“Today sees the largest change to the certification of deaths since 1953.” says LLRLMC(1).

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Immediate Release

From today the process for certifying deaths has undergone the greatest change since 1953. It is designed to improve public protection, patient care, and patient safety for the future (2).

There is now a legal requirement for every death that has not been referred to a coroner to be referred to a medical examiner.

The new system will provide independent scrutiny and an opportunity for the bereaved to speak about care and treatment in the lead-up to a natural death with a senior doctor. It is intended that the change will give assurance to relatives and reduce the risk of health scandals or malicious action by medical practitioners.

The serial killer and family GP Dr Harold Shipman evaded detection for years because he was able to issue death certificates for his victims, in which he gave “natural causes” as the cause of death with no independent scrutiny of this. The new national system was proposed in 2005 after the Shipman inquiry. Other inquiries into NHS failings have also recommended a medical examiner service. The inquiry into the scandal of failures at Stafford hospital between 2005 and 2008 heard evidence that death-certificate information had often been inaccurate or incomplete.

The new process sees the attending doctor completing a Medical Certificate of Cause of Death, which is then sent to the Medical Examiner service for scrutiny. If the Medical Examiner agrees to the cause of death they send the certificate electronically to the registrar of births and deaths. If they do not agree they will discuss a revised cause of death with the certifying doctor, and if this is not possible, refer the death to the coroner.

Dr Grant Ingrams (GP in Glenfield, and Executive Chair, LLRLMC) said: "This change will allow the bereaved to discuss the care and treatment of their loved one with an independent senior GP or hospital consultant."

"The Medical Examiner service is based in the University Hospitals of Leicester, and has been scrutinising deaths in hospitals since 2019. It has been piloted for deaths in the community since 2021."

"The new role of Medical Examiner is to scrutinise the cause of death as provided by the general practitioner or other certifying doctor. They will ensure the accuracy of the death certificate, establish whether the death should be referred to a coroner and whether there are any clinical governance concerns."

"The process will improve the experience of the bereaved, and allow feedback, both negative and positive, to be given to their general practice and others who provided care in their final illness. There will be a reduction in the number of deaths reported for investigation by a coroner, and the separate doctor's form for cremation will no longer be required."

Ends

Further Information:

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Notes to Editors:

1) The Leicester, Leicestershire and Rutland Local Medical Committee is an independent elected representative body with a statutory function to represent NHS GPs in this area. First established in 1911, they currently work under the NHS Act 2006.
2) NHS England » The national medical examiner system

3) Information and support during end of life and afterwards for patients and their loved ones in Leicester, Leicestershire and Rutland can be found at Dying Matters Leicester, Leicestershire and Rutland | HOME (dyingmattersleicestershireandrutland.com)