Government's reforms of the Coroners' system.
- 7.3 We are proposing to establish a small stakeholder working group to review the findings of this consultation and oversee the further development and piloting of the proposed new arrangements.

## Section 8: How to comment

### When should you submit your comments by?

8.1 Responses to this consultation paper should be submitted to arrive at the latest by 24 October 2007. Please send us comments and ideas on any of the issues mentioned, along with workable solutions to those issues. It will make analysis easier if responses are presented in a systematic way. The paper therefore includes a number of explicit questions to which we would particularly welcome responses.

### Where should you submit your comments?

By email to: [simon.bennett@dh.gsi.gov.uk](mailto:simon.bennett@dh.gsi.gov.uk) marking your comments clearly for the Death Certification Consultation.

By post to: 'Death Certification Consultation'  
Department of Health  
Room 8/E10  
Quarry House  
Quarry Hill  
Leeds  
LS2 7UE

8.2 Consultation respondents in Wales should address their comments to Simon Bennett as indicated above, but in the case of any specific queries in respect of Wales please contact:

Anna Slatter  
Specialist Health Policy Advisor  
Department of Health & Social Services  
Welsh Assembly Government  
Cathays Park  
Cardiff  
CF10 3NQ  
[anna.slatter@wales.gsi.gov.uk](mailto:anna.slatter@wales.gsi.gov.uk)

## Consultation Criteria

8.3 This consultation follows the Cabinet Office code of practice which is available from the Cabinet Office website at <http://www.cabinetoffice.gov.uk/regulation/consultation/code/index.asp>. This requires government departments to:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of policy.
2. Be clear about what proposals are, who may be affected, what questions are being asked and the timescale for responses.
3. Ensure that consultations are clear, concise and widely accessible.
4. Give feedback regarding the responses received and how the consultation process influenced the policy.
5. Monitor their effectiveness at consultation, including through the use of a designated consultation co-ordinator.
6. Ensure consultations follow better regulation best practice, including carrying out a regulatory Impact Assessment if appropriate.

8.4 The Code also invites respondents to “comment on the extent to which the criteria have been adhered to and to suggest ways of further improving the consultation process”. For DH consultation, comments or complaints (but not your response to this consultation) should be sent to:

Consultations Coordinator  
Department of Health  
Skipton House  
80 London Road  
London SE1 6LD

Email: [mb-dh-consultations-coordinator@dh.gsi.gov.uk](mailto:mb-dh-consultations-coordinator@dh.gsi.gov.uk)

### **Please do not send consultation responses to this address**

8.5 Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

- 8.6 If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.
- 8.7 The Department will process your personal data in accordance with the DPA and in the majority of circumstances; this will mean that your personal data will not be disclosed to third parties.

**Thank you for participating in this consultation exercise**

# Annex A: List of organisations being consulted

In addition to NHS organisations in England and Wales, copies of the consultation paper are being sent to:

