

Summary: Intervention & Options

Department /Agency: Health	Title: Impact Assessment of the Death Certification Sections of the Coroners and Justice Bill	
Stage: Legislation	Version:	Date: December 2008
Related Publications: Consultation on Improving the Process of Death Certification		

Available to view or download at:

<http://www.dh.gov.uk/consultations>

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What is the problem under consideration? Why is government intervention necessary?

The current arrangements for scrutinising death certificates, which have remained largely unchanged for over 50 years, were criticised by the Shipman Inquiry as confusing and inadequate. In particular, the Inquiry concluded that it was no longer sensible to have different certification processes for cremation and burial and that all death certificates should be subject to independent medical scrutiny. Department of Health proposals for creating a rigorous, proportionate and unified system of scrutiny were published in the consultation document Improving the Process of Death Certification in July 2007.

What are the policy objectives and the intended effects?

To ensure that the system for certifying and investigating deaths provides adequate scrutiny to identify and deter criminal activity or poor practice, without imposing undue delays on bereaved families or undue burdens on medical practitioners and others involved in the process.

What policy options have been considered? Please justify any preferred option

Three policy options have been considered:

Option 1: Do nothing.

Option 2: Upgrade cremation certification only.

Option 3: Introduce a universal check applicable to all forms of disposal.

Options 1 and 2 were not considered viable as the Shipman case exposed the failure of the cremation system to identify criminal activity over a long period, and the lack of any effective scrutiny in the case of burials.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? Following further piloting in Autumn 2009.

Ministerial Sign-off For consultation stage Impact Assessment:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options. Signed by the responsible Minister:

Ben Bradshaw MP, Minister of State for Health Services

Date: 18 December 2008

Summary: Analysis & Evidence

Policy Option: 3

Description: Single process for burials and cremations through scrutiny by a fully trained Medical Examiner. Costs and benefits are relative to a baseline of a “Do nothing” scenario.

COSTS	ANNUAL COSTS		Description and scale of key monetised costs by ‘main affected groups’ The public fees in the new system are estimated to total less than the current fees paid for Forms B, C and F in cremations. The new fee per case is estimated to be substantially less than the £160.50 currently paid in the case of cremations, but those paying for burials will now incur this as an additional fee.
	One-off (Transition)	Yrs	
	£ 1M	2009	
	Average Annual Cost (excluding one-off)		
£ -5M	2010-2020	Total Cost (PV) £ -39M (2009-2020)	
Other key non-monetised costs by ‘main affected groups’ There may be some cost to funeral directors for collecting certification for burials, and for preparing new material on fees for customers. This is currently assumed to be negligible.			

BENEFITS	ANNUAL BENEFITS		Description and scale of key monetised benefits by ‘main affected groups’ No monetised benefits are included
	One-off	Yrs	
	£ 0		
	Average Annual Benefit (excluding one-off)		
£ 0		Total Benefit (PV) £ 0	
Other key non-monetised benefits by ‘main affected groups’ The new process is expected to reduce and prevent cases of grave malpractice, improve accuracy and completion of MCCDs and improve surveillance of data on deaths. It may also reduce the number of referrals to coroners. See also cost-benefit analysis provided under evidence base.			

Key Assumptions/Sensitivities/Risks

Key assumptions which need to be confirmed through piloting are: throughput of cases per Medical Examiner, requirements on clinical governance teams, feasibility of recruitment and retention, training/CPD requirements, IT system requirements, processes for monitoring and review.

Price Base	Time Period	Net Benefit Range (NPV)	NET BENEFIT (NPV Best estimate)
Year 2007	Years 11	£ -117M to 195M	£ 39M

What is the geographic coverage of the policy/option?	England and Wales			
On what date will the policy be implemented?	2010			
Which organisation(s) will enforce the policy?	PCTs (or equivalent in Wales)			
What is the total annual cost of enforcement for these organisations?	£ 0			
Does enforcement comply with Hampton principles?	Yes			
Will implementation go beyond minimum EU requirements?	No			
What is the value of the proposed offsetting measure per year?	£ 0			
What is the value of changes in greenhouse gas emissions?	£ 0			
Will the proposal have a significant impact on competition?	No			
Annual cost (£-£) per organisation (excluding one-off) (estimated as average cost per PCT population)	Micro	Small	Medium	Large
	-	-	-	£250,000
Are any of these organisations exempt?	No	No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)			(Increase - Decrease)	
Increase of	£ 0	Decrease of	£ 4M	Net Impact
				£ -4M

Key: Annual costs and benefits: Constant Prices (Net) Present Value

Evidence Base (for summary sheets)

[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]

Purpose and intended effect

Objective

The objective of the Government's proposals in respect of death certification is to ensure that the system for certifying and investigating deaths provides adequate scrutiny to identify and deter criminal activity or poor practice, without imposing undue delays on bereaved families or undue burdens on medical practitioners and others involved in the process.

Background

Each year some 500,000 people die in England and Wales. The system for death certification in England and Wales has remained largely unchanged for over 50 years. The current arrangements require that for all deaths the doctor who attended the patient in their final illness should complete a Medical Certificate of Cause of Death (MCCD). Additional certification is required before bodies can be released for cremation. Currently around 70 per cent of deaths are followed by cremation.

In its *Third Report*,¹ the Shipman Inquiry examined the process of death certification and the coroner system. The Inquiry concluded that existing arrangements for scrutinising the MCCD are confusing and provide inadequate safeguards. A Fundamental Review² presented to the Home Office in June 2003, came to broadly similar conclusions about the shortcomings of the current arrangements.

