Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Submission on Death, Funeral, Burial and Cremation Review

To: Ministry of Health

Submitter: Canterbury District Health Board

Attn: Kirsty Peel
Community and Public Health
C/- Canterbury District Health Board
PO Box 1475
Christchurch 8140

Proposal: The Ministry of Health is consulting on proposed changes to the Burial and Cremation Act 1964 and Related Legislation.

SUBMISSION ON THE DEATH, FUNERALS, BURIAL AND CREMATION REVIEW

Details of submitter

1. The Canterbury District Health Board (CDHB) is responsible for promoting the reduction of adverse environmental effects on the health of people and communities and to improve, promote and protect their health pursuant to the New Zealand Public Health and Disability Act 2000 and the Health Act 1956.

2. We welcome the opportunity to comment on the Death, Funerals, Burial and Cremation Review and have concentrated our feedback on the questions most relevant to our organisation.

3. This feedback has primarily come from physicians who are long term members of the CDHB mortality review committee, a committee which has been operating for over 25 years. Additional contributions have come from the CDHB PMMRC coordinator and health protection officers.

Specific comments

Section A – Death certification and auditing

1 Do you agree that there should be a general duty on everybody to 'treat any dead human body or human remains with respect'? If not, why not?	The CDHB agrees with this. In the hospital environment this is essential and within CDHB is actively taught to, and upheld by, staff. This principle demonstrates respect to the deceased and also their whānau/ family where wide ranging cultural and religious beliefs are important.
2 Do you agree that any breach of this duty should be an offence punishable by infringement notice, or, on conviction, by a fine? If not, why not?	The CDHB agrees with this.
3 Do you agree that there should be a requirement that the person who has the duty to dispose of the body must do so without undue delay, including considering the mourning needs of the bereaved, any ceremonies to be performed, tikanga or other cultural practices, and any other relevant considerations (such as police investigations)? If not, why not?	The CDHB agrees with this.
4 Do you agree that any breach of this duty should be an offence punishable by	The CDHB agrees with this.

infringement notice, or, on conviction, by a fine? If not, why not?	
5 What do you think are the key problems with the current system for certifying the cause of death and existing auditing systems?	In a hospital environment, completion of the MCCD often falls to the most junior member of the clinical team, often with little or no guidance from senior colleagues. There are variable levels of education for house officers about completion of death documents and coronial processes in orientation of new doctors. Lack of knowledge and poor prioritisation can lead to inaccuracy in the details completed and delays. At CDHB we have run a Mortality Review Committee for 25 + years. This has a twofold function. Firstly, to ensure ongoing education of all medical staff on completion of death documents and appropriate coronial referral. Secondly, we conduct twice weekly reviews of all death documentation for those patients dying in CDHB hospitals. This is mainly to ensure that the MCCD is appropriately completed but also to ensure those cases that should be referred to the Coroner, are referred. As such, this acts as a safety check within CDHB and as an audit and education resource. Details are entered onto a database that is then shared with Heath Information Statistics and this is taken into account when the details are finalised. Common problems observed within the CDHB Mortality Review Committee include: • Difficulties with the legibility of the handwriting on the forms. • Common use of abbreviations (some are probably commonly known e.g. IHD for ischaemic heart disease but others are not well understood, such as ILD for interstitial lung disease). • Important contributors to death not included in part 1 of MCCD e.g. hypertension/diabetes OR recent surgery left out entirely e.g. surgery for fractured neck of femur. • Important diagnoses left out altogether e.g. dementia. • Problems included on MCCD that are not relevant to cause of death in any way e.g. gout, glaucoma • Indecision in the clinical team (at all levels of seniority) about what degree of certainty is required to complete the MCCD. Some patients are referred through the coronial process despite there being no doubt that the death was due to natural causes. In these cases, clinicians argue (strongly sometimes) that they have no idea what the final cause of death is and listing a cause is little short of “guessing”. These clinicians will ask that the Coroner take jurisdiction. The Coroner,

	however, is generally unwilling to take jurisdiction over cases where death is due to natural causes. • Delays can occur unless each hospital has good systems in place. The main issues are deaths on Friday evenings or weekends and when family/whānau may desire release of the body from the hospital. However, the primary clinical team may not be on duty and completion of the MCCD +/- cremation certificate falls to an often over-worked house officer who is unfamiliar with the deceased. • Outmoded language, especially on cremation certificates, leads to confusion e.g. "mode of death". What does this mean and what purpose does it serve? As mentioned there are duplications on cremation certificate and MCCD. The CDHB is not aware of other DHBs running similar committees. It is our understanding that there is no feedback to those medical staff completing the MCCD at most DHBs unless there is concern expressed by family/ whānau or another person in the process e.g. funeral director. The CDHB is cognizant of the fact that the committee we operate currently only covers auditing of death certificates where deaths occur in the hospital environment. We are aware that the majority of deaths occur elsewhere, including about a third in aged care facilities. Currently, the CDHB mortality review committee does not cover general practitioners who will be completing the MCCD in these cases.
6 Can you provide any evidence about the size or extent of the problems with the current cause of death certification and auditing systems?	Previous audits at CDHB suggest that <u>at least</u> 10% of MCCDs are inaccurately completed which can lead to translation of these inaccuracies to Death Certificates and national statistics. It is likely that nationwide this figure will be higher.
7 What do you think about the options identified for modernising the death certification system? Do you want to suggest any additional options? If so, please provide the reasons for your alternative options.	The CDHB believes that Option 2 seems to be a reasonable improvement over the status quo, however, there is some detail that needs to be clarified. In particular, there is a lack of detail about the oversight provided by the Ministry of Health, and if this will include periodic audit of the MCCDs produced. It is the CDHB experience that doctors need regular and ongoing education about these matters if the integrity of the system is to be maintained. The CDHB believes that some guidance around the level of certainty required for cause of death will be important so that clinicians feel empowered to complete the MCCD and avoid unnecessary coronial referrals. How this is achieved and translated to practice will require some careful consideration.
10 What is your preferred option to modernise the death certification system? Please	The CDHB supports Option 2 and agrees that additional checks about identity of the deceased is probably unnecessary. Within hospitals, doctors are usually

