

# Death certification reform in England and Wales – how will healthcare providers and commissioners be affected?

13 March 2024  Heather Caddy

The national medical examiner system was introduced in England and Wales on a non-statutory basis in 2019.

Medical examiners are senior medical doctors who provide independent scrutiny of the causes of death, and who are trained in the legal and clinical elements of death certification processes. Since 2019, it has become increasingly standard practice for medical examiners to provide independent scrutiny of deaths that are not investigated by a coroner. Medical examiners are now scrutinising almost all deaths in acute trusts and a growing proportion of deaths in all other healthcare settings (including the community).

In April 2024, death certification reforms come into force, requiring an independent review of every death in England and Wales, without exception. This will either be independent scrutiny by a medical examiner or investigation by a coroner.

The reforms will be underpinned by new medical examiner regulations, currently in draft and published by the Department of Health and Social Care (DHSC) and the Welsh Government, together with [guidance](#) on the expected changes. Additional primary legislation will also be commenced to support the reforms.

We have analysed the proposed reforms and the impact they will have on the clients we work with, in particular, NHS Trusts, healthcare providers, integrated care boards (ICBs) and Welsh health boards.

## Key procedural changes

With effect from April 2024:

- Independent scrutiny of causes of death by a medical examiner will continue and will become a statutory requirement prior to the registration of all non-coronial deaths in England and Wales.
- Medical examiners will carry out a proportionate review of the deceased's medical records and will be a contact for bereaved people who wish to ask questions or raise concerns.
- A medical practitioner will be eligible to be an attending practitioner and complete a medical certificate of cause of death (MCCD) if they have attended the deceased in their lifetime. The attending practitioner will propose a cause of death, if able, and share this and the MCCD with a medical examiner, who will then scrutinise them before submitting them to the registrar. There will no longer be a need to refer the case to a coroner for review if the medical practitioner had not attended to the deceased within the 28 days prior to death or had not seen the patient in person after death.
- A new MCCD will replace the existing certificate, which will include new information such as ethnicity (as declared by the patient on the medical record) and any medical devices or implants. An online version on the MCCD will be available later in 2024.
- A medical examiner certification will be introduced, for the exceptional circumstances where either there is not an attending practitioner or where an attending practitioner is not available within a reasonable time to complete an MCCD. Only the senior coroner can refer the death for certification by the medical examiner.

For clarity, the [Notification of Death Regulations 2019](#) will remain in place (subject to some small amendments), meaning attending practitioners are to continue to notify deaths that fall within the regulation criteria directly to the coroner, who will remain responsible to

take appropriate further action. Where an attending practitioner notifies a coroner of a death directly, there will be no regulatory requirement for the attending practitioner to tell the medical examiner they have done this.

## How will NHS trusts, healthcare providers, ICBs and health boards be affected?

NHS trusts in England, which have a medical examiner office:

- Should ensure that office is supported in the operational rollout of the updated medical examiner system before the regulation reforms come into force in April 2024.

NHS Wales Shared Services Partnership (part of Velindre Trust) as the identified appointing body and provider of the all-Wales medical examiner service in Wales:

- Should finalise their preparations for the statutory system from April 2024.

The remaining healthcare providers within England and Wales:

- Must ensure they make the necessary arrangements to inform a medical examiner of an individual's death and share their medical records in a timely manner.
- Medical examiner offices in turn will need to work with their regional (England) and lead (Wales) medical examiners, to facilitate processes with all healthcare providers in their area which have responsibility for medical practitioners completing MCCDs.

ICBs in England:

- Should contact all healthcare providers in their area and require them to establish processes to refer relevant deaths to medical examiner offices for independent review.

Welsh health boards:

- Will be required to work alongside their healthcare providers, to develop a process of referral of relevant deaths to a medical examiner's office, so that scrutiny of deaths can be undertaken.

Healthcare providers:

- Will also be required to establish processes to receive feedback from the medical examiner's office to allow for learning and development.
- Will be required to share records with medical examiners. The sharing of records between health care providers and medical examiners will become mandatory. Section 251 support, currently, has been granted for sharing records with medical examiners in England. April 2024 will see medical examiners having a right of access to patient records under section 3 of the Access to Health Records Act 1990, as amended by the Coroners and Justice Act 2009.

Training must be completed by medical examiners when the new regulations come into force.

## What is the implementation plan?

Between January and April 2024:

- Final regulations will come into from April 2024.
- Face-to-face training for medical examiners and medical examiner officers will be provided by the Royal College of Pathologists and online training provided by NHS England.
- Existing guidance, including guidance from the national medical examiner's office and office of the chief coroner, will be updated to reflect the statutory changes.
- The new MCCD will be made available in preparation for use.

## Key contact



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