



CHIEF CORONER

MEDICAL EXAMINERS

CHIEF CORONER'S RESPONSE TO CONSULTATION

Introduction

1. This is the Chief Coroner's response to the consultation exercise launched by the Department of Health (DH) on 10 March 2016, *Consultation on the introduction of medical examiners and reforms to death certification in England and Wales*.
2. The Chief Coroner would be happy to discuss any of the issues raised in this response.
3. The Chief Coroner welcomes the proposed implementation of the Medical Examiner (ME) system.¹ It should supplement and complement the work of the coroner service. It should provide, with the coroner service, a more complete and independent system of death investigation in England and Wales. It should achieve more accurate medical certificates of the cause of death (MCCDs). It should ensure more appropriate referrals (reports) of deaths to the coroner. It should also produce more accurate data about the causes of death, particularly in hospitals. These are admirable objectives.

Advantages

4. The introduction of a ME system should benefit the work of coroners. In general, it should provide greater scrutiny of all deaths, particularly at an early stage. Deaths from natural causes should be more readily identified and registered more quickly. Cases which should be reported to the coroner, and which in the past may have gone unreported, will also be more readily recognised. This should provide a more complete death investigation service, combining good medical knowledge with good investigative skills. It should benefit both bereaved families, who will have the opportunity to raise concerns at an earlier stage, and the wider public, who will have greater confidence in death investigation.
5. The coroner service should benefit specifically in three ways.

¹ Chapter 2 of the Coroners and Justice Act 2009.

Reduction in referrals

6. First, there should be fewer inappropriate referrals to coroners from medical practitioners, both GPs and hospital doctors. The reduction in referrals to coroners should be achieved by Medical Examiners (MEs) being able to advise doctors on the medical cause of death. This should reduce the number of cases referred to coroners which in due course are signed off by coroners to the registrar as natural causes deaths which require no formal investigation.
7. In 2015, there were 529,613 deaths in England and Wales. 236,406 of them were referred (reported) to coroners by doctors, although only 32,857 deaths went to inquest. This figure suggests that too many deaths are reported to coroners unnecessarily. The vast majority of the 236,400 deaths, more than 85%, were therefore sent by coroners (with or without a post-mortem examination) for registration as deaths from natural causes without a formal coroner investigation and inquest.
8. It is therefore believed that the availability of MEs to advise doctors on the cause of death should reduce the number of cases which are referred to coroners unnecessarily.

Statutory criteria for referrals

9. Secondly, the ME scheme is likely to bring with it statutory criteria for doctors on when to report a case to the coroner. At present, in the absence of criteria, there is some inevitable uncertainty. The notes for doctors attached to the MCCD state under the heading *When to Refer to the Coroner*: 'There is no statutory duty to report any death to a coroner.' The notes can therefore do no more than encourage doctors to adopt the criteria for registrars and report any death which would be referred to the coroner by the registrar of births and deaths.
10. This is a lacuna in the law. Doctors need clear statutory guidance for reporting deaths to the coroner.² This is now proposed in the draft ME Regulations, namely the Death Certification Regulations XXXX. This is welcome. It would provide the framework for MEs advising doctors about referral to the coroner. It would form the basis for better education and training for doctors and regular discussion with the local coroners about the criteria for reporting deaths. With training, education and advice, doctors should develop greater confidence and accuracy about death certification, registration and referrals.
11. If for any reason the Regulations above were not implemented, it would be imperative to introduce other statutory criteria. Some other countries provide detailed criteria for reporting, for example in the New Zealand Coroners Act 2006 and the State of Victoria Coroners Act 2008. In England and Wales Parliament has envisaged that the Lord Chancellor could make regulations 'requiring a registered medical practitioner, in prescribed cases or circumstances, to notify a senior coroner of a death of which the practitioner is aware'.³ This task should be completed as soon as possible.
12. Statutory criteria would also prevent local coroners from deciding and directing doctors what types of case to refer. There is inconsistency of practice amongst

² Report of the Inquiry into the Mid-Staffordshire NHS Foundation Trust by Sir Robert Francis, recommendation 277.

