

Cruse Bereavement Care

Response to consultation paper CPC (L) 12/07

Statutory Duty for Doctors and other Public Service Personnel to Report Deaths to the Coroner

About Cruse Bereavement Care

Cruse Bereavement Care is the major bereavement organisation, providing information, bereavement support and bereavement counselling throughout England, Wales and Northern Ireland. The organisation is a training provider to public authorities, other charities and businesses whose responsibilities bring them into contact with bereaved people.

Cruse Bereavement Care has **5,457** volunteers working through around **130** branches and areas throughout England, Wales and Northern Ireland.

Over **half a million** hours were given by volunteers in 2006-07.

In addition to supplying initial information and support to **87,386** enquirers, **22,751** clients were given face-to-face support by Cruse local services.

The Helpline is currently answering calls at a rate of almost **17,000** a year. Email support is becoming increasingly important, and **8,882** messages were responded to in 2006-07.

The rd4u message board for children and young people saw a **61%** increase in messages posted to almost **2,000**, and **1,314** children under 18 were supported by local services, an increase of **71%**.

As in previous years, the largest single group of clients was adults who had lost a parent, followed by adults who had lost a partner. Among our clients under 18, almost **60%** had lost a parent.

Whilst cancer is the commonest cause of death giving rise to bereavement among our clients, **sudden and traumatic death, caused by suicide, road and other accidents, homicide and disaster, represented a disproportionate share of the bereavements for which our clients sought support – about 12%.**

The majority of our clients – 63% – seek help within one year of their bereavement, but our support continues to be sought by bereaved people at any time after the death, with **3%** of clients receiving support more than 10 years after the bereavement.

Response to the consultation

General comments

Cruse welcomes the opportunity to take part in this important consultation. We regret that the consultation period has been so short. We feel that this should have been extended to enable respondents to align the responses to this paper with 2 later consultations covering related matters:

Improving the Process of Death Certification

Cremation Regulations Consolidation and Modernisation

We will be responding to these, and will review the content of this response at that time, in case any provisions in these later papers give rise to further comments relevant to the statutory duty to report.

Responses to specific questions

Q1. Are these the right types of public service personnel who should be given a statutory requirement to report a death to a coroner?

Broadly, yes. We welcome your proposals to bring the current statutory requirements on Prison Governors and registrars into one place. We would support the measure recommended in the Luce Report that fire service personnel should be included. As a package, the measures should increase the probability of appropriate deaths being reported to the coroner.

If not, who else should be placed under this duty and why?

We assume that the new office of medical examiner will be included on the list.

We also have some important criteria which we believe should influence the list:

Because doctors have traditionally been involved in reporting deaths to the coroner, it appears reasonable to place a statutory duty upon them. Even for doctors however, there will be training needs and a requirement for appropriate, consistent, criteria against which professional judgement may be exercised. Certainly, no other service or profession should be added to the list without appropriate protocols being in place.

These should provide:

- Clear definitions of responsibilities so that there is no danger of the need to report being overlooked when there is more than one person/agency/profession who could be responsible
- Clear protocols for the responsibilities of any front-line staff involved (e.g. ambulance personnel, fire-fighters), including definition of the management support with which workers should be provided when faced with decisions
- Before the list is finalised, a training needs analysis of relevant personnel and scoping of appropriate training should be carried out. No new profession or agency should be added to the list without appropriate training being in place.

Q2. Do you believe the proposed list of reportable deaths to the coroner is workable, effective and proportionate?

Broadly, yes. We assume that dentists would be included in the categories of health professionals relevant to the possibility of lack of care.

We think that the provision for death of a child to be reported should be elaborated; there should be a clear differentiation between the expected death of a child (i.e. death in the terminal stage of illness) and unexpected death. This makes the 24 hour provision less relevant, particularly when child protection considerations come into play. We assume that these will be integrated into the criteria for all reporting, and that the death of a child on the Child Protection register will trigger an investigation.

It is important that deaths should be reportable by Registrars, and by family members or members of the public who have concerns.

We are pleased to see that specified diseases or conditions will include well known hospital infections. On our National Helpline we have callers who are unhappy with the cause of death on the death certificate and feel that concerns about MRSA etc have been to use one caller's words "brushed under the carpet" This affects the way relatives grieve and can contribute to significant anger and a difficulty in accepting what has happened. We recommend the practice at Addenbroke's hospital which

offers family members an interview at a specified period after the death, with an opportunity to have their questions answered. Procedures like this are helpful to bereaved people, and are also likely to contribute to the reduction of complaints against NHS trusts.

Q3. Are there any additional circumstances not mentioned in the proposed list where you believe there should be a statutory duty to report a death to the coroner?

