FROM THE MINISTER OF HEALTH

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Conor Murphy MLA
Minister of Finance

Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
Tel: Irrelevant & Sensitive
Email: private.office@health-ni.gov.uk

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Dear Conor,

CORONAVIRUS ACT – DEATH CERTIFICATION AND REGISTRATION PROVISIONS

Thank you for your letter of 16 December about the current provisions in the Coronavirus Act around the certification and registration of still-births and deaths.

I note and support your intention to extend the registration provisions around electronic transfer of documents (paragraphs 18-22 and 27-30 of Schedule 13 to the Act). This reduces the need for face to face interaction and is a more modern approach to the registration process. It will also be beneficial in the future as we develop an Independent Medical Examiner service to review non-Coronial deaths.

I do, however, have concerns about the provisions in paragraphs 23-26 of Schedule 13.

Paragraph 24 allows any doctor to complete a Medical Certificate of Cause of Death (MCCD), regardless of whether they have seen and treated the patient within a specified period, provided they can state the cause of death to the best of their knowledge and belief.

Whilst it is questionable whether a medical practitioner could state the cause of death having not treated the patient within 28 days, the reality is that some MCCDs are being completed in such situations. This creates a significant risk in that many MCCDs may not be completed accurately and this has a knock-on effect in relation to statistical data and the subsequent funding associated with disease.

Inaccurate completion of MCCDs can also impact on bereaved families as many find it distressing when the cause of death for their loved one is incorrect. There is also the

potential that hereditary conditions that may affect the health of the deceased's relatives are not recorded on the MCCD with early intervention and treatment possibly delayed.

My main concern however, relates to paragraph 26 of Schedule 13 and the fact that the current position provides no assurance that deaths are appropriately referred to the Coroner for scrutiny. Prior to the pandemic, if the deceased had not been seen and treated within 28 days of death, there was a requirement to report to the death to the Coroner to provide independent assurance as to the cause.

This provided some assurance that the Coroner was satisfied that there had been no untoward activity or malpractice involved in the circumstances and approval was provided for the death to be registered. The removal of this requirement increases the risk that untoward activity or malpractice could easily be concealed if this provision is maintained.

It should also be noted that this provision is at odds with other parts of the UK. In England and Wales, the Coronavirus Act made provision that a death must be reported if the deceased had not been attended in the previous 28 days. That time frame had been extended from 14 days which was the position prior to the pandemic.

The requirement to report to the Coroner where the patient has not been seen and treated within 28 days, provides some assurance that there was no untoward activity or malpractice being concealed and that the cause of death is as accurate as reasonable in the circumstances

Whilst these provisions were legitimately considered to be necessary at the start of the pandemic, for the reasons above it is my view that it would be desirable not to extend paragraphs 23 -26 of Schedule 13, or at least to limit the extension to as short a time as possible, although I recognise that responsibility for these provisions rests with you. I am also aware that this may have implications for the Coroners' Service and as such you may wish to write to the Minister of Justice.

Yours sincerely

Personal Data

Robin Swann MLA
Minister of Health