Cabinet

15 June 2016

Medical Examiners Service

Report of Corporate Management Team

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Purpose of the Report

1 To advise Cabinet of the consultation to reform the process of death certification in England and Wales and to propose next steps for the establishment of a medical examiners service.

Background

2 On 10 March 2016, the Government launched a consultation on proposals to reform the process of death certification. This was a consultation expected at various times under the Coalition Government administration and was to involve principal authorities taking responsibility for the establishment of a medical examiners service which was to be entirely funded by payments by users of that service.

3 The stated aims of the consultation are to strengthen the safeguards to the public, make the process simpler for the bereaved and improve the quality of certification and data about the causes of death. A significant influence in the proposed changes is the 'Shipman Enquiry' (2003), which in its third report, was critical of the arrangements for scrutinising medical certificates for the cause of death (MCCDs). The recommendations of the report were accepted by the Government of the day, and there have been a number of pilots in the Country testing new unified systems of certification and independent scrutiny of all deaths.

4 Another influence behind these reforms is the 'Francis Enquiry' Report published in February 2013, which made observations about certification and inquests involving hospital deaths. One of the principal observations was "*it is of considerable importance that independent medical examiners are independent of the organisation whose patients' deaths are being scrutinised".*

The Aims of the Reforms

5 The consultation states that the proposed new medical examiner system will benefit the public, the health service and local authorities in a number of significant ways:-

- **It will be fair** - all deaths will be scrutinised in a robust and proportionate way, regardless of whether they are followed by burial or cremation;
- **It will be independent** - a medical examiner will scrutinise all medical certificates of cause of death (MCCD) prepared by the attending doctor;
- **It will be transparent** - families will have the cause of death explained to them, including clarification of medical terms, and be able to ask questions or raise concerns;
- **It will be robust** – there will be a protocol that recognises different levels of risk depending on the circumstances and stated cause of death;
- **It will be accurate** - the medical examiner will be an experienced doctor, capable of ensuring that the MCCD is completed fully and accurately, providing the NHS, the Office for National Statistics, local authorities and a wide range of other users with better quality cause of death statistics, to inform health policy, the planning and evaluation of health services and international comparisons;
- **It will be efficient** - it will help to make sure that the right cases are reported to coroners; and
- **It will improve safety** – the new system will allow easier identification of trends, unusual patterns and local clinical governance issues and make malpractice easier to detect.

