Death Certification – Further Guidance for GP Practices

Since the Death Certification Reforms became statutory on September 9, 2024 (see the LMC's guidance), the LMC has been engaging with GP practices and system partners to gather feedback and monitor how the changes are working.

Updated government guidance is now available: Guidance for medical practitioners completing medical certificates of cause of death in England and Wales.

We have had several examples reported to us from both North and South bank where a GP has attempted to make a referral to the coroner's office and been redirected to the Medical Examiner. Unfortunately, we also have examples where GPs have been threatened with GMC referral by the coroner's office despite them acting in good faith and in line with the national and local guidance.

The LMC wrote to the coroner's offices in direct response to these issues, and has objected in the strongest possible terms. We have met with the Medical Examiner teams and requested an urgent joint meeting with the coroner. Having escalated this to GPC England, it is apparent this is a national issue linked to conflicting guidance from the Chief Coroner, and National Medical Examiner office. Unfortunately, this leaves general practice in the middle, trying to do our best for bereaved families. Our secondary care colleagues are encountering similar challenges.

Following recent discussions with the Medical Examiner Office, we are issuing the following updated guidance to practices. We have been reassured that the Medical Examiner Office has no intention of making GMC referrals and remains happy to discuss any cases or concerns with general practice.

Engagement of GPs with the Medical Examiner Office

- The Medical Examiner Office reports that, although the change has been a steep learning curve for all, they have no concerns regarding engagement with local GPs. The volume of community cases for scrutiny is even higher than predicted. Over the last couple of weeks there have been delays of 7+ days for scrutiny of routine community cases and longer delays where the coroner is involved. Again, this is a national issue. There are shorter delays for hospital cases as doctors are on site.
- Doctors can only complete an MCCD if they have attended the deceased in their lifetime – there is still some confusion about this. There is no official definition of 'attended' but it is not necessarily restricted to F2F or video consultation only. It

could include if you had talked to the patient or liaised with a relative or specialist palliative care team – even if you had not seen the patient in person. Any medical practitioner who has attended the deceased within their lifetime can complete an MCCD if they can establish the cause of death to the best of their knowledge and belief, and the death is not required to be notified to the coroner.

- Although there is no legal definition of 'attended', it is generally accepted to mean a medical practitioner who has cared for the patient and who is familiar with the patient's medical history, investigations and treatments. The attending practitioner must also have access to relevant medical records and the results of investigations. It is a legal requirement for a medical practitioner - who meets the necessary criteria to complete the MCCD - to establish the cause of death and complete the MCCD.
- The Medical Examiner Office requests that GP practices complete the 'last seen alive' box on the Ardens template to confirm that the AP has attended the patient during their lifetime. This saves valuable time for the Medical Examiner.
- A copy of a recent discharge letter from a hospital other than HUTH can be very helpful in confirming the last illness, particularly for East Riding practices where patients are regularly admitted to York, Scarborough and NLAG hospitals.

CN1A and CN1B forms

- A doctor should continue to report unnatural, suspicious, and unexplained deaths to the coroner. When, after completing initial enquiries, a coroner decides they do not have a duty to investigate a death, a CN1A is sent to the attending practitioner (AP) with reasons why the duty is not engaged.
- The AP should send the CN1A form, together with sufficient supporting information to allow scrutiny, to the Medical Examiner office without delay (include Ardens template, reasons for proposed cause of death, and MCCD).
- The Medical Examiner will scrutinise the case and sign the MCCD in straightforward natural deaths. If following discussion, the AP and medical examiner are unable to establish a cause of death, the medical examiner will refer the case back to the coroner. The Medical Examiner Office is happy to discuss cases at any point in the process.

Identification of an Attending Practitioner (AP) for community deaths.

- A GP practice may be informed of an expected death by paramedics, nursing team, family etc. The practice will identify a doctor (the AP) who has attended the patient during their lifetime and ask them to complete the death paperwork. The AP can complete the MCCD provided they know the cause of death on the

balance of probabilities. This is a continuation of usual practice from pre-September 9, 2024.

- Issues may arise where community deaths have initially been referred to the coroner by agencies other than the usual GP practice, but the coroner decides not to investigate. The coroner's officers would have spoken to family previously and liaised with the GP practice before deciding to proceed with either 100A or further investigation. Post- September 9, 2024, any deaths that are deemed 'natural' by the coroner will be referred back to the registered GP practice via the CN1A form, potentially without discussion with the bereaved. Some of these patients will not have been seen by an AP at the practice – the most common example is someone transferred to a care home for end-of-life care in a location that requires a change of GP.
- There has been uncertainty, both locally and nationally, about whose responsibility it is to locate an AP in these circumstances. The CN1B, the Medical Examiner MCCD, was designed to be used occasionally for natural deaths where an AP cannot be found, although Medical Examiner MCCDs have to date been issued more than anticipated both locally and nationally.

Implantable Medical Devices

The information on the MCCD about implantable medical devices will be transferred to the certificate for burial or cremation (the green form). Not providing this information can lead to delays to funerals.

The MCCD refers to 'implantable medical devices'. However, you only need to state whether there is a hazardous implantable medical device in the body of the deceased person, and if so, the type of device and whether it has been removed.

For more information including a list of potentially hazardous implantable medical devices see the government guidance.

Responsibility for Identification of the Attending Practitioner

The Chief Coroner and National Medical Examiner have issued joint guidance that clarifies the responsibility for identification of the AP:

Finding an attending practitioner

- *Medical examiners' duties commence when they receive the MCCD, and medical examiner offices do not have the capacity to search for and identify attending practitioners in other cases.*
- *The CN1A form is copied to the medical examiner office for information, and medical examiner offices may support attending practitioners to understand*

death certification reform processes, but responsibility for completing the MCCD lies with the attending practitioner.

Uncertified deaths

- *In the exceptional circumstances that no attending practitioner who attended the deceased in their lifetime can be identified, a medical practitioner should contact the coroner.*
- *If the coroner's office is unable to identify an attending practitioner who is available in a reasonable time, the coroner should send a CN1B to the medical examiner office including reasons why the duty to investigate is not engaged, the name of the referring medical practitioner, and requesting completion of the Medical Examiner MCCD (ME MCCD). If the medical examiner is able to establish the cause of death, they will complete the ME MCCD. However, if the cause of death cannot be established, the medical examiner office will notify the death to the coroner.*

Ministry of Justice guidance for registered medical practitioners on the notification of deaths regulations states:

Where there was no attending practitioner, or an attending practitioner is not available within a reasonable time to sign an MCCD in relation to the deceased person

40. A registered medical practitioner will be eligible to complete the MCCD if they attended the deceased person during their lifetime. The introduction of MEs will see routine independent scrutiny of the cause of death proposed by the attending practitioner.

41. In hospitals, there may be several registered medical practitioners in a team caring for a patient. It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. In general practice, more than one general practitioner may have been involved in the patient's care and so will be able to certify the death.

42. Where there is no attending practitioner, or where an attending practitioner is not available within a reasonable time, the death is referred to the coroner by a notifying registered medical practitioner. If the cause of death is known and the coroner decides not to investigate, the coroner will refer the case to the ME who will certify the death by completing a ME MCCD.

We will continue to keep you updated. If you experience any issues, please flag them to the LMC via our main inbox humberside.lmcgroup@nhs.net

Humberside LMCs

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