REVIEW OF DEATH CERTIFICATION IN NORTHERN IRELAND

A PUBLIC CONSULTATION PAPER

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GLOSSARY

Coroners Service

A regional service where independent judicial officers are available at all times to deal with matters relating to deaths that may require further investigation to establish the cause of death. A Medical Officer, currently located in the Coroner's Office provides medical advice to the Coroner and other staff, communicates with registered medical practitioners reporting deaths and meets with bereaved families to provide advice on the cause of death and to discuss any concerns they may have.

General Medical Council Number

A seven-digit, unique identifier given to registered medical practitioners when they first register with the General Medical Council (GMC) which enables patients, employers and others to confirm registered medical practitioner's registration details via the GMC website, in particular whether a particular registered medical practitioner is licensed to practise medicine in the UK.

General Register Office

Office which is responsible for the administration of marriage and civil partnership law and the provision of a system for the civil registration of births, deaths, marriages and civil partnerships and adoptions in Northern Ireland. The office is a branch within the Northern Ireland Statistics and Research Agency (NISRA) which is part of the Department of Finance and Personnel.

Health and Care Number

A unique identifier allocated to all users of health and social care services in Northern Ireland. It is used in all General Practice and Patient Administration systems to identify individual patients/clients.

Health and Social Care Board

Organisation which has responsibility for commissioning, resource management, performance management and improvement of health and social care services in Northern Ireland.

Health and Social Care Trusts

Provide a wide range of health and social care services to the community. There are six Trusts in Northern Ireland, five of which manage and administer hospitals, health centres, residential homes, day centres and other health and social care facilities in their own geographical area. The sixth Trust, the NI Ambulance Service serves the whole of Northern Ireland.

District Councils

The 26 local government bodies in Northern Ireland which are responsible for functions such as waste and recycling services, leisure and community services, building control, local and cultural development and council-owned cemeteries. Belfast City Council is responsible for operating the Belfast Crematorium.

MCCD

Medical certificate of cause of death (death certificate)

Public Health Agency
Organisation which has responsibility for health protection, health improvement and addressing existing health inequalities/public health issues in Northern Ireland.

Registered Medical Practitioner
A doctor registered with the General Medical Council and holding a licence to practise medicine. This includes General Practitioners (GP's) and individuals who practise medicine in hospitals.

Registrar/s
Individual/s responsible for the collation and custody of all birth, death and marriage records in Northern Ireland.

Regulation & Quality Improvement Agency
Independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland.

FOREWORD

This consultation document sets out proposals to enhance the existing arrangements for death certification in Northern Ireland, with a view to strengthening and improving the current process.

The consultation follows consideration of the recommendations of an Inter-Departmental Working Group involving representatives from our three Departments and a range of organisations with a particular interest or involvement in post-death procedures. The Working Group reported to an Inter-Departmental Steering Group, jointly chaired by the Chief Medical Officer and the Registrar General for Northern Ireland.

We believe that the proposals in this consultation will deliver many benefits, most importantly that people in Northern Ireland have similar protections and standards of service in relation to the death certification process as afforded to those living in other parts of the UK. The changes are designed to ensure that arrangements for certifying deaths are consistent and fair to all bereaved families and are sufficiently robust to inspire public confidence and to prevent any potential abuse by unscrupulous individuals.

We also believe the proposed changes represent a proportionate response to improving arrangements for death certification. They take account of our existing assurance arrangements and the organisational structures in Northern Ireland.

Dealing with the death of a loved one is always a very difficult time for people. We believe these changes will deliver a fairer and more robust system for certifying deaths, while at the same time minimising the impact on bereaved families.

We would welcome your views on the proposals in this paper. We very much value input from consultees, and look forward to receiving your response to the consultation

questions. Your comments will be carefully considered as part of the final decision-making process.



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Minister for Health, Social and Services & Public Safety	Minister of the Environment	Minister for Finance Personnel

EXECUTIVE SUMMARY

Background / Drivers for Change

For many years the death certification process in England, Wales, Scotland and Northern Ireland has remained largely unchanged. In 2003, however, the publication of the Shipman Inquiry (3rd Report)[1] and the Luce Review[2] branded the current death certification process in England and Wales confusing and inadequate. The remit of the Luce Review which extended to Northern Ireland, included specific recommendations in relation to death certification processes here.

While the remit of the Shipman Inquiry was confined to England and Wales, and did not therefore directly criticise the death certification process in Northern Ireland, it did highlight weaknesses in similar processes nationally. The Department of Health, Social Services and Public Safety recognised the importance of ensuring that the lessons emerging from the Inquiry were considered and adequately addressed in a Northern Ireland context, and accordingly published 'Improving Patient Safety: Building Public Confidence[3]' in November 2006, a formal Departmental response to the recommendations contained in Shipman Inquiry Reports 3, 4 and 5.

That document contained a number of recommendations in relation to death certification processes in Northern Ireland, and these are being progressed, along with recommendations arising from the White Paper on reform of regulation of health professionals, 'Trust, Assurance and Safety', as part of the Departmental 'Confidence in Care' programme.