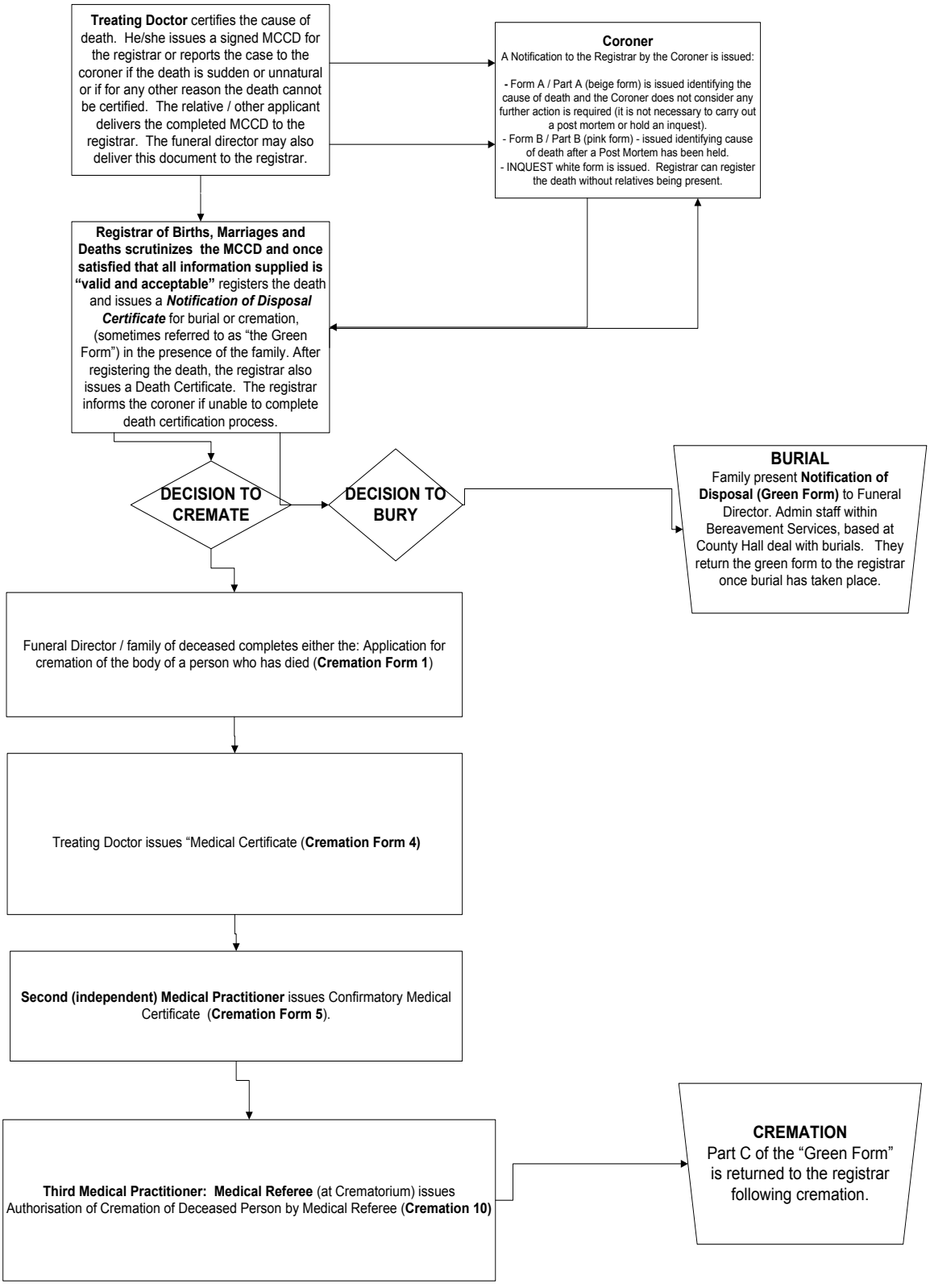
The Legal Basis for the Reforms

6 This is set out in Chapter 2 of Part 1 of the Coroners and Justice Act 2009, which has yet to enter into force. When in force, section 19 of the 2009 Act, as amended by the Health and Social Care Act 2012, will require medical examiners to be appointed and monitored by upper tier and unitary local authorities in England and by Local Health Boards in Wales. In addition, section 20 of the 2009 Act will enable regulations to be made setting out the procedures and requirements for the preparation, scrutiny and certification of MCCDs. Section 21 of that Act will also enable regulations to be made setting out the functions of the National Medical Examiner.

The Current System in County Durham

7 Figure 1 below maps out the current process:

Figure 1: Current Death Certification Process



Certifying a Death

8 As highlighted in the Shipman Inquiry (2003), there remains no single agency or authority with primary responsibility for responding to the cause of death, and there is no general obligation to report a death to the police, unless it appears that the death was a result of a criminal act or resulted from a road traffic accident, or accident at work. There is also no legal requirement for a doctor to confirm the fact that life is extinct. If there is no medical practitioner willing and able to issue a MCCD, however, the death must be reported to the coroner.

There are also entirely separate processes followed for burial and cremation as shown in figure 1.

Once a death has been registered and a disposal certificate issued by the registrar, burial can take place without any further check or formality. If any suspicion arises in the future that a death was caused by an unlawful act, the body can be exhumed for forensic examination.