The Government accepted the Shipman Inquiry's conclusions, and its action programme in response to the Inquiry's key recommendations³ outlined proposals for creating a new rigorous, unified system of death certification for both burials and cremations in England and Wales. The Department of Health consultation paper *Improving the Process of Death Certification*⁴ set out these proposals in more detail (details of the response to the public consultation is included later in this Impact Assessment).

This is one of eight Impact Assessments prepared in relation to specific provisions included in the Coroners and Justice Bill. These are all summarised in an overarching Impact Assessment produced by the Ministry of Justice who are leading on the Bill.

Policy Options

Option 1: Do nothing

The current process has some advantages in that it is quick and convenient for burials. Some 70% of deaths result in cremation, and so are already subject to additional scrutiny before the body is disposed of.

¹ Third Report – Death Certification and the Investigation of Deaths by Coroners (TSO, 2003)

² Death Certification and the Coroner Services in England, Wales and Northern Ireland: The Report of the Fundamental Review (TSO, June 2003)

³ Learning from Tragedy, Keeping Patients Safe (TSO, February 2007)

⁴ Consultation on Improving the Process of Death Certification (DH July 07)

However, the Shipman case exposed the failure of the cremation system to identify criminal activity over a long period, and the lack of any effective scrutiny in the case of burials.

We believe that there is a need to strengthen the existing system to bring it under more effective scrutiny linked to clinical governance, to provide a greater deterrent to malpractice and a means of driving up quality and accuracy across the board.

Option 2: Upgrade cremation certification only

This option would be cheaper (producing annual savings to the public of approximately £17m relative to a baseline of a “Do nothing” scenario) and would remove any risk of delays to funerals involving burial. However, a key recommendation of the Shipman Inquiry was that a common system of death certification should be introduced for all deaths, regardless of the form of disposal (*Shipman Inquiry Third Report, paragraph 19.36*). The option of upgrading only the arrangements for cremation certification was rejected as it would have meant that certification of these deaths would have continued to be dependent on the judgement and integrity of a single medical practitioner, without any form of independent scrutiny.

Option 3: Introduce a universal check applicable to all forms of disposal

The consultation paper *Improving the Process of Death Certification* set out proposals for a unified system applying to both burials and cremations that can be delivered at a reduced cost (baseline scenario) and provides additional protection for the public against criminal activity of the sort exposed in the Shipman case. A full description of the new process was given in the Consultation document.

Impact

Private and voluntary sector

The procedure would apply to doctors completing MCCDs regardless of whether they are employed in the NHS or the private sector. We are not proposing significant changes to the MCCD itself, so the impact for doctors completing the MCCDs is likely to be essentially the short-term need to get to know the new procedures and establish key contacts with Medical Examiners. The impact overall should be negligible.

Under the proposed system, doctors currently completing Forms B and C and medical referees will not carry out these functions and therefore no longer receive fees for this activity. However, the Medical Examiner function will result in remunerated work of a similar nature. We are working with the profession to ensure the Medical Examiner role is properly remunerated.

Apart from doctors working in a private capacity, the only businesses likely to be affected by the proposals will be Funeral Directors. Traditionally, funeral directors have arranged for the completion of cremation forms and have collected the doctors' fees from bereaved families as part of the bill for the funeral. Under the new proposals, a lower fee will be paid for the Medical Examiner function in all cases instead of just for cremation cases as at present. Therefore, there will be additional activity for funeral directors. Currently about 70% of deaths result in cremation so there is likely to be approximately a 30% increase in this activity. However, so long as the new system does not introduce additional delays for the forms to be completed, it is unlikely that the additional costs will be significant, and the assumption is they will be negligible. There may also be one-off costs to funeral directors e.g. in preparing revised information for bereaved families, which we have also assumed to be negligible. The National Association of Funeral Directors and the National Society of Allied and Independent Funeral Directors are represented on the steering group directing and supporting the development and implementation of these proposals.

Public sector

NHS

The proposal is that Medical Examiners and their support officers will work alongside clinical governance teams in Primary Care Trusts, and will have training needs and overheads. Medical Examiners will be independent in the way they exercise their professional judgement as medical practitioners but will be managed and held accountable in the same way as other trust staff for the performance of the service they provide. Systems for recruiting and training Medical Examiners will also be required. PCTs may also need to develop systems for recording and analysing data arising from MCCDs and Medical Examiners' findings.

Introduction of the medical examiner's service will have an impact on the NHS through: its contribution to and use of data related to clinical governance; the requirement for PCTs to recruit and train medical examiners and their support officers; the requirement for PCTs to monitor and manage performance of the service (whilst ensuring that medical examiners are independent in how they exercise their professional judgement as medical practitioner); the requirement for PCTs to provision office facilities, resources and access to information systems.

While these costs will be initially borne by the PCT, a flat fee will be paid per case by the public to cover all the costs incurred by the service, so in financial terms the net financial impact on the NHS will be zero. PCTs are represented on the steering group directing and supporting the development and implementation of these proposals.

Registrars

The new process will have a direct impact on Registrars but will not impose any additional burdens on them. On the contrary, the role proposed for Medical Examiners in confirming the cause of death for all deaths not investigated by the coroner will mean that Registrars will no longer need to make judgements about the content of MCCDs – an activity for which they are often poorly qualified – and will need to report fewer MCCDs to the coroner. We are working with the General Register Office (GRO) to ensure that the Medical Examiner function dovetails smoothly with registration procedures. The GRO is represented on the steering group directing and supporting the development and implementation of these proposals.