The Select Committee on Constitutional Affairs 8th report in Parliamentary session 2005-2006 drew attention to the fact that “the existing statutory rules are opaque, that those rules have been built upon and there are lists in existence which try to elucidate the statutory rules, that local coroners have their own local rules and it is extremely difficult for doctors to form a view.” (evidence from Dame Janet Smith).

This level of confusion is not in the interests of bereaved people, and therefore, the attention to detail given to compiling the list of circumstances should be underpinned by a clear drive towards national standards, binding upon all local services.

Q4. Are there any circumstances where deaths are reported to the coroner unnecessarily? If yes, please specify. (Please do not mention deaths occurring outside of England and Wales in this section.)

The 45% reporting rate (2005) illustrated in the Select Committee report would appear to indicate that there are. The ideal situation is obviously one where the profile of deaths reported to the coroner fits reasonable criteria for professional concern and public confidence. This is difficult to achieve. Perhaps the possibilities for performance management and audit systems should be examined with a view to their potential for increasing public confidence, which then might feed back into improved professional discretion. Without this change, professionals may be tempted to report deaths unnecessarily, for fear of criticism.

Q5. Do you agree that the 14 day rule is arbitrary and unnecessary? If not, what length of time limit would you suggest?

We note that the Select Committee Report stated that “There is also considered to be a lack of adequate training in some pathology matters at medical schools.” It is important that this is improved, to support any changes to the 14 day rule, and to improve confidence generally.

We certainly believe that some distress is caused to relatives when, through the use of deputising services, or because of hospital shift systems, the relevant doctor is not available, even though the cause of death may be clear. We commend the practice at Birmingham NHS Trust, whereby for patients in the last phase of an illness, the expectation of death is noted in the patient record for handover, so that a doctor covering the weekend shift is able to ensure that the patient is seen, and that s/he is able to provide the certificate, if death occurs.

Unexpected deaths will always be more problematic. The GP member of our team has told us that: “The 14 day rule is somewhat arbitrary but we (GPs) have always had the option of speaking to the Coroner for advice and if we have not seen the deceased for longer than 14 days before death but have sufficient knowledge of the patient and the death then the coroner will give permission for us to issue a certificate; there is a box to tick indicating we have consulted with the coroner. “

In all such procedures, the procedure itself is never the whole story. Open, sensitive and considerate communication with bereaved families is essential.

Q6. Do you believe that a deliberate or wilful failure to discharge this duty on the part of a doctor or other public service professional should be dealt with as a criminal offence as described? We would be interested to hear any reasons behind your views.

Q7. Do you agree that the most appropriate sanction is through the employer's code of conduct and the relevant professional regulatory body? Again, we would be interested to hear any reasons behind your views.

Not all those in the potential list to have a duty to report (e.g. fire-fighters, care home workers) may be considered to have appropriate professional regulators. The interests of justice demand that where the criminal law applies, this is an equitable process across professions and occupations. We draw attention to our point about protocol and management support given in our response to Q1. In all settings, consideration should be given as to whether mistakes arise from lack of knowledge, from inexperience or from inadvertent oversight. There must be a spectrum between such failings, which may give rise to the need for further training, and persistent neglect, carelessness or wilful concealing of the facts, to which of course, ultimately, the criminal law must apply in serious cases.

Q9. Do you foresee any practical difficulties arising from the introduction of a second scrutiny of death certificates and the list of reportable deaths?

We believe that second scrutiny is an important and necessary reform. We are concerned that we have to respond to this consultation without knowing:

What resources will be devoted to this, and what standards put in place, to ensure that delays are not caused? Delayed certification has the potential to cause distress to all families and to cause offence to some faith groups.

How will medical examiners gain access to records?

What procedures will be put in place to ensure the right balance between proper scrutiny and personal confidentiality?

We welcome the proposal that the medical examiner will be empowered to discuss the circumstances of the death with bereaved family members. Training in bereavement awareness and appropriate communication skills will be essential for these professionals.

Q10. Do consultees agree with the principles which will inform a reporting system?

We agree with the objectives of keeping bureaucracy to a minimum, not adding to delays for family members and that the reporting process should be simple to use and understand. We would welcome involvement in the detailed thinking on the mechanics of the referral process after the Coroners Bill receives Royal Assent.

It is our experience that currently the relatives of a person who has died may not always know why a death has been referred to the coroner. The effect of this is to affect the grieving in the short and long term of those who have been bereaved. We therefore welcome attempts to clarify which deaths should be referred to the coroner, and who should hold this responsibility.

The Ministry of Justice consultation paper is in full here:

<http://www.justice.gov.uk/docs/cp1207.pdf>