Before a cremation can take place, three different cremation forms must be completed by medical practitioners who are paid for providing this service. The fees are usually collected by funeral directors on their behalf and the total fees paid are in the region of £184.00.

The process for arranging for disposal of the body

9 Usually on Form 100A.

Summary of the Proposals for a Medical Examiners Service

10 Under the new system, in the case of deaths that do not require coroner investigation, the cause of death will need to be confirmed by a medical examiner before a medical certificate of cause of death is issued.

11 Where the deceased is cremated, the scrutiny provided by medical examiners will replace the current arrangements for the completion of cremation forms (forms 4, 5 and 10).

12 When someone dies, and the death is apparently natural, a doctor who attended the person in the previous days will be required to prepare a medical certificate of cause of death (MCCD). If this doctor decides that the death needs to be notified to a coroner, or if the doctor is unable to establish the cause of death, he or she will contact the coroner's office. Medical examiners will be able to provide advice to a doctor in preparing an MCCD.

13 Where a death is not notified to a coroner, or it is notified but the coroner decides that it does not need to be investigated, the doctor will prepare a MCCD and provide a copy to the medical examiner together with the relevant medical records and other information.

14 The medical examiner will scrutinise the deceased person's medical records and may choose to carry out a thorough (non-forensic) external examination of the body (or arrange for it to be carried out by someone else), to determine whether or not he or she agrees with the cause of death that the attending doctor certified.

15 If the medical examiner disagrees with what the attending doctor has written on the MCCD, there will be a discussion and the medical examiner will either invite the doctor to prepare a new MCCD, or conclude that the death needs to be referred to a coroner. If the medical examiner otherwise believes that the death needs to be notified to a coroner, the medical examiner must do so in accordance with regulations made under section 18 of the Act.

16 After scrutinising the deceased person's medical records and the results of any external examination, the medical examiner (or an officer acting on his or her behalf), will speak with a member of the bereaved family (or a prospective informant where there is no family member), usually by telephone, to discuss the cause of death with them and to offer them the opportunity to raise any concerns they may have. If concerns are raised, the medical examiner will usually discuss them with the attending doctor and then, if necessary, refer the death to a coroner. If, as a result of the discussion, the death is not subsequently referred to a coroner, the person with whom the death is discussed will be asked to sign a form confirming the discussion. This can be done prior to, or at the same time, that the 'informant' provides the MCCD to the local registrar of births, deaths and marriages. The 'informant' may also sign this form, even where the informant wasn't a party to the discussion providing he or she is aware that it has been held. The informant is the person who informs the local registrar of births, deaths and marriages that the death has occurred and gives the information for the registration. This process will ensure it has been confirmed to the registrar that the death has been discussed and that no concerns were raised that might require the death to be investigated by a coroner.

17 If at the end of the process the death does not need to be investigated by a coroner and an agreed MCCD has been seen and checked by the medical examiner, the medical examiner will sign a Notification of Confirmed Cause of Death as soon as practicable, and on the same day arrange for a copy to be sent to the registrar for the district where the death occurred. A copy will also be sent to the attending doctor (or the ward staff, practice staff or bereavement service acting on the doctor's behalf). The medical examiner pilots suggest that copies should be transmitted electronically to avoid delays.

18 Within two days of receiving that notification, the original MCCD must be finalised and issued to a person who intends to be the informant in registering the death. When the confirmed MCCD is given to a registrar and matched to the notification provided by the medical examiner, it can be used to register the death unless, in exceptional circumstances, the informant provides new information to the registrar that suggests the confirmed cause of death may

be incorrect or the death may be unnatural. In these exceptional cases, the registrar will speak with a medical examiner's officer first and if necessary, invite the attending practitioner to prepare a new MCCD. There might be other reasons where the registrar might first need to contact the medical examiner's office, for example, the informant refuses to sign part B of the ME-2 form which confirms that a conversation about the cause of death between a member of the bereaved family and the medical examiner had taken place.