Coroners

The new proposals are not expected to have a significant impact on the workload of Coroners. The over-arching principle governing the Medical Examiner scrutiny will be the safety of the certification process – i.e. safeguarding against certifying deaths, which should be investigated by the coroner. The initial assessment by the ME of the stated cause of death will be to determine whether or not the death should be referred to the coroner. We anticipate that by exposing MCCDs to medical scrutiny at an early stage in the process, referrals to Coroners will be better targeted and will therefore make more efficient use of Coroners' resources. Again, we are working with Coroners and the Ministry of Justice (MoJ) to ensure that the interface between the Medical Examiner and Coroner functions works smoothly. The Coroners' Society, Coroner's Officers Association and the MoJ are represented on the steering group directing and supporting the development and implementation of these proposals.

The public

Currently some 70% of deaths result in cremation and, where these are not investigated by the coroner, require payment of certification fees totalling £160.50: these fees are paid to doctors for completion of cremation forms B and C and to the medical referee for completion of form F. Cremations that follow investigation by the coroner only require Form F and therefore incur a fee of £18. We estimate that the total annual expenditure on cremation fees is about £45 million.

In the proposed system, a flat fee would be payable irrespective of whether a body is buried or cremated, instead of the current situation where those who choose to bury their relatives pay nothing and those who choose to cremate pay £160.50. We estimate that the cost of the new system will be less than the current one, so the total amount paid by the public should be less than at present; and the flat fee should be less than the current fee for cremation. The assumptions on which we have based our estimates (for example the average time it will take for a medical examiner to scrutinise an MCCD) will be refined through continued discussions with stakeholders and piloting exercises.

Local Authorities

In certain cases, for example where there is no next of kin or a person dies with no estate, the Local Authority may arrange for a funeral (this is generally referred to as “welfare burials”). LAs are empowered to recover costs from any estate of the deceased person, in which case the impact of the new proposals will be neutral. However, where there is no estate the LA will need to meet the full costs. The number of such cases is very small, and we do not anticipate this having a significant impact. The Local Government Association is represented on the steering group directing and supporting the development and implementation of these proposals.

Department for Work and Pensions

The impact on benefits payable to people unable to afford funeral costs needs to be considered. Overall, the impact should be neutral or positive since cremations (the bulk of funerals) will attract a lower fee, which should counteract the new fee for burial cases.

Response to public consultation

The Department of Health conducted a public consultation on these proposals between July and October 2007. A total of 157 written responses to the consultation were received. As part of the consultation process, the Death Certification Programme Manager also met with a number of national stakeholder organisations and attended some meetings with councillors and representatives from local communities. Many of those who submitted a written response or attended a meeting (and some did both) responded to each of the questions included in the consultation paper. However, some contributors covered only those points of particular concern to them, or points where they had particular expertise or personal experience.

Almost all respondents recognised and acknowledged the concerns expressed about the current process of death certification in England and Wales. The vast majority of respondents supported the proposed introduction of a process of secondary certification of deaths that are not referred to the coroner, and for this scrutiny to be undertaken by appropriately qualified Medical Examiners. Many respondents also supported the proposal that Medical Examiners should provide general medical advice to coroners, helping them to fulfil their duty to establish the cause of death in cases referred to them.

The main concerns raised by respondents were over ensuring that the scrutiny process does not cause significant delays to funerals and ensuring that medical examiners are able to carry out their duties with the necessary degree of independence from NHS and other public authorities. Several respondents also highlighted the importance of ensuring that development

and implementation of the proposed improvements to the process of death certification are closely co-ordinated with the Ministry of Justice's coronial reform programme. Further information about these issues is included in the summary of responses to the consultation⁵.

Cost-Benefit Analysis

Methodology

The benefits of having a death certification process include – legal proof of death, generating data for epidemiological studies or future healthcare provision, and deterrence of crime. However, failings in the current system have become glaring in the light of the findings and recommendations of the Shipman Inquiry and the fundamental review of death certification and investigation in England, Wales, and Northern Ireland chaired by Tom Luce. In response to these, the following changes to death certification process have been proposed:

- Introduction of independent medical scrutiny and analysis of deaths by a Medical Examiner (ME) working alongside the clinical governance team of a Primary Care Trust (PCT).
- Common process for both burial and cremation.
- Removal of the role of Cremation Referee.
- Increased involvement of / communication with bereaved families.

It is estimated that the new system will cost about £40m per year resulting in a cost saving of about £5m per year when compared to the cost of the current system (£45m per annum).

The expected benefits of the changes include:

- Crime and malpractice deterred by the knowledge that MCCDs will be scrutinised by a medical examiner.
- More coordinated and consistent use of evidence-based patterns and trends leading to earlier detection of criminal activity and the prevention of future deaths.
- MCCDs provide more accurate information about the causes of death.
- Improved information for clinical governance and local health monitoring.
- System is easier for bereaved families to understand, ensures that they can see and comment on the MCCD and provides reassurance that an independent doctor is checking the cause of death.

Monetising these benefits is difficult because they are mostly intangibles and because the rarity of the events that they seek to avoid would make any estimates too spurious. However, it is still important to evaluate the benefits and having considered various approaches we selected the method used in evaluating situational crime prevention projects.

