Leicester City and South Leicestershire Coroner's Service

02 August 2024

Dear General Practitioner,

GP impact of medical examiner introduction on 9 September 2024

GPs are about to be substantially affected by major changes in the way death certification operates in England and Wales. On 9 September 2024, GPs will be required to discuss all deaths with either a medical examiner or a coroner. Previous working practices regarding death certification will either be substantially amended or no longer apply.

The principal changes are that:

- a doctor can certify the death of a patient whom they have attended (assessed and treated) for any condition at any point in the patient's life, irrespective of the form that the consultation took; and
- there is no longer a requirement to have seen the patient within 28 days of death and seeing the body after death is no longer a requirement.

In addition, an attending physician has two statutory duties as follows:

- to provide a cause of death where possible; and
- to send the APMCCD with a brief summary to the ME "*as soon as practicable after becoming aware of a death*". It is appreciated that a GPs priorities are often dictated by the needs of the living.

The Coroner only has powers to investigate where either the cause of death is unknown or the death is caused or contributed to by an unnatural event.

Cause of Death "Unknown"

A GP is qualified to complete an APMCCD if they have "*attended*" (assessed and treated) the deceased at *any point* during the deceased person's lifetime by any form of consultation including telephone. A GP is able to complete an APMCCD if they can state a cause of death "***to the best of their knowledge and belief***". This test does not require the GP to "know" the cause of death to any specific level of certainty, but only to:

- consider / have information about the deceased patient's medical records; and
- how they died (for example, a sudden collapse clutching their chest); and
- provide the most likely cause of death 'to the best of their knowledge and belief' gleaned from the above.

This test does not require a specific level of certainty in respect of the suggested cause of death. The test only requires the GP to consider the information available to them and provide the cause of death for which there is some supporting clinical evidence. As in most aspects of medicine, the information at a clinician's disposal is rarely complete and a cause of death, like treatment, may be provided on the basis of clinical suspicion alone.

A referral to a medical examiner has been introduced to assist GPs with providing the cause of death. Speaking to a medical examiner provides a reassurance to the GP that the death does not require the involvement of the Coroner and has a number of advantages as follows:

- Most GPs deal with a handful of deaths each year, whilst a medical examiner deals with upwards of ten deaths each day. What may appear to a GP to be an unknown cause of death may be an obvious cause of death to a medical examiner; and
- the medical examiner has experience of completing APMCCDs where there is a complex medical history and competing causes of death.

Referral to the Coroner

The Coroner's Service will continue to accept direct referrals from GPs in the following circumstances:

- No Attending Practitioner available within a reasonable time;
- No patient consultation for over six months by a GP, ANP or paramedic for a patient who is not known to have any conditions that may cause death;
- Death where there is no known cause of death and no co-morbidities and minimal medication.

It remains a possibility for a general practitioner to refer a cause of death directly to the coroner for cause of death unknown. However, historically GPs have too often applied the same standard of "knowing" the cause of death as that which they would apply to a diagnostic or treatment decision, which is a wholly incorrect approach. The standard for a GP to certify a cause of death is "*to the best of their knowledge and*

belief". Certainty is not required. The cause of death unknown is where, after consideration of the records, circumstances of the death and history from the relatives or any other source, there is no information as to what the cause of death may be.

Deaths where the deceased has conditions linked to sudden death should be discussed with the medical examiner. For example, patients with significant conditions such as hypertension, diabetes and hypercholesterolaemia, particularly if severe enough to be treated, are linked with coronary artery disease, sudden collapse and death and may therefore justify putting forward a cause of death 'to the best of the doctor's knowledge and belief.

If the death is referred to the coroner via the coroner's portal, the coroner will consider the case. However, if the coroner forms the view that the GP may be able to issue, the coroner will send the case back to the GP who will be required to complete a new referral to the medical examiner on the ME portal and discuss the matter with her/him. A referral to the medical examiner can therefore avoid additional work for the GP.

Unnatural Deaths

Deaths are referred to a coroner if there is reason to suspect that the death was either caused, or significantly contributed to by, an unnatural event. Some events are obviously unnatural such as drugs deaths, hangings, road traffic collisions and poisonings.

However, within medicine it is becoming increasingly difficult to identify unnatural events. Firstly, the current death certification system regards deaths due to smoking/lung cancer and chronic alcohol abuse/cirrhosis as natural events and, as such, they do not require a referral to a coroner. Secondly, therapeutic interventions, such as prescription of diamorphine in end-of-life care is known to accelerate death whilst providing pain relief, but no one would consider reporting such a death to a coroner. Consequently, in complex medical situations a more useful definition, albeit far from perfect, is to ask if the death is an "*unexpected death that may have been associated with a human failure*".

