General Dental Council

Death reporting research project

Evidence review

30 May 2023

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1. Context

Research has identified that the fitness to practice (FtP) process can be a stressful experience for dental professionals. Moreover, concerns have been raised that some dental professionals undergoing FtP processes may take their own lives. The General Dental Council (GDC) doesn't currently record information on cause of death for any professional on its register. In October 2022, the GDC stated that it intended to report data in Q2 2023, unless it was not able to do so (Czerniawski, 2022). To inform our thinking and ensure we were evidence-led, we carried out a review of current sources which provide cause of death information. As part of the review, we also scoped current data holdings on how we record registrant deaths.

The aim of this review was to scope how the GDC could identify deaths that occur during an investigation. Based on these aims, the questions that this review sought to answer were:

- What information does the GDC currently collect when notified of a registrant's death?
- Who to contact and when to request information on cause of death?
- How to categorise cause of death from various sources?
- How to ensure the validity/reliability of the data?
- How to ensure validity/reliability of the reporting of the data?

This was an initial desk study, not an exhaustive review. We present here a brief overview of sources, produced between 2010 and 2022, that explore the questions identified above. We excluded sources which were predominantly concerned with processes for reporting deaths in countries outside the UK. Although every effort was made to review all pertinent information, due to the complexity of the subject, the differences to the processes between UK nations, and the limitations in time and resources for this scoping, some subtleties may have been inadvertently missed.

1.1. Informing the GDC of a death

The GDC asks relatives or representatives of registrants who have died to notify it by providing relevant personal details (i.e. registrant's full name, date of birth and registration number, if known) and an original death certificate or a copy of the coroner's certificate (GDC, n.d.). The GDC website emphasises that an original copy of the death certificate is necessary to remove someone from the registers (GDC, n.d.).

Where the GDC hasn't previously been informed of a death, if there is an open FtP case but there is no payment at the Annual Retention Fee (ARF) renewal date, the registrant's name will go onto a non-payment list that is sent to FtP to confirm if the registrant needs to be retained or removed from the GDC register. If there has been no contact with the registrant or their representative, the case is sent to the head of service for consideration.

In either circumstance, the cause of death is not currently recorded, only the date of notification and that the registrant is deceased.

2. Recording of deaths

2.1. England and Wales

The General Register Office (GRO) maintains the national archive of all deaths for England and Wales (HM Passport Office, 2022). It holds all death records from July 1837

to six months prior to the present day (HM Passport Office, 2016). Death certificates include information on the deceased's occupation and the cause of death.

Death certificates can be requested online through an ordering process (requires the creation of an account) or by contacting the GRO for assistance; there is a fee charged for every certificate requested (HM Passport Office, 2022). A GRO index reference number is needed to order a death certificate. The GRO number can be obtained by searching a database for records post 1984. Without it, additional fees will be charged for the search (HM Passport Office, 2022b).

The GRO does not issue certificates for deaths that occurred within the last six months, instead they can be obtained from the register office where the death was registered (HM Passport Office, 2022b; GOV.UK, 2022a). Deaths must be registered within five days of occurrence, including weekends and bank holidays (GOV.UK, 2022b). If the coroner decides there needs to be an inquest, an interim death certificate can be issued by the coroner while awaiting the outcome of the inquest, which can be used to notify a registrar of the death (GOV.UK, 2022c). The coroner will inform the registrar of the cause of death after the inquest has concluded.

Coroners in England and Wales are responsible for investigating deaths which are unnatural or violent, if the cause is unknown, or if it happened while in state detention (Courts and Tribunals Judiciary, 2022). Coroners are appointed by local authorities, with the Chief Coroner heading the coroner service (Courts and Tribunals Judiciary, 2022). Since 2015 there have been several mergers of coroner areas with long-term plans to reduce them to approximately 75; in England and Wales, there are currently 83 coroner areas (Courts and Tribunal Judiciary, 2022b). In 2021, the average time to process an inquest was 31 weeks (up from 27 weeks in 2020), however this can vary by area with some areas reporting a maximum average time of 75 weeks (Ministry of Justice, 2022).