Situational Crime Prevention

The main aim of the proposed system is to prevent future Shipman type crime/malpractice. This type of crime is best described as situational because it depends on the existence of an opportunity that occurs when there is a suitable target (the patient), a likely offender (the

⁵ Summary of Responses to the Consultation on Improving the Process of Death Certification (Department of Health, May 2008)

aberrant doctor), and a lack of a suitable 'guardian' to prevent the crime (an independent medical examiner). Existing literature (Chisholm, J. 2000)⁶ suggests that programmes aimed at preventing situational crimes are usually more readily, amenable to cost-benefit analysis than other crime prevention programmes. This is primarily because the estimates of the costs of such programs' requirements (hardware, labour etc) are usually easy to obtain and it is therefore possible to compare the cost outlay with cost savings.⁷ By adopting this approach, we are able to focus on how well the death certification programme is able to meet its costs.

Costs

We estimate that the proposed system will cost about £40m per annum. Our baseline assumption is that Medical Examiners will scrutinise an average of 8 cases per day. Using standard PSSRU⁸ assumptions for sick leave, training requirements etc, this equates to c.240 WTEs for England and Wales. It is further assumed that there will be one WTE Medical Examiner's Officer (MEO) to each WTE Medical Examiner and that the average ratio of WTE to headcount for will be 1:2 for Medical Examiners and 1:1.25 for MEOs. On-going training for Medical Examiners and MEOs are estimated at one three-day course every 2 years. Overheads are included at £5,000 per WTE and cover facilities and standard information technology (IT). Additional costs may be incurred to provide specialised software to enable the collection and analysis of data, however findings from pilot sites suggests that most services already have existing IT systems and software that could be adapted with relative ease.

The minimum cost scenario in the evaluation is based on an average throughput of 16 cases per Medical Examiner per day resulting in half the number of Medical Examiners and MEOs, and hence half the total costs. The maximum cost scenario is based on reducing average throughput to around 5 cases per day (equivalent to spending an extra 50% of time on each case). This increases costs by 50%. It is likely that, because of the low numbers of Medical Examiners required per PCT, more posts will be required than are strictly necessary when considered national level volumes of work. To account for this and other unknown factors we have included a 20% contingency in all scenarios.

The principal start-up cost associated with the new system will be for recruitment and training of newly appointed Medical Examiners and MEOs. The cost is based on a requirement for 3 days of professional training prior to confirmation of appointment.

All costing assumptions will be reviewed regularly as the piloting process is taken forward and will be tested as part of a simulation model that the programme is developing with the Sheffield University's School of Health Related Research.

Cost Savings

The proposed changes are expected to create cost savings by simplifying the system and hence reducing the administrative burden on doctors, bereavement officers and funeral directors. The new system will replace cremations forms B, C and F with a single authorisation issued by the Medical Examiner. Although this authorisation will now be required for burials as

⁶ Chisholm, John (February, 2000). *Benefit-Cost Analysis and Crime Prevention*, Trends and Issues in Criminal Justice paper no. 147, Australian Institute of Criminology. See citation of Forrester et al. (1990) and Clarke & McGrath (1990).

- Clarke & McGrath (1990). "Cash Reduction and Robbery Prevention in Australian Betting Shops", *Security Journal*, vol. 1, pp. 160-63
- Forrester et al. (1990). *The Kirkholt Burglary Prevention Project: Phase 2*, Crime Prevention Unit paper no.23, Home office, London.

⁷ In the Kirkholt project, for every pound spent on the program, about 5 pounds could be saved in reduced burglary costs

⁸ <http://www.pssru.ac.uk/uc/uc2006contents.htm>

well as for cremations, the total number of forms required is reduced, and assuming this saves 10 minutes per form, the result is a net reduction in admin burden of about £4M p.a.

There may also be some impact on the number of cases reported to the coroner (currently about 47% in England and Wales) and to the number of post-mortems that are carried out because there is no Attending Practitioner to prepare the MCCD. Whilst Medical Examiners are likely to identify and report a number of cases that would otherwise not have been reported to the coroner, they will also be able to reduce the number of 'false positives' i.e. cases that doctors report to the coroner which, after an initial assessment, the coroner decides does not need to be investigated. Early evidence from piloting suggests that once the new system is bedded in it may lead to a reduction of about 10% in the number of 'false positives'. Data is not yet available on the number of additional cases that that may be referred to the coroner by the Medical Examiner. Since the net effect of these two factors is not yet known, they have been excluded from the analysis.

The estimated annual cost of the proposed system is about £40m. Compared with the estimated £45m cost of the current system, the proposed system is expected to generate a net saving to the public and to be neutral to the exchequer.

Enforcement and sanctions

PCTs will be required to monitor the performance of the Medical Examiner's Service for their area by reference to expected standards. However, PCTs will not be allowed to take any role in relation to the way in which individual Medical Examiners exercise their professional judgement as medical practitioners. Enforcement and sanctions will therefore be limited to the way in which the Medical Examiner's Service is organised and managed and will not apply to decisions on whether or not to confirm individual causes of death or report them to the coroner.

Monitoring and review

We propose to monitor implementation and the impact of the new system on NHS frontline staff, and private and voluntary organisations. For this purpose, we have set up a Steering Group with all relevant stakeholders represented to direct and support the development and implementation of these proposals. Terms of reference for the Steering Group, along with details of membership, are included in the summary of responses to the consultation.