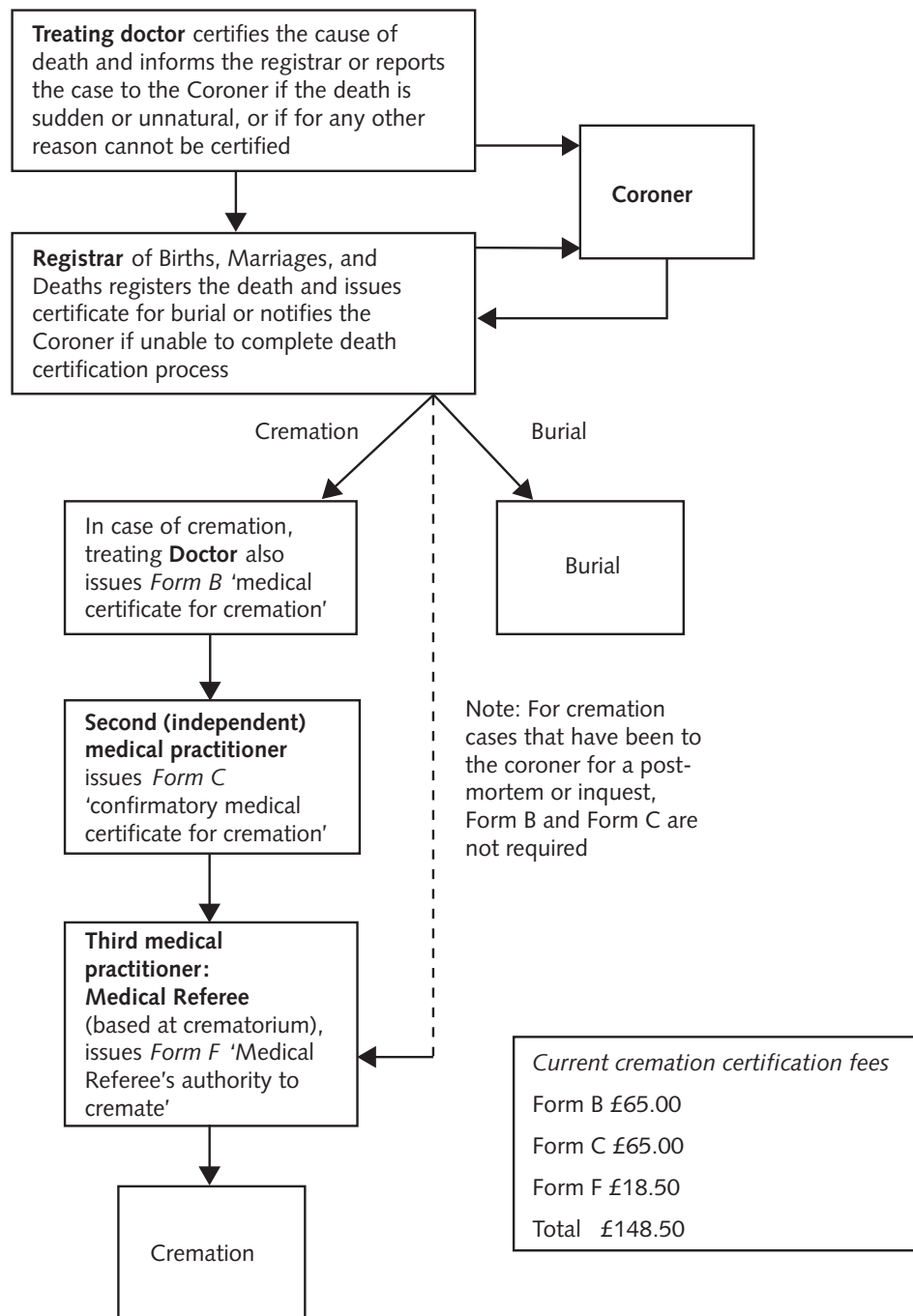
Academy of Medical Royal Colleges  
Action against Medical Accidents (AvMA)  
Adverse Psychiatric Reactions Information Link (APRIL)  
Asbestos Support Group Forum  
Association of Chief Police Officers  
Association of Public Health Observatories  
Association of Registration and Celebratory Services (ARCS)  
British Medical Association  
Cardiac Risk in the Young (CRY)  
Centre for Corporate Accountability  
Chief and Assistant Chief Fire Officers' Association (CACFOA)  
Child Bereavement Trust (CBT)  
Church in Wales  
Churches Together in England  
Coroners' Courts Support Service (CCSS)  
Coroners' Officers Association  
Coroners' Society of England and Wales  
CRUSE Bereavement Care  
CRUSE Cymru  
Department for Communities and Local Government  
Epilepsy Bereaved  
Faculty of Public Health  
Families against Corporate Killing  
Forum for Preventing Deaths in Custody  
Foundation for the Study of Infant Deaths

Funeral industry representatives  
General Medical Council  
General Register Office  
Health Statistics User Group  
Home Office  
Information Centre for Health and Social Care  
INQUEST  
Independent Police Complaints Commission  
JUSTICE  
Justice for Victims  
Liberty  
Local Authority Co-ordination of Regulatory Services (LACORS)  
Local Government Association  
Marchioness Action Group (MAG)  
Medical Defence Union  
Medical Protection Society  
Merseyside Asbestos Victim Support Group  
Ministry of Justice  
MRSA Bereaved UK  
National Bereavement Partnership  
National Patient Safety Agency  
National Society for the Prevention of Cruelty to Children (NSPCC)  
NHS Employers  
Northern Ireland Executive  
Office for National Statistics  
Police Federation (England and Wales)  
Prison Governors Association (England and Wales)  
Prison Service  
Refuge  
Rethink  
RoadPeace