2.1.1. Inquest conclusions

Short form conclusions

Short form conclusions are those that fit into established categories (i.e. accident or misadventure, alcohol/drug related, industrial disease, lawful/unlawful killing, natural causes, open, road traffic collision, stillbirth, suicide) (The Coroners (Inquests) Rules, 2013). Although there is a list of short form conclusions, it is not exclusive (Courts and Tribunals Judiciary, 2021). It is recommended that coroners conclude with these when possible (Courts and Tribunals Judiciary, 2021). They make up the majority of returned conclusions (see section 3.4) (Hill & Cook, 2011).

Open conclusions are a type of short form conclusion. Their use is generally discouraged except where necessary (Courts and Tribunals Judiciary, 2021). However, if the evidence is not sufficient to prove another short form conclusion, an open verdict may be returned (Carroll, et al., 2011; Courts and Tribunals Judiciary, 2021).

Narrative conclusions

A narrative conclusion can be used as an alternative or in addition to short form conclusions (Courts and Tribunals Judiciary, 2021). Instead of relying on short form conclusions, narrative conclusions briefly explain the circumstances of the death,

answering the four statutory questions (i.e. who, how, when and where) (Carroll, et al., 2011; Hill & Cook, 2011; Courts and Tribunals Judiciary, 2021; Ministry of Justice, 2022). A study in 2011 found that since 2001, there had been an increase in the use of narrative conclusions (see section 3.4) (Hill & Cook, 2011). Narrative conclusions should not be confused with findings of facts (Courts and Tribunals Judiciary, 2021).

2.2. Scotland

The National Records of Scotland (NRS) maintains records for deaths in Scotland (GOV.UK, 2022d; NRS, 2022). Statutory death records include information on the deceased's occupation and the cause of death. Certificates can be ordered through the 'ScotlandsPeople' website (this requires the creation of an account), by applying in writing, or through a local registrar (NRS, 2022b). There is a fee charged for every certificate requested; the fee varies depending on how the request is made. It is not possible to view death certificates online for deaths which occurred in the last 50 years, as these are restricted, based on the National Records of Scotland's privacy policy (ScotlandsPeople, 2022).

Deaths must be registered within eight days of their occurring, including weekends and bank holidays, at any registration office in Scotland (GOV.UK, 2022b; NRS, 2022c). A medical certificate showing the cause of death is also sent to the selected registrar by the certifying doctor, hospital, or hospice (NRS, 2022d).

The Crown Office and Procurator Fiscal Service's (COPFS) Scottish Fatalities Investigation Unit (SFIU) are responsible for investigating cases of sudden, suspicious, or unexplained deaths (Crown Office and Procurator Fiscal Service, 2021). Sudden deaths are those where a doctor has determined that the death was "clinically unexpected", while unexplained deaths are those where "the cause of death is not known or clear to a doctor" (Crown Office and Procurator Fiscal Service, 2021). A suspicious death is "where the circumstances suggest that criminal conduct caused the death" (Crown Office and Procurator Fiscal Service, 2021).

2.2.1. Final cause of death determination

If a post-mortem examination is required, the pathologist will issue a medical certificate after completing their examination. If further tests or examinations are required, the pathologist may issue a provisional cause of death until all examinations are completed (COPFS, 2016). At that point, a final post-mortem report will be produced, and the final cause of death amended on the death certificate, if required. (COPFS, 2016). This process is normally concluded within 12 weeks (COPFS, 2016). In some cases, particularly for suspicious deaths, the Procurator Fiscal may conduct further investigations (COPFS, 2016). By convention, the word suicide or any synonym is not used on death certificates in Scotland (NRS, 2021).

