Death Certification

The Luce Report

Death certification and investigation in England, Wales and Northern Ireland. The Report of a Fundamental Review 2003
(www.official-documents.co.uk/document/cm58/5831/5831.htm)

Following extensive consultation, they recently reported, and found that the current system was 'not fit for purpose', and made 123 recommendations for change.

They noted that the current system remained essential unchanged from that set up by the Coroners Act 1887, with more recent consolidation by the Coroners Act 1988.

Both the death certification and Coroner's systems have recently come under intense scrutiny, particularly following the activities of the Greater Manchester GP Harold Shipman, who was convicted of the murder of 15 patients, although the Shipman Inquiry has found him to have killed 200. Of these only 2 were were reported to the local Coroner, whose investigations have been criticised by Dame Janet Smith at the Inquiry.

Of particular interest to pathologists is the comment that the number of autopsies carried out on behalf of the Coroner (23% of deaths referred to Coroners in England and Wales) was far greater than in other countries (11% in Canada, for example), and there was great variation within the country (Wirral 32.5% and Lowestoft 97.5%).

The Luce Report identified the following weaknesses with the current system;

- Fragmentation
    - Local Authorities appoint
    - Home Office oversee
    - Lord Chancellor's Department (now Department for Constitutional Affairs) & Lord Chancellor discipline

- Death certification and the coroner's system are separate, not interlinked
- There is no concern with patterns or trends
- Coroners have no responsibility for deaths not reported to them
- There is a lack of supervisory structures
- No formal links with public health services and systems
- Isolated from the mainstream of medicine (coroners and pathologists)
- Lack of participation for bereaved relatives and families
- No systematic response to minority community wishes
- Lack of medical skills to supervise death certification process
- Lack of sustained and consistent training (coroners and officers)
- Most coroners are part-time and are lawyers – there is no leadership
- Lack of resources
    - Funding for services
    - Premises
    - Staff
    - Court rooms

- No mechanisms to encourage adaptation and development
- No agreed objectives and priorities

Luce Report Recommendations

Reporting deaths to coroners

- Report all deaths
- Coronial Council to issue statutory guidance

Most reports to be made by the doctors providing care during the final illness or by police who attend the scene of a sudden death;

- A range of other persons also to have a power to report deaths, including health care personnel and members of care inspectorates, etc.
- Families with concerns to have the ability to report a death to a coroner
- Doctors to tell families promptly when a death has been reported

Death Certification Support & Supervision

- New primary legislation required
- Provide support for doctors in death certification
- Audit the death certification process
- There should be linkages between death certification and investigation
- Create a new post of **Statutory Medical Assessor** in each coroner area
- The SMAs will work alongside the coroner (and assist in deciding which deaths should require autopsies)
- SMAs to be employed by NHS Strategic Authority and seconded to coroners
- GMC and medical royal colleges to acknowledge importance of death certification in the initial training and CPD of medical students and doctors

Verifying and certifying deaths

- All deaths to be subject to professional verification of the **fact** of death
- **Fact** of death verifiable by doctors or 'other suitably qualified persons'
- Bodies to be viewed before verification
- The present cremation system should be abolished
- All deaths not reported to coroners to be subject to the same certification process, whether burials or cremations

- Death certification requires **two medical signatories**, not one

Statutory Medical Assessor (SMA)

- SMAs in each area to appoint a panel of doctors for community 2nd certifications
- No general requirement that all bodies should be viewed by the certifying doctor before certification
- Deaths in hospital – same 2-stage certification but SMA to appoint and support doctors to perform second certification
- All certifiers to be registered medical practitioners
- Second certifiers in hospitals to be of consultant status
- Authorisation for disposal to be given by second certifier, at the time of certification; "no need to wait on the process of registration"
- Deaths in general practice –doctor looking after patient to act as first certifier
- Max. interval between death and preceding medical attendance to be 28 days
- First certifier to inform family representative of the death

Death investigation issues

- New coroners to have legal qualification and experience
- There should be a duty to comply with statutory guidance
- Must comply with guidance from Coronial Council
- Statutory powers should be given to coroners
- Families should have more rights – e.g. to meet investigator.
- Scope of investigations of death defined
- Inquests should only be public hearings in limited circumstances
- Inquests should, otherwise, be private
- Juries should be retained for some special cases

Handling of inquests

- There should be about 60 new coroner areas
- Coroners to be full time appointments
- There should be regional co-ordinating coroners
- Some complex cases should be heard by more senior judiciary (Circuit or *puisne*)
- There should be a Rules Committee to establish detailed rules
- There should be a trend towards specialism – coroners specialising in, e.g., work-place deaths; major disasters, etc.

Response to families

- There should be an improved response to families
- Audit timings of responses
- Inform families about post-mortems, viewings, etc.
- Issue a Family Charter

Science and pathology

- Coroners Council to issue guidance on autopsy arrangements
- Achieve consistent standards and practices
- Open competition for coroners' work
- CHAI to conduct periodic inspections of pathology for coroners
- Pathologists to have formal contracts with coroners
- Regulate tissue retention
- Families to have more rights over autopsy
- Charter for Families to include rights of families concerning autopsy

NB. The power to order an autopsy is found in sections 19 and 20 of the Coroners Act 1988, and the ability to take histology is found in the Coroners Rules 1984. Material which in the pathologist's opinion bears on the cause of death may be retained 'for such a period as the Coroner thinks fit'.

Luce thinks that the reason for holding a post-mortem should only be to deal with a specific uncertainty which can be resolved through no other means, and should only be resorted to when the available information (such as medical notes etc) have been thoroughly examined. The view of Counsel for the group was that unless the need for a post-mortem was genuine, the decision to order one could contravene the European Convention of Human Rights.

The group noted that the quality of Coroner's autopsies was not always up to scratch (and quoted a Confidential Enquiry into Peri-operative Deaths which found that 35% of reports were less than satisfactory), and that the BMA were in favour of fewer, more focused reports. The effect that this will have on the ability of pathology trainees to learn effective autopsy techniques is unclear. They also noted that there appeared to be no available evidence base on when an autopsy would be useful or not.

In terms of tissue retention, the Group note that the Retained Organs Commission has yet to deliver their final report, and that the Department of Health are preparing human tissue legislation.

However, the removal of tissue should be a matter for the pathologist, and the SMA would have a final say about disposal. However, tissue must only be retained in so far as it stems from a direct need of the autopsy, and not, for example, for teaching and research (unless the family have expressly consented to this purpose).

Government Responsibility

- Death certification to transfer to Department of Health, from Home Office
- General responsibility for supporting the service to transfer to LCD (now DCA)
- Should be a statutory coronial council
- Should be a small coroner service inspectorate
- New coroner service to have a high and pro-active public profile
- Aim to inform the public about its role and purpose

Appointments and training; No more Treasure jurisdiction

The system envisaged by the Luce report aims to concentrate resources on the investigation of fewer deaths, that would be investigated more thoroughly.

The group recognise that Coroners require more medical advice, and that new categories of reportable deaths should be introduced, such as ' any death which is the subject of unresolved concern/ suspicion on the part of a family member, or a member of the public (or any other person); and any child on the 'at risk' register'.

In summary, the Luce report aims to reduce the number of deaths reported to Coroners, to make more use of medical advisors to reduce the number of post-mortem examinations required, to improve the quality of autopsies carried out for Coroners, and to improve and extend the role of the family in the death investigation process.

At the same time as this group was looking into the Coroner system and that of death investigation, Dame Janet Smith was also carrying out her own Inquiry.