Timescales for completing the Certification Process

19 The consultation document states that pilot sites that have tested the new system have found that the process from the medical examiner being notified of a death to the provision of a copy of the statutory notification confirming a cause of death - can usually be completed within one working day, and that in many cases this time can be absorbed within the one to two days taken for a MCCD to be prepared and issued in the existing process. Where additional time is required, the experience of the pilot sites is that this need not cause unnecessary distress to the bereaved if there is a shared understanding of when the MCCD will be available, and if there are local procedures for prioritising the process, without any loss of safeguards, in cases where there is a need for urgent certification.

20 The feedback from the pilot sites is that the demand for urgent certification is manageable within the new process, and that in areas where it is a significant requirement, it can be met by arranging for medical examiners to be available for extended hours during the week and for specified periods during the weekend and on bank holidays.

The Medical Examiners Service

21 Medical examiners must be medical practitioners with at least five years full registration with the General Medical Council, and licensed to practice. They must complete prescribed training and meet the skills and competencies essential for the role set out in a specification drawn up by the National Task Team on Medical Examiners which will be produced in guidance to be provided to Local authorities.

22 Under the Coroners and Justice Act 2009, each local authority is required to appoint enough medical examiners and make available funds and resources to enable those functions to be discharged in the area. Medical Examiners may be contracted on a full or part time basis.

23 The Government has indicated in its consultation document that it expects that many examiners will provide two or three sessions or programmed activities a week alongside their existing work in senior medical or GP roles, meaning that the typical configuration of a typical medical examiner service will involve a small team of medical examiners working on a rotational basis, but not in isolation from each other. The draft regulations provide for participating in peer reviews and self-audits. Medical examiners will also be

subject to revalidation of their licenses and to be part of published performance standards.

24 The consultation document does not prescribe the remuneration of the medical examiner, but guidance will advise that it should be at a level to attract suitable candidates, and the Governments impact assessment is based upon the mid-point of a consultant's salary range.

25 Prior to the plans for a medical examiner service being postponed prior to the last general election in May 2015, a small team comprising the Head of Legal and Democratic Services, a representative from Public Health (Dr Mike Lavender), and a Project Officer from ACE, carried out an information gathering exercise on current processes and a project brief was put together which produced an estimated cost for a medical examiners service. It drew on the experience of pilots in Sheffield and Brighton which indicated revenue costs per annum of around £550,000. This comprises staffing and training costs but excludes accommodation, ICT or other overhead costs. Estimated net staffing and training costs for County Durham are referred to in appendix 2.

An estimate from figures compiled by the registration service for 2015/16 (still to be verified by the GRO), the medical examiner would have had to have dealt with approximately 3,300 deaths.

The coroner was involved either where a post mortem had been carried out or where inquest were held with approximately another 800 deaths.

26 Appendix 2 also contains an analysis of the predicted shortfall to the council based on the charging rates suggested in the consultation, where the maximum fee chargeable is £100. It also incorporates an estimate of the cost which increased referrals to the coroner requiring investigation will have on the coroner's service, the costs of which are met by this council.

The Government has indicated that the Medical Examiner's Service should be self-funding and there are no indications that new burdens funding is available to meet shortfalls within the council's budgets. The shortfall, which it is estimated will range from circa £100,000 to circa £166,000, would be a pressure in the MTFP that would have to be met corporately.

The Effect of the Intended New Arrangements on Coroner and Local Authority Services

27 The consultation document highlighted the effects as predicted on the Government on all professional agencies involved in the bereavement process. Of particular relevance to councils are the predicted impacts upon the Coroner (funded by the council), registrars and crematoria services.

Coroners Service

28 The consultation document advises that the pilots suggest that the new process will reduce the number of deaths reported to the coroner, but increase the number that require investigation because more cases are referred appropriately. This is likely to increase the costs of the coroner's service, and the consultation document suggests that this is an issue which will be kept under review as the reforms progress.