2.3. Northern Ireland

The General Register Office for Northern Ireland maintains records for deaths in Northern Ireland (GOV.UK, 2022e; NIdirect, 2022a). They hold death records from 1864 to present. Certificates can be ordered online (this requires the creation of an account), by phone, by post or in person; there is a fee charged for every certificate requested (NIdirect, 2022b;

NIdirect, 2022c). Ordering a certificate requires the full name of the person, the date and place of death, their usual address, and for deaths which occurred in the last three years, and if the coroner was notified (NIdirect, 2022d). It is not possible to view the death certificates for deaths which occurred in the last 50 years online, as these are restricted, but they can be viewed in person by appointment in the Belfast search rooms (NIdirect, 2022c).

Deaths must be registered at any registration office in Northern Ireland within five days from receiving the Medical Certificate of Cause of Death from the hospital (NIdirect, 2022e). Due to Coronavirus restrictions these certificates were forwarded automatically to the registrar corresponding to the deceased person's home address (NIdirect, 2022e).

However, if the death is referred to the coroner, it can only be registered after the necessary certificate is sent to the registrar by the coroner (NIdirect, 2022e).

Coroners in Northern Ireland are the ones who investigate deaths which are, among others, sudden, unnatural, violent, unexpected, or unexplained (NIdirect, 2022f). There are currently four coroners in Northern Ireland (Department of Justice, n.d.). Requests for copies of inquest papers or findings can be made by post to the coroner (at a central address); this is at the discretion of the coroner and there is a fee for copies (Department of Justice, n.d.).

2.3.1. Findings

In Northern Ireland outcomes of inquests are in the form of findings. Findings describe the facts concerning the circumstances of the death (i.e. who was the deceased person and how, when and where they died), outlining the causes of death (i.e. direct, underlying and contributory) (NI Courts and Tribunals Service, 2013; Coroners Act (Northern Ireland), 1959; NISRA, 2022). By convention, the word suicide or any synonym is not used on death certificates (NISRA, 2022).

3. Validity and reliability of cause of death classifications

3.1. Changes to standard of proof requirements

In July 2018, England and Wales changed the standard of proof required to establish a verdict of suicide (ONS, 2019; ONS, 2019b). Prior to July 2018, the standard of proof for coroners to return a verdict of suicide was that of beyond all reasonable doubt (Hill & Cook, 2011; ONS, 2019). Since July 2018, the standard applied is the same as the civil standard (i.e. the balance of probabilities) (ONS, 2019; Courts and Tribunals Judiciary, 2021). All other possible explanations must be ruled out for a coroner to arrive at a verdict of suicide (ONS, 2019). Northern Ireland confirmed the same required standard of proof (the balance of probabilities) in November 2018 (NISRA, 2022).

3.2. Impact of COVID-19

In March 2020, the Coronavirus Act 2020 was introduced. It included "easements" to the process associated with the registration of deaths for England and Wales, Scotland, and Northern Ireland (BMA, 2022; Coronavirus Act, 2020). The act was repealed on 24 March 2022 (BMA, 2022; Coronavirus Act, 2020).

3.3. Changes to process in England and Wales

In England and Wales, there will be a new medical examiner system from April 2023 to "provide independent scrutiny of the cause of death" for all cases not referred to a coroner for instigation (NHS England, n.d.; NHS Wales, n.d.; Department of Health and Social Care, 2016). The implementation is expected to be incremental with this and the previous approaches running in parallel for three to six months (NHS, 2020).

3.4. Use of narrative and open conclusions

Unclassified conclusions, including narrative conclusions and non-standard short conclusions, have been increasing in England and Wales (Hill & Cook, 2011; Ministry of Justice, 2022). In 2021, 25% (8,125) of inquest conclusions were unclassified conclusions (Ministry of Justice, 2022). The rise in unclassified conclusions is partly attributed to the increased use of narrative conclusions by coroners (Ministry of Justice, 2022; Hill & Cook, 2011).

