Outcome following meeting with Acting Senior Coroner for, Somerset Foundation Trust Medical Examiner Team, PCN and LMC representatives on 26 August 2022

The purpose of the meeting was to seek clarification from our new acting Senior Coroner for Somerset (Samantha Marsh) on the implementation of current legislation with respect to death certification. The legal position and our coroner's view is outlined below along with guidance to doctors in the hope that unnecessary coroner referrals can be avoided, and - where referrals are required - adequate information can be provided for the coroner to fulfil her duties. This supplements national guidance for registered medical practitioners on the Notification of Deaths Regulations.

It is worth noting that Medical Examiner (ME) scrutiny of all community deaths is expected from April 2023 subject to legislation being passed, with a pilot already underway in Mendip PCN. The ME system will be able to offer support and guidance to GPs in the process of death certification, given one of its core purposes is to improve the quality of death certification and mortality data.

Key points:

1. **Any natural death of a patient not seen by attending doctor within 28 days before, or viewed after death, requires referral to the coroner using an Electronic Death Referral Form (EDRF).**
2. **Legally uncertified deaths (Form 100As) can only be issued in limited circumstances, otherwise an investigation is required.**
3. **Coroner Reports allow the coroner to establish the likely medical cause of death as part of her investigation.**
4. **Certain medical causes of death risk rejection by the registrar and subsequent referral to the coroner and this may be avoided.**
5. **Frailty of old age requires supporting information if being referred to the coroner**

1. Any natural death of a patient not seen by attending doctor within 28 days before, or viewed after death, requires referral to the coroner using an Electronic Death Referral Form (EDRF).

The position in terms of death certification (for cases which are of a natural cause) is that the law requires a doctor to do two things if they are to produce the Medical Certificate of the Cause of Death (MCCD):

1. attend to someone in their final illness; and

2. see them 28 days before or view them after death.

The emergency provisions in the Coronavirus Act 2022 that gave the temporary provision allowing any medical practitioner to complete the MCCD was repealed on 24 March 2022, which means only the attending doctor during the final illness can legally complete the MCCD. The coroner does not have discretion to allow completion of the MCCD by a doctor who has never seen the deceased in life, based on the notes of a colleague, regardless of how comprehensive those notes are or how many times the deceased was seen by another professional who is not a doctor (the law insists the

attending professional must be a doctor and not another type of health professional such as an advanced nurse practitioner or paramedic).

An actual consultation must have taken place for the doctor to meet the definition of having attended the patient prior to death, and this may include a video (but not telephone) consultation. Exchanging pleasantries in passing (for example, during a hospice or ward round), routine jabs such as influenza/Covid vaccinations or appointments for blood tests are not sufficient.

Doctors querying whether they should refer a death to the coroner can email the office at coronersofficerssomerset@avonandsomerset.police.uk for advice.

It is good practice to let the next of kin know when a referral to the coroner has been made so that they are aware that the coroner's office will be contacting them and that there might be a delay in the issuing of the MCCD. The requirement to register the death within five days does not apply when a referral to the coroner has been made. Sign posting to the Somerset Coroner's Service website may be helpful.

2. Legally uncertified deaths (Form 100As) are only issued in limited circumstances, otherwise an investigation is required.

Truly 'uncertified deaths', where a doctor hasn't seen the deceased during their last illness but provides information to the coroner and effectively asks the coroner to 'sign it off', are not accepted in Somerset, and this is in line with most other jurisdictions in England and Wales. In these circumstances, one of two things will happen:

- When a referral is made by the doctor who cannot issue without authority (for example, they saw the deceased during their last illness but that was six months ago) a Form 100A can potentially be issued. The issuing of the Form 100A confirms that the coroner has considered the referral and is satisfied that she has enough information to enable her to decline to open an investigation under section 1 of the Coroners & Justice Act 2009 safely. Effectively, this means she does not consider that her section 1 duty to investigate is engaged, because, based on the evidence, she is satisfied the death is not violent, unnatural and the cause is known.
- If the coroner cannot be satisfied on the evidence when applying the law, then the cause of death will need to be ascertained by a post-mortem. If a natural cause of death is revealed, the coronial investigation is discontinued (under Section 4 of the Coroners & Justice Act 2009) and a Form 100B is issued to the registrar stating the cause of death. If an unnatural cause is revealed or the cause of death is still unknown, the matter will proceed to inquest. Relatives can request an interim death certificate to notify a registrar of the death while the inquest is still taking place.