Registrars Service

29 At present, registrars act as a safety net because there is no system for the scrutiny of MCCDs, other than where a death has been referred to the coroner. In future, registrars will not be required to fulfil this role. The General Register Office intends to remove the duty on registrars under Regulation 41 of the Registration of Births and Deaths Regulations 1987, to refer certain deaths to the coroner. Instead, if an informant raises any concerns about the cause of death at the time of registration, the registrar will discuss that with the medical examiner that scrutinised the death (or, in practice, with the medical examiner's office) and, if necessary, invite the attending practitioner or medical examiner to prepare a fresh certificate to be issued.

Crematoria Services

30 In the new process, it is intended that crematoria will be able make the arrangements for a cremation on receipt of documents listed below, and will not require any review or confirmation by a medical referee.

- Application for Cremation (Cremation 1 form)
- Registrar's certificate for burial or cremation (Green Form) or Coroner's
- Certificate for cremation (Cremation 6 form)
- Information issued at the same time as the MCCD (or by or on behalf of the coroner) on the existence or removal of any implants or medical devices and on the transmission route and hazard group of any communicable infection.

Funding the Local Medical Examiners Service

31 The Coroners and Justice Act 2009 (as amended by the Health and Social Care Act 2012), provides for medical examiner services to be funded by a fee payable to a local authority in England, or local health board in Wales.

32 The Government's preferred option is that a single fee is paid by families irrespective of whether the death is followed by cremation or burial (excluding cases referred to the coroner). The consultation acknowledges that the fee needs to cover the cost of providing the service and concludes that there should not be a variation across local authorities. Using the pilots, suggestion

is made in the consultation document of a national fee in England of around £80 to £100. The consultation document highlights that in general, families paying for cremations are paying in the region of £184 for the cremation forms signed by medical practitioners. The proposed fee will represent an increased overhead for families choosing burial, but that same assurance about the circumstances surrounding death before burial, as for cremation, was preferred.

How Should Councils Collect the Fee?

33 The consultation considers the issue of collection of the fee. In the current system, the cremation form fees signed by medical practitioners are due to the doctors and funeral directors contract with doctors to collect them, and they appear as separate items on the funeral directors final account. The new medical examiner fee will be due to the Council and it is for the Council to decide upon its collection method.

34 The consultation discusses the possibility of councils letting contracts to work with funeral directors to collect the fee on their behalf and advises local authorities of the need to be sensitive to the bereaved and be mindful as to whether expecting immediate payment is appropriate. The consultation is currently proposing that families be allowed a period of three months to pay.

Next Steps

35 The document referred to in this report is a consultation on legislative changes and a number of issues covering the wide range of stakeholders involved in bereavement.

36 Officers will prepare responses where appropriate, but it does appear that this Council will need to prepare for and implement. This will require input from :-

- Finance
- ICT
- Bereavement Services
- Legal
- Registrars
- Public Health

and also seek input from the coroner.

37 A project team will be established to prepare proposals for the implementation of a medical examiners service from October 2017.

Recommendations and reasons

38 Cabinet is asked to:-

(a) Note the contents of this report and the consultation response at Appendix 3.

(b) Agree that further reports are presented to Cabinet on proposals for implementing a medical examiners service in due course.

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Appendix 1: Implications

Finance – The introduction of a new medical examiners service would not be self-funding and there are no indications that new burdens funding will be available to meet these costs. The shortfall is estimated to be between £100,000 to £166,000, depending on the national fee that is subsequently set and would be a pressure in the MTFP that would have to be met corporately. The Council is of the view that this is a new burden and the Council has written to the LGA.

Staffing – An indicative structure is provided within the body of the report. The establishment of the service will require input from various areas of the Council. The Registrars and Bereavement Services will need to link with the new service: it will require a reliable ICT link with medical agencies; management oversight within the Council including Legal, Financial and Auditing and Facilities Management support.