³ Coroners and Justice Act 2009, section 18 (not yet in force).

coroners.⁴ Some coroners request doctors to report, for example, all still births and all child deaths. There is no legal basis for this approach and a neighbouring coroner area may have no such policy. This is confusing for doctors who travel and work in different parts of the country. It is a matter for Parliament in regulations to decide what types of death should be referred.

13. Doctors should make these referrals to coroners electronically, not orally, by email or other means, such as a web-based solution. The Chief Coroner is devising a recommended standard reporting form.

Medical advice for the coroner

14. Thirdly, the presence of a local ME should make medical advice more freely available to the coroner. Most coroners have no medical qualifications. Since 2013, coroners are required only to have the judicial eligibility appointment of five years' legal qualification and practice. No medical qualification or experience is necessary. Some coroners will have medical knowledge. They may for example have been solicitors practising in medical negligence cases. But some coroners will not have that experience. They have to learn the medical side of things through training and on the job.
15. In Northern Ireland the coroner's office has the benefit of a medical practitioner employed in-house. This person has advised coroners on medical issues. As a result, it is believed, the post-mortem rate has reduced substantially. Any significant reduction in the post-mortem rate in England and Wales would be welcome. It would represent a considerable saving of distress for families as well as a saving of money.
16. Coroners in England and Wales do not have the luxury of in-house medical practitioners, although some senior coroners use the services of assistant coroners who are doctors (appointed before 2013). As a result, the post-mortem rate across England and Wales is very variable. It ranges from 20% to 62%. That level of inconsistency is unacceptable.
17. Accordingly, the benefit of a local ME to advise the coroner should be of considerable advantage. It should reduce the number of post-mortems.
18. These three advantages are therefore to be welcomed.
19. The Francis Report made a number of recommendations about coroners and inquests.⁵ The majority of them concern the benefit of the introduction and application of MEs. The other coroner recommendations have been followed and implemented.
20. In addition, the Chief Coroner welcomes the Law Commission's recommendation that those who die while subject to a Deprivation of Liberty Safeguard (DoLS) authorisation should be scrutinised by MEs and not subject to coroner investigation *per se* unless there is a specific reason for referral to the coroner.⁶

⁴ There are 88 senior coroners in England and Wales.

⁵ Recommendations 273-285. See note 2.

⁶ The Chief Coroner has argued elsewhere that coroners should not have to deal with DoLS cases at all, particularly where the death is from natural causes and the family has expressed no concerns.

Concerns

21. Nevertheless, despite these advantages, the Chief Coroner has a number of concerns about the implementation of the ME scheme and its impact upon coroner services.
22. Although the advantages of fewer unnecessary referrals to coroners, of statutory criteria for reporting deaths and of medical advice available for coroners are to be welcomed, the Chief Coroner has concerns on the likely increase in the workload of coroners without additional resources.
23. It is generally believed that there will be an increase in the number of cases referred to the coroner which will proceed to inquest. It is also expected that many of these cases will be more difficult and more complex medical cases.
24. How great the increase in inquests will be is undoubtedly uncertain. None of the pilot schemes have been complete. The Sheffield scheme, for example, which has been the most developed pilot has not dealt with community deaths.
25. Nevertheless, the figures from Sheffield are troubling. Sheffield has faced an increase in inquest work of some 35%. This is a very significant increase. It has only been managed in Sheffield thanks to an excellent coroner, an excellent Medical Examiner and an understanding local authority.
26. Some coroner areas in England and Wales could not, however, readily take the burden of such an increase. Even a smaller increase of 25% in inquests would impose an intolerable burden for many areas⁷. Many coroner areas have been neglected for years if not decades in the provision of resources. They have a very modest number of coroners' officers to investigate and prepare cases for the coroner, and very few administrative staff to support them. Local authorities are, of course, currently seeking extensive reductions in spending, as too are police authorities. Most coroners' officers are employed by the police.
27. An increase in inquest work of this sort of proportion will not be funded by central Government. There may be insufficient funding from local Government. Coroners' work is stressful work. It is particularly stressful for coroners' officers who are constantly dealing with death and grieving families who usually want as little to do with the coroner service as possible. Coroners' officers have reported significant levels of stress when giving feedback to the Judicial College, the organisation which trains all coroners and coroners' officers.
28. From the Chief Coroner's point of view, coroners and their staff must be protected from extra and intolerable burdens of work. The Department of Health (DH) does not appear to recognise the existence of these impending burdens and how they will be resourced. It would be wrong to ignore this. There is no point in developing one part of a death investigation service to the detriment of another part. That will not achieve success. Coroners and local authorities are sceptical of the value of a DH review of the financial impact upon coroners' services 18 months after implementation and whether it would be likely to produce support funding in the event of increased coroner work. Even if it did, it would mean greatly stretched