provide the reasons for your view.	advised to use wrist bracelets as a secondary form of identification (and if the deceased is unknown to them).
11 What do you think about the options identified regarding the auditing of death certification? Do you want to suggest any additional options? If so, please provide the reasons for your alternative options.	The CDHB considers that Option 2 is a sensible improvement, where each DHB will establish a committee that audits a defined number of MCCDs. Information could then be sent back to the individual clinician. Some detail needs further development, such as how will the committee communicate with the Ministry for coding and feedback, and if the committee finds a significant error in the MCCD, how is the MCCD altered (or is it?).
12 Do you agree with the impacts of the options regarding the auditing of death certification? Why/why not? Can you suggest other likely impacts from the three options?	The CDHB agrees with the documented impacts. There will need to be a mandated requirement for DHBs to allocate resources to this in order to achieve the desired outcomes.
13 Can you provide any information to help the Ministry gauge the size of any potential impacts, costs or benefits that would affect you?	In order to get buy-in from General Practice, the CDHB would need to involve GPs in the auditing process which would involve paying for their time. Additional administration support would also be required to co-ordinate this.
14 What is your preferred option for auditing death documentation? Please provide the reasons for your view.	The CDHB supports Option 2 and considers that a central reviewer, as outlined in option 3, is probably unnecessary and would add considerable cost.

Section B – Regulation of the funeral services sector

15 Do you agree that there are issues that could be improved with the funeral services sector? Are you aware of any other problems?	The CDHB considers there needs to be clarity and transparency around funeral charges and improved communications with families about these before they engage a provider. It does seem reasonable that some form of formalizing the complaint system would also improve services generally.

Section C – Burial and cemetery management

25 Do you agree that there are issues that could be improved with the current framework for burials and cemetery management? Why/why not? Are you aware of any other problems?	Community and Public Health, the CDHB's public health service has seen an increase in the number of applications for private cremations and enquiries into private burials. Proving religious beliefs has been a point of contention (how is this proved?). While our health protection staff currently attend private cremations for which a licence has been issued, it is our experience that the public health risks in these situations are very low or non-existent. Community and Public Health has never issued a license for a private burial and discourages applications

	as it is very difficult to meet the current criteria. Community and Public Health's main duties under the current legislation is with regard to disinterments, where a health protection officer is required to attend. Given that there are very few diseases that would survive in a dead body for any extended period, the public health risk from this activity is very low, even after recent interment, and non-existent when the original interment was decades ago.
30 What is your preferred option for a new framework for burial and cemetery management? Please provide the reasons for your view.	The CDHB supports Option 3 and agrees with the Ministry analysis of the impacts.

Section D – Cremation

31 Do you agree that there are issues that could be improved with the current cremation or medical referee systems? Are you aware of any other problems?	The Cremation form completed by a medical practitioner needs updating and the language and duplication in the current form needs addressing. It can be very stressful for families of babies who have died to complete the application for cremation and to have to answer irrelevant questions like those about pacemakers and biochemical aids. The current process for the appointment of crematorium referees is cumbersome but, once appointed, there are few, if any checks on/audits of their practice. The involvement of the local Medical Officer of Health in this process serves no particularly useful purpose. The current legislation also allows for the local Medical Officer of Health to act as a crematorium referee, if no referee is available. This is not a matter of public health and is outside the scope of practice and training of most public health physicians who are designated Medical Officers of Health.
40 What is your preferred option for changes to the medical referee system? Please provide the reasons for your view.	The CDHB considers that Option 2 (repealing the medical referee system) may be appropriate, particularly if it reduces costs for families. However, the CDHB believes it is important to obtain the perspective of medical referees to understand how often the actions of the medical referee has resulted in a meaningful intervention. The current medical referees are best placed to provide this feedback. The upcoming referendum on the End of Life Choice Bill could lead to a law change in the near future. This will be unknown territory for the health system as far as death certification is concerned. The CDHB believes it will be important to consider the impacts of this change to the potential importance and future role of the medical referee.

Person making the submission

Name Sue Nightingale Date: 12/03/2020

Position Chief Medical Officer

Contact details

Kirsty Peel

For and on behalf of
Community and Public Health
C/- Canterbury District Health Board
PO Box 1475
Christchurch 8140

P +64 3 364 1777
F +64 3 379 6488

Kirsty.peel@cdhb.health.nz