Piloting

A Pathfinder Pilot was established in March 2008 at the Sheffield Teaching Hospitals NHS Foundation Trust in collaboration with the HM Coroner for South Yorkshire (West) to test and evaluate the proposed role of the Medical Examiner in scrutinising MCCDs for deaths in hospital. The report⁹ of the first 3 months of the pilot in Sheffield concluded by saying:

"Including a ME in the MCCD process improves quality, accuracy, and the service to the bereaved, without introducing delays in certificate issue. There is an overall reduction in the number of referrals to the Coroner, but preservation of appropriate referrals.

It is likely that through reform of the death certification process the ME role will become commonplace and formalised. Around 1,000 experienced doctors will be required to fulfil this role in England and Wales but we have shown that MEs can be established from an existing consultant workforce. The necessary attributes do not include or exclude any specialty per se, but a generalist approach is helpful. Scrutiny of out of hospital deaths is likely to present its own challenges, and is beyond the scope of this pilot.

⁹ Improving the Death Certification Process: The Sheffield Medical Examiner Pathfinder Pilot (Northern General Hospital, Sheffield, July 2008)

The development of a ME curriculum is currently underway under the supervision of the Academy of Medical Royal Colleges. The information gained from this pilot will hopefully inform future planned pilots throughout England and Wales. An extension to the pilot is already progressing and will explore the formal development of a ME Support Officer.

In summary, working as an ME is interesting, stimulating, and at times challenging. The role enhances and improves the death certification process for the bereaved and a close working relationship with the Coroner is essential. This work is the first of its kind to formalise MCCD advice in this way and is at the forefront of ensuring that national plans for service improvement progress in a clinically informed way.”

Next Steps

A second pilot at the Gloucestershire Hospitals NHS Foundation Trust will begin on in December 2008, followed by a pilot in Powys early in 2009. Further pilots are also being considered in Northumberland, Swansea and Leeds. The pilots will be developed over time to include deaths in the community and to test engagement with coroners, registrars, funeral directors and other stakeholders.

In addition to piloting, an extensive programme of work is underway to support implementation of the new process of death certification in England and Wales. This includes:

- the development of guidance for medical examiners on the proportionate and effective scrutiny of MCCDs;
- the development of guidance on the appointment, independence and accountability of medical examiners and on the support and infrastructure they will require;
- the design and development of accredited materials to train and assess new medical examiners and their support officers.

Risks

The following key risks have been identified:

➤ Introduction of delays

Currently, Form B and C are completed by a large pool of doctors, so there are no capacity constraints if an unusually high number of certifications are required. In the new system, there may be only 1-2 WTE Medical Examiners per PCT, so there may be issues of cover and availability, with limited flexibility to cope with peaks in workload. Although it should be possible for MEs from other PCTs to assist in peak times, even introducing delays of 1-2 days could cause difficulties to grieving families (especially those whose religions mandate immediate funerals) and incur additional costs to undertakers. There is therefore either a risk of delays occurring, or a risk that additional resources may be required; the latter risk is considered in the sensitivity analysis.

- Recruiting and retaining Medical Examiners and support officers

The current proposal makes a clear and plausible estimate of staff requirements. However, experience suggests that there is some risk attached to the recruitment and retention of Medical Examiners and support officers (both initially and over time). The sensitivity analysis allows for transitional and ongoing training costs to reflect the financial aspect of this risk.

Summary

The Third Report of the Shipman Inquiry showed that the current arrangements for certifying deaths do not provide adequate safeguards and are inequitable. We believe the proposed system of death certification represents a proportionate and affordable response that will provide greater protection for the public, improve the quality and accuracy of death certification and remove current inequalities in the way burials and cremations are dealt with. It is likely to do so at no greater cost to the exchequer and with an estimated decrease in the amount paid by the public.

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	No	Yes
Small Firms Impact Test	No	Yes
Legal Aid	No	Yes
Sustainable Development	No	Yes
Carbon Assessment	No	Yes
Other Environment	No	Yes
Health Impact Assessment	No	Yes
Race Equality	No	Yes
Disability Equality	No	Yes
Gender Equality	No	Yes
Human Rights	No	Yes
Rural Proofing	No	Yes

Competition Assessment

We have applied the competition filter test and are satisfied that the proposed system of death certification would:

- have no differential effect between firms;
- not affect market structure;
- not discriminate against new entrants;
- not impact on the range of services or location of private healthcare providers.

Small Firms Impact Test

We believe these proposals will not have a disproportionate impact on small businesses, but we will continue to work with the funeral industry as the proposals go forward and will keep this IA under review..

Legal Aid Impact Test

In our view the Bill will have no impact on the provision of legal aid.

Sustainable Development

In line with Cabinet Office guidance, we have considered the potential economic, environmental and social impact of the Bill, and consider that it complies with the principles of sustainable development.

Carbon Assessment

We have not identified any carbon related issues.

Other Environment

We have not identified any other environmental issues.

Health Impact Test

Using the Department of Health checklist, no specific health impact issues were identified as a result of this Bill. We do, of course, expect the reform of the death certification to produce a significant improvement in the quality and consistency of certification. MCCDs provide a valuable source of information on diseases, which is important for the general public, clinicians and those responsible for planning health services.

Race, Disability and Gender Equality

An Equality Impact Assessment has been undertaken to consider the possible impact of these proposals on people according to their age, disability, race, religion and beliefs, gender and sexual orientation. Religion and beliefs are

clearly very important considerations in the processes surrounding certification of death and the release of bodies for burial or cremation. These issues are covered further in the Equality Impact assessment attached at **Annex B**. There are no obvious issues concerning age, disability, race, gender or sexual orientation.