Sometimes a death is due (at least in part) to entirely appropriate medical treatment; for example death due to some form of spontaneous haemorrhage in a patient on anticoagulants for atrial fibrillation. Medical or surgical treatments should not normally be mentioned in a cause of death unless the treatment hastened the death. However, sometimes it is impossible to give a complete account of the death without mentioning treatment (in the above example it would probably be appropriate to include *'Anticoagulation for atrial fibrillation'* in Part 2). Such a cause of death will require the approval of the coroner, but the advice of the medical examiner should always be sought in such cases and the coroner should be alerted to the reason for referral.

Falls in the elderly are particularly problematic. The patient cohort a GP deals with today is increasingly elderly. A frail elderly person who is falling for no reason other than their frailty, often has multiple comorbidities and poly medication. When such a frail elderly person falls, a number of questions arise: Did the bone break causing the fall (natural cause)? Was the fall caused by frailty and any fracture of a bone with such

minimal trauma suggest that the underlying causes for this death (frailty and osteoporosis) are all natural? In such cases, a discussion with the medical examiner as to the underlying causes of death would be more appropriate than an immediate referral to the coroner. If the medical examiner considers the fall was the cause or contributory factor in the patient's death, they will advise referral to the coroner is indicated. Similar issues arise in respect of pressure ulcers which may simply be occurring due to the fact that the deceased has deteriorated to such a point they cannot maintain the integrity of their skin, whatever nursing care was provided.

Summary

The Medical Examiner's Service was introduced to assist general practitioners in dealing with people that have died. Their role is to assist GPs in navigating the new system and to appropriately identify those cases that need to be referred to the Coroner's Service. Thank you for your time and anticipated cooperation.

Yours sincerely

Professor Catherine Mason

HM Senior Coroner

Leicester City and South Leicestershire

Appendix

Set out below are the circumstances when a ***doctor has a duty to inform the Coroner*** of a death, based on the Notification of Death Regulations 2019. Additional comments have been added to assist in interpreting the Regulations.

- The attending practitioner suspects (*there is some reliable evidence to suggest*) that that the person's death was caused or contributed to by:

    - **poisoning** or exposure to either a toxic or an otherwise benign substance;
    - prescribed or social **drugs** or other psychoactive substance;
    - **violence**;
    - **trauma or injury** (*trauma and injury in the elderly is difficult due to increasing frailty, multiple comorbidities and polypharmacy. For example, if a frail elderly person has a fall in fractures and osteoporotic bone, you may take the view that the trauma and injury is minimal and the death is due to the underlying and osteoporosis. In such circumstances, the medical examiner should be asked for advice*);
    - **self-harm**;
    - **neglect and self-neglect** (*neglect in the coronial sense is a gross failure to provide basic care to a person in a dependent position that has caused or contributed to the death. Consequently, this has to be a really serious failure of care that has made a significant contribution to the death. Self-neglect is where a person neglects their own care. However, most cases of self-neglect are due to an underlying physical condition, for example lack of nutrition in terminal cancer, or a psychiatric condition. If this is the case the underlying driver for the self-neglect is a naturally occurring illness and should be discussed with the medical examiner*);
    - **medical treatment or a procedure** *where the attending practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death to occur. Questions that may assist the attending practitioner are included as a footnote*[1]);
    - an injury or disease attributable to any **employment** during the person's lifetime. If the deceased only has pleural plaques, this indicates asbestos exposure but does NOT prove that asbestos contributed to the death; the case should be discussed with the medical examiner;

- The attending practitioner suspects (*there is some reliable evidence to suggest*) that the death was **unnatural** (*wholly unexpected and often associated with culpable human failure*) but does not fall within any of the circumstances listed above;

- The person died in some form of **state detention** (*this includes deaths of those in state detention in hospital whilst receiving medical attention, but no longer includes DOLS orders*);

[1] Would the person have died at about the same time if the medical procedure was not undertaken? Referral is appropriate if the procedure hastened death.
Was the medical procedure necessary for the person's recovery, rather than being optional or elective?
Was the medical procedure carried out with reasonable care and skill?
Before the medical procedure was performed, was the person's condition such that the death was foreseen as more likely than not to occur?
Was the decision to perform the medical procedure reasonable, given the person's condition including the quality of life?

- there is **no attending practitioner** for the deceased person or the attending practitioner is unable to certify the death within a reasonable time; or

- The **identity** of the deceased is unknown.