Additionally, variations in practices between coroner areas, and between UK nations, may result in variations in the type of conclusions returned. For example, a 2011 study in England and Wales found that there can be variations in the proportion of "other" conclusions (mainly composed of narrative conclusions); in some areas "other conclusions" represent upwards of 20% of all conclusions, while in other areas they represent less than 2% of all conclusions (Carroll, et al., 2011).

The use of narrative conclusions was found to be inversely related to the use of suicide conclusions (Carroll, et al., 2011). Therefore, reviewing only short form conclusions risks omitting probable suicides included in narrative conclusions. However, narrative conclusions are "sometimes returned by coroners where the cause of death does not easily fit any of the standard 'short form' conclusions" (ONS, 2019). Therefore, identifying probable suicides among narrative conclusions may pose some challenges. This is particularly the case when a narrative conclusion contains "insufficient information" or level of detail (narrative conclusions can vary in length and in the level of detail provided) (Hill & Cook, 2011; ONS, 2019). However, in October 2011, an advice note issued to coroners in England and Wales advised that for potential self-harm cases "the description of the circumstances should make clear the intention of the action that led to death" (ONS, 2019).

Open conclusions could also include cases of probable suicide when the evidence is not definitive. However, studies looking at the relationship between suicide verdicts and open or undetermined cause of death verdicts in the UK did not find an association (Carroll, et al., 2011).

3.5. National statistics

3.5.1. Registration delays

The ONS uses the year of death registration for the reporting of statistics on suicide (ONS, 2022). In England, Wales and Northern Ireland it can take months or years to establish the cause of death in cases referred to a coroner for an inquest. This creates a gap between the date of the death and the date it is registered; referred to as "registration delay" (ONS, 2019b; ONS, 2019). It is estimated that approximately half of the suicides registered, occurred in previous years (ONS, 2019b). The medians for registration delay for deaths recorded as suicide in 2016 were, 149 days

in England, 126 for Wales, and 147 for Northern Ireland (ONS, 2019). For Scotland, which does not have a coroner system, the 2016 median registration delay was seven days (ONS, 2019).

3.5.2. 2021 statistics

In 2021, the proportion of deaths reported to a coroner in England and Wales was at its lowest level since 1995, but the number of inquest conclusions increased by 4% against the number recorded in 2020 (Ministry of Justice, 2022). 2021 also saw a significant increase in the number of inquest suicide conclusions compared to 2020 (Ministry of Justice, 2022; ONS, 2022). However, the suicide rate was similar to rates in 2018 and 2019 (ONS, 2022). Around half of these deaths may have occurred prior to 2021, but due to restrictions during the COVID-19 pandemic causing delays to registrations and inquests, they may have concluded or been registered in 2021 (Ministry of Justice, 2022; ONS, 2022). It may also be a consequence of changes to the required standard of proof (see section 3.1) (Ministry of Justice, 2022).

3.5.3. Cause of death classification

When the Office of National Statistics (ONS) reports on death statistics, it uses internationally agreed rules for comparability of statistics (Hill & Cook, 2011). Coding for underlying cause of death is done using National Statistics definitions, which are defined from the International Statistical Classification of Diseases and Related Health Problems (ICD); the version in use since 2001 is the ICD-10[1] (ONS, 2019).

The National Statistics definition of suicide for adults includes “deaths with an underlying cause of intentional self-harm […] and deaths with an underlying cause or event of undetermined intent […]” (ONS, 2019). The Northern Ireland Statistics and Research Agency (NISRA) uses the UK National Statistics definition of suicide (NISRA, 2022). The NRS in Scotland uses a similar classification in terms of ICD rules, with the suicide category combining events coded as “of undetermined intent” and “of intentional self-harm” (NRS, 2021). Changes in the classification of deaths based on new coding rules by the World Health Organisation (WHO) were adopted by the ONS, NRS and NISRA in 2011 (ONS, 2019).