Both Shipman and Luce recommended the introduction of a single system for death certification, regardless of whether the deceased was to be buried or cremated. They also found that the scrutiny of medical certificates of cause of death fell short of what is required to provide adequate protection for patients.

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[1] http://www.the-shipman-inquiry.org.uk/tr_page.asp
[2] http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf
[3] http://www.dhsspsni.gov.uk/improving_patient_safety_-_building_public_confidence.pdf

Significant developments have taken place in England and Wales to implement the Shipman and Luce recommendations[4] in respect of death certification processes and the Scottish Government has recently consulted on proposals to strengthen arrangements for death certification in Scotland.

It is important therefore that current practice in respect of certifying deaths in Northern Ireland be reviewed in light of these developments to ensure that it remains fit for purpose. Accordingly, an Inter-Departmental Death Certification Working Group for Northern Ireland was established in November 2008 to review local death certification processes, and to make recommendations for improvement.

Working Group Options

The Working Group has now completed its review, and the purpose of this consultation document is to set out the recommendations it has made to improve the current process for certifying deaths in Northern Ireland, and to invite views on its proposed options for future arrangements for death certification here.

The Working Group proposed two models for future death certification arrangements in Northern Ireland:

Option 1

The first option would involve the introduction of a number of measures designed to enhance the existing assurance arrangements for death certification, with a view to strengthening and improving the current process. These measures would include:

- Adding the General Medical Council and Health and Social Care number to the existing MCCD to facilitate improved statistical analysis;
- Improving death certification training for registered medical practitioners;

[4] 'Learning from Tragedy – Keeping Patients Safe' (2007) which can be viewed at:

http://www.dh.gov.uk/en/PublicationsandStatistics/Publications/PublicationsPolicyAndGuidance/DH_065998

- Incorporating death certification practice as part of the appraisal of registered medical practitioners;
- Developing a set of system standards and improved guidance for death certification;
- Establishing an appropriate mechanism to facilitate review of implementation and compliance with standards and guidance on certifying death across organisations;
- Building on learning from other established death reporting systems already in place; and
- Analysis of completion of MCCDs by registered medical practitioners who work in hospitals under existing governance arrangements in Health and Social Care Trusts.

The Working Group acknowledge that Option 1 does not extend as far as the options proposed for implementation in Scotland, England and Wales and that it will not deliver a single system of scrutiny for all deaths. However, the Group considers Option 1 to be a proportionate response to the risks and gaps in the current death certification process in Northern Ireland taking into account a number of mitigating factors such as the integrated nature of the Coroners Service in Northern Ireland and the proportion of deaths that are currently subject to scrutiny and analysis through death reporting systems already in place here. The Working Group's view is that Option 1 will significantly improve the death certification process in Northern Ireland and strengthen local assurance with no increase in time between death and disposal.

Option 2

The second option would involve the introduction of the enhancements proposed in Option 1, but in addition would include the establishment of a new post of Medical Examiner. In Option 2, registered medical practitioners would contact the Medical Examiner to discuss completion of the MCCDs for all deaths apart from cases which must be reported to the Coroners Service. Every death would

be subjected to a basic scrutiny by the Medical Examiner who would discuss the deceased's past medical history and the circumstances surrounding their death with the registered medical practitioner completing the MCCD. Once the Medical Examiner is satisfied that everything is in order, the registered medical practitioner would forward the MCCD to the Medical Examiner who would authorise it and forward to the General Register Office.

Option 2 would also require all deaths to be registered before disposal.

A sample of cases would be subjected to a more rigorous scrutiny based on specific identified criteria. This would include the basic scrutiny, viewing of the body, reviewing the healthcare records, discussing the circumstances surrounding the death with those responsible for the deceased's care and in some instances, talking with relatives.

The Working Group consider Option 2 to be a more comprehensive system for death certification in Northern Ireland, and do not envisage that its implementation would significantly increase the time between death and disposal in the majority of cases.

Working Group Recommendations

The Working Group's recommendation is that Option 1 should be introduced initially, and analysis of the improved mortality rate statistics which it will generate should be used to inform a decision on a subsequent move to implement the more comprehensive arrangements proposed in Option 2.

Location of Medical Examiner

Should Option 2 be implemented subsequently, the Working Group recommends that the proposed Medical Examiner post be located within either the Health and Social Care Board or the Public Health Agency.

Introducing a Fee

Having carefully considered the arguments for and against the introduction of a single fee to meet the costs associated with implementing these improved arrangements, the Working Group's view is that the introduction of a fee to fund the relatively small additional costs required to implement Option 1 would not represent a proportionate or cost effective means of sourcing revenue for this option.

However, the Working Group concluded that the introduction of a single flat fee would be a feasible means of meeting the additional costs associated with Option 2, and has therefore recommended that the option of introducing a fee for Option 2 be included as part of the consultation process.

The introduction of a proposed fee to fund Option 2 would represent a new charge for deaths where disposal is by burial and, in the view of the Working Group, would result in a more equitable system, as there would be a single flat fee per disposal regardless of the method of disposal chosen. The Working Group also took into account the proposed level of fee that would be required, noting that this represented a comparatively small proportion of the overall cost of an average funeral.