The introduction of these proposals will address three potential areas of discrimination:

- there will be a common level of assurance for the certification of all deaths;
- certification will be carried out to a common timetable;
- a single (lower) fee will be charged for certification removing the differential in charges between certificates for cremation and burial.

Human Rights

It is possible to argue that the insertion of an additional step in the death certification process might have the effect of delaying the disposal of bodies. This might give rise to concerns for those religious groups whose practices demand that disposal takes place as soon as possible after death and therefore bring into play article 9(1) (right to freedom of thought, conscience and religion). The ECtHR has held that the right to have a burial in accordance with the practice of a certain religion does come within article 9(1) (*Islamic Community in Bosnia and Herzegovina v. Serbia (Burials and Cremation)*(2001)).

In the event of a challenge on these grounds, the Department's argument would be that these proposals do not infringe article 9(1). This is because the procedures which will be put in place to enable the medical examiner to carry out the scrutiny, will be such that any additional delay to that which currently applies will be kept to an absolute minimum. Indeed, given the use of electronic communications, it is entirely possible that there would not be any additional delay at all. It is also important to note that this procedure will apply only where the cause of death is known, natural and non-suspicious and so it is in everyone's interest to expedite the certification process as far as possible.

Rural Proofing

The Bill will have no specific impact on rural communities.

Equality Impact Assessment

Death Certification Sections of the Coroners and
Justice Bill

December 2008

Executive Summary

1. The Department of Health accepts that in developing proposals to modernise arrangements for death certification it has an obligation to consider the impact of changes on different groups in society and where possible to remove aspects of the existing arrangements which may be discriminatory or potentially so.

2. The new arrangements for death certification must ensure that all bereaved relatives receive the same level of assurance that there has been nothing untoward surrounding the circumstances of the death of their family member, regardless of the choices the family may make for disposal of the body i.e. burial or cremation. Similarly, the arrangements for death certification must ensure that the choice of either burial or cremation does not involve significant additional delays or costs for families, which would not be incurred if the other choice was made.

3. This Equality Impact Assessment, like all others, considers the possible impact of new policy proposals on people according to their age, disability, race, religion and beliefs, gender and sexual orientation. Religion and beliefs are clearly very important considerations in the processes surrounding certification of death and the release of bodies for burial or cremation. There are no obvious issues concerning age, disability, race, gender or sexual orientation.

Current arrangements for death certification

4. Each year some 500,000 people die in England and Wales. The system for death certification in England and Wales has remained largely unchanged for over 50 years. The current arrangements require that for all deaths the doctor who attended the patient in their final illness should complete a Medical Certificate of Cause of Death (MCCD). Additional certification is required before bodies can be released for cremation. Currently around 70 per cent of deaths are followed by cremation.

Weaknesses in the current system

5. There are a number of weaknesses and anomalies in the current arrangements, particularly the difference in the level of certification required for cremation rather than burial:

- there is no additional medical scrutiny for burial cases (30% of all funerals) once the Medical Certificate of Cause of Death (MCCD) has been completed. The Registrar does an administrative check on all MCCDs, and has a legal duty to refer to the Coroner in certain circumstances. However, the Registrar is not medically qualified and does not have access to supporting information such as medical notes. The Registrar is therefore not in a position to make effective judgements about the reliability of the cause of death recorded on the MCCD;
- in contrast, cremation cases are subject to a series of checks involving three different doctors (completing Forms B, C and F). However, the scrutiny is not always sufficiently independent of the doctor signing the MCCD and is not subject to effective quality assurance;
- there is no routine system of analysis for local clinical governance¹⁰ purposes of the information on MCCDs or on the additional forms completed for cremations, and no explicit link to clinical governance processes in either Primary Care Trusts or hospitals;
- The absence of a link with the clinical governance framework means best use may not be being made locally, of data about deaths to identify concerns, and there is no real oversight of quality and accuracy.

¹⁰ Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.

6. Fees associated with medical certification for cremation are usually paid by the family of the deceased as part of funeral expenses. Most of the fees for cremation certification go to the doctors who carry out the examinations. The higher cost of certification associated with cremations as opposed to burials is potentially discriminatory.

7. The argument for more stringent procedures for cremation was that once a body has been cremated there is no possibility of further examination should there need to be further investigation of the cause of death. Exhumation is a possibility where a body has been buried. However, the system was introduced at a time when cremation was a rarity, and it could be argued that it was justifiable to charge bereaved people for a service that was over and above the norm. Nowadays, the vast majority of people opt for cremation. We also live in a multi-cultural society in which for some people the method of disposing of a body is not a matter of personal choice but of cultural or religious practice.

8. Families opting for burial, also deserve the same degree of reassurance that all is well before the burial takes place as those opting for cremation. Any necessary investigations should take place before burial, with all steps being taken to minimise the need for possible exhumations which are both distressing for families and less likely to reveal useful information than investigations carried out before burial.

9. There is also some inconsistency in determining which cases are referred to Coroners by doctors completing MCCDs. About half the deaths reported to Coroners require neither post mortem nor inquest, and these cases have been increasing in recent years – from 39% in 1995 to 52% in 2007¹¹. Currently, many cases are referred to the Coroner because the deceased person has not seen their doctor in the 14 days preceding death, and the doctor has not seen the body after death. This inevitably causes delay and distress for bereaved families.