When applying ICD codes to coroner verdicts, misclassifications can occur due to insufficient information or level of detail (e.g. accidental vs suicide) (Hill & Cook, 2011). However, the ONS undertook a simulation for 2001 to 2009 data and found that if all, or half, of ICD identified accidental hangings and poisonings were reclassified as “suicide/intentional self-harm” - there would be a change in the reported rate of deaths per million for some years - but that these differences would not be statistically significant (Hill & Cook, 2011). The ONS also found that coders were consistent in their application of ICD classification rules (Hill & Cook, 2011).

In 2011, the ONS coding team was provided with additional guidance to improve the coding of narrative conclusions in England and Wales, which combined with the 2011 advice note to coroners on narrative conclusions for potential self-harm cases, may have resulted in an increase in the number of self-harm cases identified from

[1] On 1 January 2022, a new version of the International Classification of Diseases (ICD-11) came into effect (WHO, 2022). During the literature scoping for this report, we could find no information on whether or when this new version would be adopted by statistical agencies in the UK.

narrative conclusions since 2011 (ONS, 2019). Similarly, in Scotland in 2009, COPFS procedures for informing the NRS about suicides were changed, contributing to "the reduction in the number of probable suicides" (NRS, 2021, p. 6).

3.5.4. Review of suicide statistics in Northern Ireland

In 2022, the NISRA and the Coroners Service for Northern Ireland (CSNI) undertook a review of suicide statistics for 2015 to 2020 after identifying an issue with the classification (NISRA, 2022). The issue related to the process of classifying information using ICD codes for statistical use and did not have any bearing on the cause of death recorded on death certificates (NISRA, 2022). The review resulted in fewer cases coded as suicide in Northern Ireland for the 2015 to 2020 period (NISRA, 2022).

4. Good practice in reporting

4.1. Including information for the media

In their publications and/or on their webpages, when reporting on suicide, the ONS, NISRA and NRS include information for journalists and the media linking to the Samaritans' media guidelines on the reporting of suicides[2] (ONS, 2022; NISRA, n.d.; NRS, 2022). The Samaritans' guidance provides information on responsible reporting of suicide. The NISRA also provides a link to the WHO and the International Association for Suicide Prevention's (IASP) booklet on preventing suicide, as a resource for media professionals[3] (NISRA, n.d.). As with the Samaritan document, it provides information on responsible reporting on suicide.

4.2. Including information on where to seek help

The WHO and IASP suggest that responsible reporting on suicide should include information on where those affected can seek help or support (including prevention centres, crisis helplines, self-help groups, health and welfare professionals) (WHO and IASP, 2017). However, they advise against providing "a long list of potential resources" and suggest providing "a limited number of resources" (WHO and IASP, 2017). The Samaritans provide similar instructions about signposting to appropriate sources of support (Samaritans, 2020).

The ONS, NRS and NISRA provide information on where individuals can seek help when reporting on suicide. These organisations use a variety of approaches, this can include using a paragraph of text and listing websites and contact details for organisations that can provide support (e.g. Lifeline, Samaritans, Minding Your Head) or to the NHS help for suicidal thoughts webpage[4] (NISRA, n.d.; NRS, 2022; ONS, 2022).

4.3. Reporting on suicide

Both the Samaritans and the WHO/IASP information booklets include a list of "Dos and Don'ts" of reporting on suicide. These include ensuring the provision of accurate information on where to find help, and avoiding myth-spreading, using language that

[2] Samaritans' media guidelines for reporting suicide | Samaritans
[3] MediaBooklet_A4_180521.ai (who.int)
[4] Help for suicidal thoughts - NHS (www.nhs.uk)

normalises, sensationalises or oversimplifies suicides, and describing the methods used (WHO and IASP, 2017; Samaritans, 2020).