Royal College of Pathologists  
Royal College of General Practitioners  
Royal College of Physicians  
Royal Statistical Society  
Scottish Executive  
Society of Registration Officers (SRO)  
Sudden Adult Death Trust  
Support after Murder and Manslaughter  
Support after Murder and Manslaughter Abroad  
Survivors of Bereavement by Suicide (SOBS)  
The Board of Deputies of British Jews  
The British Humanist Association  
The British Sikh Consultative Forum  
The Catholic Bishops' Conference of England and Wales  
The Childhood Bereavement Network (CBN)  
The Compassionate Friends  
The Hindu Forum of Britain  
The Inter Faith Network for the UK  
The Jain Samaj Europe  
The Muslim Council of Great Britain  
The Network of Sikh Organisations  
The Right Honourable Lady Justice Smith DBE  
The Zoroastrian Trust Funds of Europe  
Tom Luce  
Victim Support  
Victims' Voice  
Welsh Assembly Government  
Wales BMA  
Welsh Local Government Association

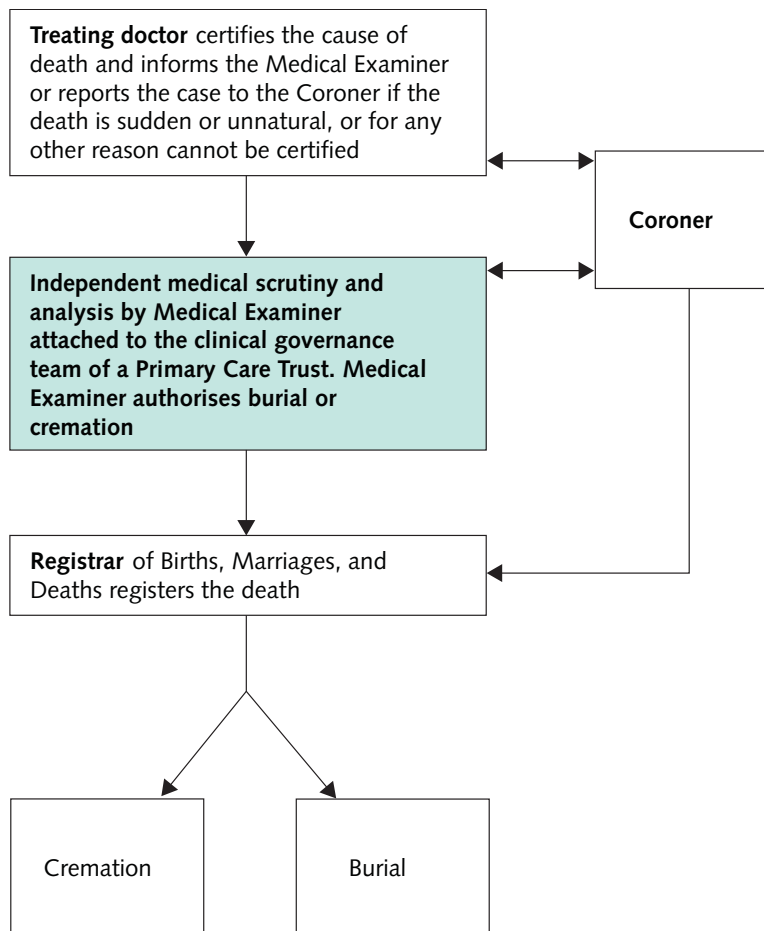
This list is not meant to be exhaustive, or in any way exclusive, and responses are welcomed from anyone with an interest in or views on the subject covered by this consultation paper.

# Annex B: Current death certification process<sup>8</sup>



<sup>8</sup> This process map is intended to provide a high level summary of the current death certification process. Inevitably, some individual cases will follow slightly different paths through the various processes e.g. cases where the Coroner authorises disposal and provides, direct to the Registrar, information to allow the death to be registered.

# Annex C: Proposed death certification process



## Main changes

New independent medical scrutiny and analysis of deaths

Common process for both burial and cremation

Burial or cremation authorised by Medical Examiner (or Coroner)

Removal of cremation certification processes and associated forms

Removal of the role of Cremation Referee











© Crown copyright 2007  
282947 1p 400 July 07  
Produced by COI for the Department of Health  
[www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)