¹¹ Source: Ministry of Justice

10. In its *Third Report*¹², the Shipman Inquiry examined the process of death certification and the coroner system. The Inquiry concluded that existing arrangements for scrutinising the MCCD are confusing and provide inadequate safeguards. A key recommendation of the Inquiry was that a common system of death certification should be introduced for all deaths, regardless of the form of disposal¹³. A Fundamental Review¹⁴ presented to the Home Office in June 2003 came to broadly similar conclusions about the shortcomings of the current arrangements.

Proposals for change

11. Proposals for creating a new rigorous, proportionate and unified system of death certification for all forms of disposal in England and Wales were set out in a consultation document published by the Department of Health in July 2007¹⁵. Ensuring that the new death certification system is sensitive to the needs of the bereaved and can provide them with reassurance at an inevitably difficult time is central to the proposals.

12. A high-level process map of the proposed system of death certification is included at the end of this document. The key features of the proposed new system are:

- **a common approach** to the medical certification and subsequent registration of all deaths not requiring coronial autopsy or inquest. This will mean a simpler process for Funeral Directors, and result in the removal of current inequalities;
- **a robust, proportionate and consistent scrutiny** and confirmation of all medical certificates of cause of death (MCCDs) by an independent 'Medical Examiner'. An out of hours Medical Examiner's service will be

¹² Third Report – Death Certification and the Investigation of Deaths by Coroners (TSO, 2003)

¹³ Third Report, paragraph 19.36

¹⁴ Death Certification and the Coroner Services in England, Wales and Northern Ireland: The Report of the Fundamental Review (TSO, June 2003)

¹⁵ Improving the Process of Death Certification (DH, July 2007)

provided where it is needed by local communities to comply with religious practices;

- **close working between the Medical Examiner and Coroner** and between their officers;
- **a transparent process** in which the certified cause of death will be explained to relatives after it has been scrutinised and, if relatives have concerns, will enable the death to be reported to the Coroner;
- **a focus on speed and convenience** - electronic transmission will be used to enable efficient scrutiny. The confirmed MCCD will be available for collection from a local hospital or GP or, if required, will be sent by secure post;
- **the registrar will be able to provide a final check** prior to completing authorisation for disposal without needing to understand medical terminology; and
- **the routine analysis of information** on cause of death for local clinical governance and public health surveillance. This will allow identification of areas where training and development is required to improve quality and accuracy of MCCDs prepared by primary certifiers.

Consultation

13. A public consultation on the proposals to improve the process of death certification was conducted between July and October 2007. A total of 157 written responses were received. Almost all respondents recognised and acknowledged the concerns expressed about the current process of death certification in England and Wales. The vast majority of respondents supported the proposed introduction of a process of secondary certification of deaths that are not referred to the coroner, and for this scrutiny to be undertaken by appropriately qualified medical examiners.

14. As part of the consultation process, the Death Certification Programme Manager also met with national stakeholder organisations and attended some meetings with councillors and representatives from local communities and faith groups. This approach has particularly increased the Department's awareness of the cultural and religious requirements of different communities and informed the development of the proposals.

Equality issues

15. A number of respondents to the public consultation, while acknowledging the need to reform the current process of death certification and introduce a unified system of secondary certification, expressed concern that the proposed scrutiny process would delay funerals. This issue is of particular concern to Jewish and Muslim communities whose religious practice requires burial to take place as soon as possible after the death.

16. The Department of Health is proposing to respond to these concerns in the following ways:

- Registrars will be able to issue a 'Deferral of Registration' to allow burial or cremation prior to registration where it is necessary to do so (once the cause of death has been confirmed by a medical examiner);
- the flexibility of the medical examiner service will be maximised through the use of part-time appointments;
- consideration is being given to different models of service provision, including an out-of-hours 'emergency medical examiner service'. These arrangements will be tested as part of the piloting process;
- understanding the particular needs of different faith communities will form part of the training curriculum for all medical examiners.

17. In the proposed system, a flat fee would be payable irrespective of whether a body is buried or cremated, instead of the current situation where those who choose to bury their relatives pay nothing and those who choose to cremate pay £160.50. We estimate that the cost of the new system will be less than the current one, so the total amount paid by the public should be less than at present; and the flat fee should be less than the current fee for cremation. The assumptions on which we have based our estimates (for example the average time it will take for a medical examiner to scrutinise an MCCD) will be reviewed regularly as the piloting process is taken forward. Financial assistance to cover the cost of these fees will be available from the Department of Work and Pensions, to those who qualify for help, through the Social Fund.

18. The introduction of the unified system of death certification will address the three potential areas of discrimination identified earlier in this Equality Impact Assessment, namely:

- there will be a common level of assurance for the certification of all deaths;
- certification will be carried out to a common timetable;
- a single (lower) fee will be charged for certification removing the differential in charges between certificates for cremation or for burial.

The Department of Health's view is that removing these areas of potential discrimination the proposals will help promote equality.

Piloting

19. The proposed improvements to the process of death certification are being piloted in a number of different locations in England and Wales. An initial Pathfinder Pilot was established in March 2008 at the Sheffield

Teaching Hospitals NHS Foundation Trust in collaboration with the HM Coroner for South Yorkshire (West) to test and evaluate the proposed role of the Medical Examiner in scrutinising Medical Certificates of Cause of Death for deaths in hospital.