Advice on reporting recommends obtaining the assistance of suicide prevention experts to help interpret data, and ensure that reports on suicide avoid increasing risks (e.g. imitative behaviour, copycat suicide) (WHO and IASP, 2017). Reporting organisations are also advised to be mindful of statistics and using trend data, particularly when looking at small geographic areas or specific groups, as a single year data may deviate from overall trends (Samaritans, 2020). Timeframes of at least three years are recommended when aiming to identify significant patterns (Samaritans, 2020).

5. Conclusions

Does the GDC currently hold or collect information on cause of death for registrants?

Typically, the GDC is made aware of the death of a registrant when notified by an individual connected to the person who has died or when there is a review following non-payment of the ARF for registrants with an active FtP case. A death certificate would have to be provided by the individual for the cause of death to be known by the GDC. These are requested by the GDC.

Who to contact and when to request information on cause of death?

If the information on cause of death is not provided by the individual notifying the GDC that a registrant has died, death certificates can be obtained from centralised national register/records offices (i.e. GRO, NRS, GRONI). Using these centralised offices, rather than local registrars and/or coroners[5], eliminates the need to identify where the death was originally recorded (which can be different to where the death occurred), or the coroner's office that undertook the inquest (if required), although it would still be necessary to identify the UK nation in which the death was recorded. Deaths which occur outside the UK, with some exceptions, will not be held by the national register/records offices.

There can be delays between a death occurring and when it is registered. In the case of deaths reviewed by a coroner or the Procurator Fiscal, registration delays can be longer, with average inquest processing time in England and Wales being 31 weeks in 2021. Further, the GRO does not hold death certificates for the most recent six-month period, creating a potential six-month wait to obtain a death certificates.

How to categorise cause of death from various sources?

Coding deaths into categories based on the cause of death, as is done for national statistics (e.g. ONS, NISRA, NRS), is a complex process undertaken by professionals. Attempting to replicate this process carries risks of miscoding data and inaccurate reporting.

Coding based on short form categories limits the potential of miscoding. However, Northern Ireland and Scotland do not use the word suicide or a synonym on death certificates, by convention. If short form categories only were used for the purposes of reporting, suicide deaths for Scotland or Northern Ireland would potentially be excluded from the "suicide" category if using this approach. The same issue would arise in England, as potential suicide

[5] For England and Wales or Northern Ireland.

deaths included in narrative conclusions would be excluded from the “suicide” category if using this approach.

How to ensure data are valid and reliable?

The categorisation of cause of death will have an influence on the validity and reliability of the data. Precise categorisation is key to ensuring the cause of death is accurately reported. Death registration, cause of death determinations, and processes to determine the cause of death vary across the UK. These differences need to be considered when working to ensure validity and reliability of data.

Reporting one year in arrears, would normally allow time for any post-mortem or inquest or to conclude, but some inquests may take longer. Therefore, if reporting the cause of death using rolling periods (e.g. three years), it would require previous years’ data to be reviewed and updated at regular intervals.

Changes which may or have influenced the process of recording deaths or in determining the cause of death should be considered when contextualising data. This includes the change in standard of proof in 2018, the changes associated with the Coronavirus Act 2020, and the introduction of a new medical examiner system in England and Wales in April 2023.

How to ensure validity and reliability of reporting?

Due to the nature of the information being reported, there is a need to ensure that individuals cannot be identified from the data. As low numbers of deaths among registrants are expected, various measures should be adopted to ensure anonymity such as using a rolling reporting period and not reporting exact numbers below a certain threshold.

Good practice (e.g. language used, presentation and information provided) should be integrated into any report produced. Good practice in reporting also has an influence on how the data itself should be reported, interpreted and presented.

There is a strong need to consult with a variety of experts (e.g. those with expertise in mental health or suicide prevention and in the interpretation and reporting of death data) and stakeholders to ensure that the data reported is useful, valid, reliable and does not cause harm.

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