Risk – There is a risk that the costs and demands upon the service and other parts of the Council (e.g. the Coroners Service), outstrip the income received from the charges. It is difficult to predict realistically predict the cost of the impact on coroners services at this this stage but appendix 2 contains an estimate of the likely financial impact.

Equality and Diversity / Public Sector Equality Duty – Any service would need to be complaint with equality legislation both in terms of the service to the public and the establishment and structure of the service itself. An equality impact assessment of any proposes service would need to be carried out in early course.

Accommodation – Accommodation for the service will be required.

Crime and Disorder – none specific in this report, although these recommendations partly arise from the fact that unlawful deaths went unidentified for prolonged periods due to failings in the process for certifying the cause of death. The process may therefore enable earlier detection of criminal activity.

Human Rights – None specific with this report.

Consultation – This report refers to the establishment of a service under a statutory obligation and is the subject of a consultation by the government which closes on 15 June 2016.

Procurement – None specific in this report, although the project may identify certain issues requiring procurement advice during the project.

Disability Issues – See equality and diversity above.

Legal Implications – Within the body of the report.

Appendix 2 - Medical Examiner Service - Planned Introduction in April 2018

		National			Durham @ £81 per case			Durham @ £100 per case		
Para	Heading	FTE	Cost per FTE £	Cost £	FTE	Cost per FTE £	Cost £	FTE	Cost per FTE £	Cost £
	Costs									
112/Annex A section 3	Number of Medical Examiners required	110	134,919	14,841,090	1.50	134,919	202,379	1.50	134,919	202,379
112/Annex A section 3	Number of Medical Examiners Officers required	234	42,993	10,060,362	2.50	42,993	107,483	2.50	42,993	107,483
112/Annex A section 3	Number of Other carrying out external examinations needed per death*	32	40,972	1,311,104	0.34	40,972	13,930	0.34	40,972	13,930
				26,212,556			323,791			323,791
124	Recruitment and Training			200,000			1,736			1,736
124	Printing/distribution of forms			310,000			2,690			2,690
124	Cost of scanning or transporting paper-based health records			140,000			1,215			1,215
124	Cost of collection - payments to Funeral Directors			2,080,000			18,052			18,052
124	Cost of collection - direct billing			930,000			8,071			8,071
124	Bad Debt Provision			800,000			6,943			6,943
	Total Costs			**30,672,556**			**362,499**			**362,499**
	Income									
106	Number of cases			380,239			3,300			3,300
91	Charge per case			81			81			100
	Total Income (number of cases x charge per case)			**30,672,556**			**266,200**			**330,000**
	Budget Shortfall			**0**			**96,299**			**32,499**

Annex A section 3	* Includes running cost overheads
108	** Mortuary Technicians and Funeral Director Staff in study

	Additional Coroner Costs	**8,000,000**	**69,430**	**69,430**

Durham County Council's Response to the Consultation on Policy and Draft Regulations "Introduction of Medical Examiners and Reforms to Death Certification in England and Wales"

Thank you for providing Durham County Council with the opportunity to respond to the Government's consultation in respect of the introduction of the Medical Examiners and Reforms to Death Certification in England and Wales. Please find below a combined response including the views of Durham County Council, the Public Health Team and the HM Coroner for County Durham.

Chapter 3: Funding local medical examiners' services in England, Questions 1-5:

Question No.	Question:	Response:
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. The local authority requires an identified source of funding to support the delivery of the new service
2.	**Should the person prescribed be the individual that collects the MCCD from the medical examiner, or the death registration informant?**	Yes. The person prescribed as being responsible to pay the medical examiner fee should be the person who collects the MCCD.
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.
4.	**Should there be a 28 day or 3-month period for payment of the medical examiner fee?**	We would suggest 28 days. At a time of austerity, councils will need to recover fees as quickly as possible and this would support the ability to use funeral services as a conduit to collection of the payment.
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**	n/a - but see answer to question 4 above

Chapter 4: Death certification regulations, Questions 6-12:

Answers to this section have been provided on behalf of the County Durham Public Health team.