It is established in law that the coroner's duty to investigate has a low threshold. Our coroner's view - in line with the Chief coroner's - is that the coroner system cannot push the limits of its legal powers in order to routinely facilitate the issuing of MCCDs via the Form 100A route to absorb cases where doctors are unavailable. Whilst the issuing of a Form 100A form may be appropriate in individual cases, it is not something that the law envisages as a structural solution to the problem.

It is worth noting that if the deceased had recently been discharged to the community from hospital and are likely to have been seen by a doctor during this admission, the hospital's bereavement office should be contacted as they can usually assist with tracking the relevant doctor down and arranging for them to issue the MCCD, thus avoiding the need for a coroner referral and subsequent investigation with or without a post-mortem.

Contact details for the hospital bereavement offices: YDH 01935 384746 / MPH 01823 343753 / RUH 01225 824015.

3. Coroner Reports allow the coroner to establish the likely medical cause of death as part of her investigation.

Coroners inquire into the causes and circumstance of a death under section 5 of the Coroners and Justice Act 2009; inquiries are directed solely to ascertain:

- who the deceased was;
- when they died;
- where they died; and
- how their death came about.

In most inquests, answering the 'How' question extends to the coroner ascertaining the medical cause of death and how death occurred. As part of this process, coroners will often need written reports from those involved in the care of a deceased patient.

A good report aims to assist the coroner in answering the above questions, minimise the risk of the coroner asking for clarification, and reduce the possibility of having to attend the inquest. The report should be a detailed factual account, based on the medical records and knowledge of the deceased, avoiding medical jargon where possible. Most medical defence organisations' medico-legal advisers will review draft statements before submission.

Generally, when the Somerset coroner's office requests a report, they will give guidance as to what is required along with the medical cause of death. The coroner is generally looking for an overview of relevant past medical history along with any conditions or diagnoses that may have caused or contributed to death. For example, if an elderly person had fallen, sustained a fractured NOF and died of pneumonia, they would expect the GP to provide relevant information such as any diagnosis of osteoporosis that predisposed them to a significant injury, any episodes of dizziness (did they fall or collapse), the frequency of any previous falls and injuries sustained, any associated conditions such as frailty, COPD etc.

4. Certain medical causes of death risk rejection by the registrar and subsequent referral to the coroner and this may be avoided.

Certain medical causes of death risk rejection by the registrar and subsequent referral to the coroner. In some circumstances this is avoidable by, when appropriate, using alternative terminology. Examples include causes that, without the word "spontaneous" preceding it, could be interpreted as unnatural, such as "subarachnoid haemorrhage" or "gastrointestinal haemorrhage." Terms such as "septic shock" will trigger a referral to the coroner whereas "sepsis of unknown

aetiology" will usually not. Check your proposed cause of death with Cause of death list produced by the Royal College of Pathologist (used by registrars) or contact the ME team if in doubt.

5. Frailty of old age requires supporting information if being referred to the coroner

If "Frailty of Old Age" or "Old Age" is being offered as 1a on the MCCD and the case is being referred to the coroner, the coroner will require this to be supported in the EDRF by a history of decline (whether acute or chronic), with supporting information such as:

- A frailty index score
- Evidence of limited mobility (i.e. bedbound) including the duration in this state
- Evidence the patient had been refusing food and/or drink during the final illness

This risk inherent in this cause of death is that it cannot be evidenced by anything other than a birth certificate; there are no biopsy results, scans, or blood tests to back up such as cause in the same way that there would be for other medical conditions. The coroner needs to be satisfied that the cause of "Frailty of Old Age" is supported and genuinely believed by the attending doctor to have caused the death on the balance of probabilities. There have been concerns in other jurisdictions that GPs have been pressured by families into offering this cause in order to avoid a post-mortem and circumvent the legal duties of the coroner. It is fundamentally important as a matter of public health that the correct and accurate medical cause of death is recorded, not just any cause.

Dr Robert Weaver
GP & Medical Examiner
September 2022

Useful links:

Guidance for registered medical practitioners on the Notification of Deaths Regulations

https://www.themdu.com/guidance-and-advice/guides/writing-a-report-for-the-coroner

https://www.cps.gov.uk/legal-guidance/coroners

G199-Cause-of-death-list.pdf (rcpath.org)