20. The Report of the first three months of the pilot concluded by saying:

“Including a ME in the MCCD process improves quality, accuracy, and the service to the bereaved, without introducing delays in certificate issue. There is an overall reduction in the number of referrals to the Coroner, but preservation of appropriate referrals.

The Report also provided evidence of an overall reduction in the number of referrals to the coroner (down from 36 per cent to 28 per cent), but preservation of appropriate referrals.

21. A second pilot at the Gloucestershire Hospitals NHS Foundation Trust will begin in December 2008, followed by a pilot in Powys early in 2009. Further pilots are also being considered in Northumberland, Swansea and Leeds.

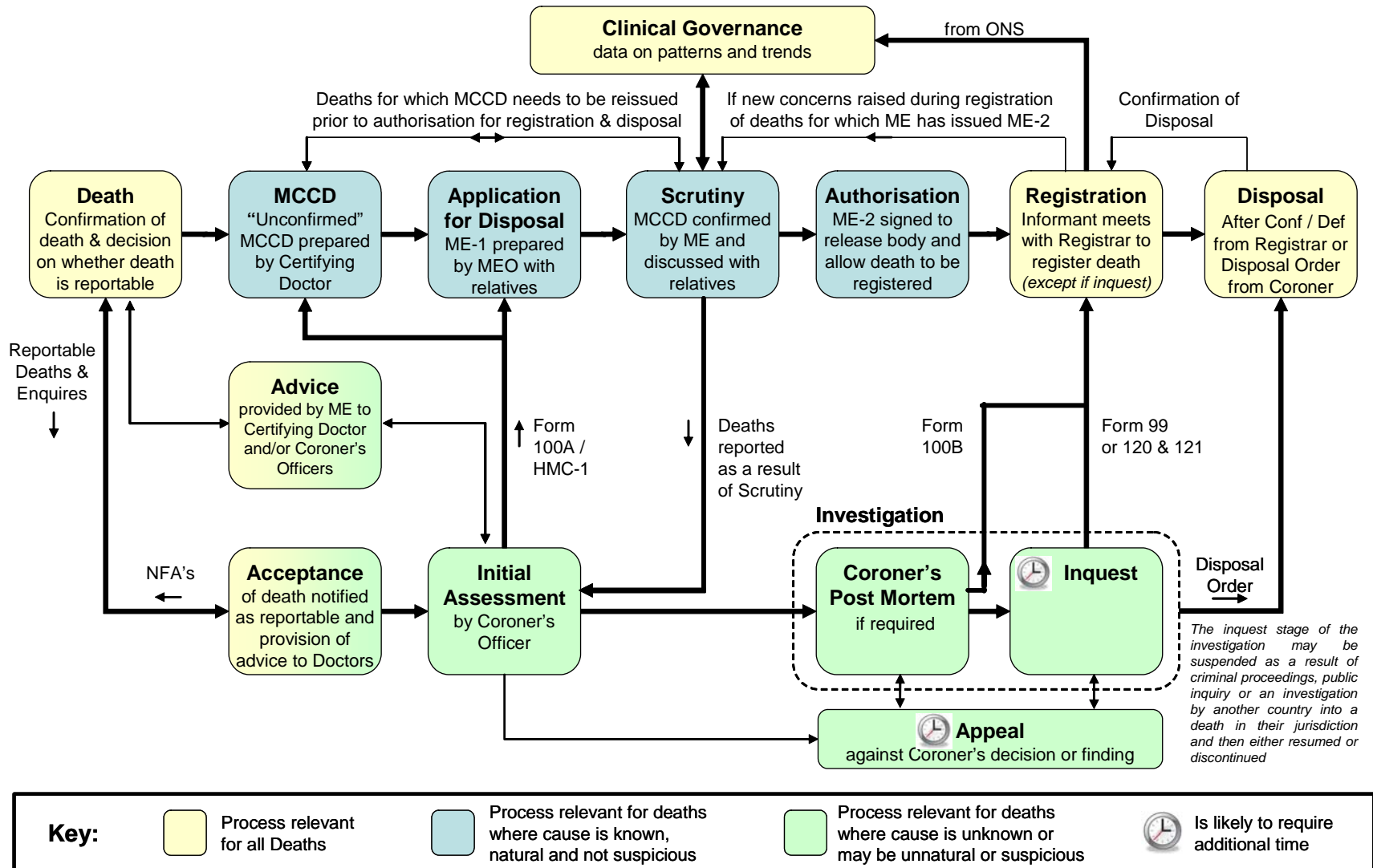
Decisions

22. Tackling inequalities is priority for the Government. Introducing a single system of death certification regardless of whether bodies are to be released for cremation or burial will ensure that everyone has the same level of assurance regarding the cause of death stated on the MCCD. All steps are being taken to ensure that any delays to funerals are kept to an absolute minimum.

Publication

23. This Equality Impact Assessment will be published on the Department of Health’s website at www.dh.gov.uk/consultations as an annex to the final Impact Assessment.

Overview of Proposed Process for Death Certification



Note: ME is an abbreviation for Medical Examiner. MEO is an abbreviation for Medical Examiner's Officer. ME-1 is the proposed name of the form used as the Application for Disposal and the ME-2 the Medical Examiner's Authorisation to Release Body and Register Death. The Certifying Doctor holds on to the original MCCD until a copy has been scrutinised by the ME and the cause of death has been confirmed and discussed with relatives, s/he then gives the original to the informant to deliver to the Registrar.