Question No.	Question:	Response:
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?**	We would suggest that "ethnicity" be added. This would be useful in investigations of death and for understanding any bias in cases examined. Also the last date that the resident was at last known address and 'homeless' should be added as options.
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
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, but this is dependent on the particular training required and given. Additionally, there should be a clear pathway for obtaining advice / second opinion from more senior staff with a medical degree.
9.	**Under regulation 26, do you agree that the medical examiner process should be suspended during a period of emergency?**	Yes. We believe that there should be discretion to suspend the process in extreme cases.
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?**	No. We do not agree. We believe that this would be inappropriate. An emergency with perhaps a high mortality rate could allow the opportunity for cause of death to be hidden. The only obvious additional impact of an emergency would be additional morgue time/storage. This would seem to be acceptable, especially when one considers that such capacity will already be included within many emergency plans.
11.	**Are the proposed certificates and medical examiner forms set out in schedules 2- 7 fit for purpose? If not, please say why.**	With reference to: - Schedule 2 – 'Attending Practitioner's Certificate - Other Cases' (assuming this is 'Medical Certificate of Cause of Death') add ethnicity. - Schedule 3 – 'Attending Practitioner's Certificate - Live-Born Child Dying within the First Twenty-Eight Days of Life': add

Question No.	Question:	Response:
		ethnicity and names of parents. - Schedule 4 – 'Medical Examiner's Notification of Confirmed Cause of Death': add ethnicity. - Schedule 5 – 'Medical Examiner's Certificate – Other Cases': add ethnicity. - Schedule 6 – 'Medical Examiner's Certificate – Live-born Child Dying within the First Twenty-Eight Days of Life' (assuming this is the form called medical certificate of cause of death of a live-born child dying within the first twenty-eight days of life): add ethnicity and parents' names. - Schedule 7 – 'Medical Examiner's Notification of Certified Cause of Death': add gender and ethnicity.
12	**In relation to regulation 5 of the NME regulations, what other aspects should standards cover for monitoring medical examiners' levels of performance**?	- Personal standards related to maintenance of GMC membership. - Number of cases investigated per year. - Number of cases seen but not investigated per year. - Proportion of times where cases investigated where Medical Examiners conclusions did not meet Coroner's initial findings.
13	**There is no question 13.**	There is no question 13.

Chapter 5: Notification of deaths to Coroners' regulations, Questions 14-25

In order to provide a holistic response to the consultation, the answers to questions 14-25 have been provided by the HM Coroner for County Durham.

Question No.	Question:	Response:
14.	**Do you agree that a death should be notifiable if it is "otherwise unnatural"?**	Yes. The interpretation of "otherwise unnatural" is not easy as a death could appear to have a natural medical cause but the condition could have been caused by an unnatural event earlier in the deceased's life. The coroner will have a wider, more probing perspective whereas the medical interpretation may be more restricted, so it is important that "otherwise unnatural" deaths should be notifiable.
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.**	No. There isn't sufficient understanding and commonality of approach between members of the medical and coronial professions on the meaning of "unnatural". The medics and coroner may interpret a cause of death in a different way with the medical practitioner having a more restricted interpretation and coroner a wider and more legalistic view. It is important not to be too prescriptive so cases can be considered based upon the merits of the information available.
16.	**Do you agree that provision needs to be made with regard to poisoning, given that cases of poisoning are rare?**	Yes. It is important that provision for poisoning is included to ensure doctors remain alert to the possibility. To ensure medical staff are alerted to a possible case without delay a specific pathway should be considered in 5.5 to enable automatic referral and faster process as some poisons can present health risks during investigation.
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?**	We would recommend the word "toxic" is removed as a chemical does not necessarily need to be toxic to kill. Including "toxic" narrows the description and is too prescriptive.
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?**	No. There is not sufficient understanding of the word neglect and this will mean something significantly different to a member of the public as opposed to a coroner. There is a high risk of confusion. It