⁷ The Francis Inquiry found that an audit of practice in the Mid-Staffordshire NHS Trust concluded that 27% of deaths that were certified as due to natural causes should have been referred to the coroner but were not.

and under-resourced coroner services for at least two years after implementation of the ME scheme.

29. In addition there will be other costs which may impact upon the coroner service. MEs or their officers may have to find accommodation in coroners' offices, some of which are extremely limited.
30. These concerns are in addition to some basic concerns about payment for the ME scheme. Who will pay for the service? How much will they pay? Who will collect payment? What will happen in the event of default of payment?
31. It seems clear that bereaved families will be burdened with this payment even if they have not obviously benefited from the scheme. The suggested DH figure of £80-£100 is not considered to be sufficient. Local authorities who have spoken to the Chief Coroner have struggled to arrive at a minimum figure of £150. Funeral directors seem reluctant to collect payment off bereaved families in mourning. In default of payment local authorities will probably foot the bill.
32. Other concerns centre around the independence and quality of MEs. Will they be, and be seen to be, sufficiently independent of those they are scrutinising?⁸ If they are (or were) hospital doctors, will they be sufficiently independent of their colleagues and former colleagues and of the hospital trusts in England and health boards in Wales? They must be independent in their appointment and in the execution of their functions.
33. Will they be of sufficient quality? Are there enough doctors or recently retired doctors at consultant level to provide this service?⁹ Will they be sufficiently accredited in this specialist field?
34. Finally, the Chief Coroner raises the issue of possible delays. Increased coroner workloads without extra resources may lead to delays, both in releasing bodies and in concluding inquests. The ME service could also add delay by introducing an extra layer of investigation. And if MEs are part-time appointments will they be sufficiently available for early release of the body for burial or cremation? This issue is particularly acute for faith communities, such as Muslim and Jewish, who seek very early burial. Will MEs be available to make relevant decisions out of hours, at weekends and on bank holidays?
35. These are not trivial issues. A public service of death investigation which is not understood and valued by the public, particularly those required to pay, and where lack of planned resources could lead to delays in releasing bodies and completing inquests, will not flourish. If local authorities have to face increased costs, coroners' services will undoubtedly suffer as a result.

A proposal

36. The Chief Coroner respectfully submits that the concerns set out above are real concerns with practical consequences. There must be clear resolution of all of them before full implementation of the ME scheme.
37. One possible way forward would be to introduce in advance of full implementation further pilot schemes which are fully operational. At present none of the pilot

⁸ Francis Report recommendation 275.

⁹ Francis Report recommendation 276.

schemes covers all deaths in the locality. None of the pilots operates on a payment and collection of fee basis. The financial side has simply not been tested.

38. One possible way forward, it is therefore suggested, would be to develop three fully-fledged pilots in three different types of area: urban, rural and mixed.

**HH JUDGE PETER THORNTON QC
CHIEF CORONER**

15 June 2016