Question No.	Question:	Response:
		therefore needs to be made clear and either a new word used entirely or it should be made completely clear what neglect is. Sir Thomas Bingham in the case of Jamieson provides a detailed definition.
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, regulation is clear that it is only in relation to the deceased and no other members of the family even though other members may experience some exposure.
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?**	No, notifications should always be in writing and notifications by junior doctors should be always be counter-signed by a consultant. Modern technology e.g. text and e-mail is fast and ensures the information is properly communicated and less open to change at a later date. The need for oral communication is therefore negated.
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.**	An assumption, even a reasonable assumption or belief can still lead to confusion, **i.e. does Regulation 3 apply or not.**
22.	**Do you have any other comments about the draft Regulations?**	Clarity is needed over what is a "Notifiable Accident" (referred to in regulation 3.2 and referenced to Section 7.4 of the Coroners and Justice Act 2009).
23.	**In relation to the guidance, do you agree with the examples used under each category of death? If not, we should be grateful for further examples or suggestions for definitions.**	Further examples and suggestions for definitions: - Re. Paragraph 4 (Guidance para 6) – legal highs. Query over what is the test for causation or contribution. The complication may not have been known at the time but now might be. - Para 9 - excessive drinking can cause problems with the

Question No.	Question:	Response:
		liver which may be classed as a natural death but excessive drinking may lead to an acute and sudden death which would normally be reportable to and considered by the coroner, which might result in a conclusion of alcohol related or accidental death, misadventure or even suicide. These could be considered as lifestyle choices? - Para 10 - a home owner may have erected scaffolding and be undertaking work at his own home, which is not employment. "Work" is an imprecise word. Have previously mentioned that Section 7.4 of the Coroners and Justice Act 2009 is imprecise. - Para's 14 and 15 - are self-contradictory by use of expressions such as neglect, failure of care and culpable human failure. These terms will provide confusion and possibility of litigation. - Para 17 - what of voluntary patients as opposed to detained patients that are resident in a mental health hospital or similar.
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. Don't need to put anything in because it's in primary legislation.
25.	**Do you have any other comments about the guidance?**	No. However, major concern that it will not be possible for the new system to be self-funding resulting in a substantial shortfall that in these times of austerity the authority will not be able to afford to cover.

Chapter 6: Cremation Regulations, Questions 26-28

Question No.	Question:	Response:
26	**After the changes are brought in, there will be no provision for medical examiners to be involved in the certification of the cremation of body parts. Do you agree that the requirement to complete a statutory application form and provide a registration document and a certificate from the hospital trust or other authority holding the body parts will provide sufficient scrutiny prior to the cremation of body parts? If not, what further scrutiny do you think would be needed, in the absence of medical referees?**	Yes, we agree with this requirement.
27	**Do you agree that this proposal will provide a sufficient level of scrutiny in stillbirth cases? If not, what further scrutiny do you think would be needed, in the absence of medical referees?**	Yes. We agree that this proposal will provide a sufficient level of scrutiny in stillbirth cases.
28	**Do you agree that investigation and clearance for cremation by a coroner provides sufficient assurance for cremation to take place without a further check by a medical referee based at the crematorium? If not, what further scrutiny do you think would be needed, in the absence of medical referees?**	Yes. We agree that investigation and clearance for cremation by a coroner provides sufficient assurance for cremation to take place without a further check by a medical referee based at the crematorium.

Further Comments of Durham County Council:

Durham County Council wish to state in clear terms that the current proposal to limit the amount that can be charged to the prescribed person in relation to issue of death certification will result in significant deficits to the Council's budget.

Even if the maximum proposed fee was to be used, the Council stands to suffer a further significant impact in financing the HM Coroner service as the pilots have shown that referrals to the coroner for investigation will increase. It is therefore suggested that new burdens funding is made available or that councils be allowed to charge on a full cost recovery basis.