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Title: Procedure for referral to the Medical Examiner in the event of the natural death of a patient in a Tees, Esk and Wear Valleys inpatient service.

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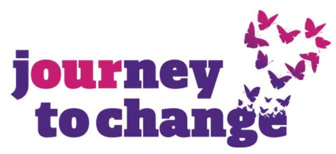


Contents

1 Introduction 3

2 Purpose 4

3 Who this procedure applies to 5

3.1 Roles and Responsibilities 6

4 Related documents 8

5 Procedure for Referral to the Medical Examiner Service 8

5.1 In event of an expected death in a TEWV inpatient setting 8

5.2 Identify a member of the ward medical staff who will be the Attending Practitioner 8

5.3 If Coroner required 8

5.4 If Coroner not required 9

5.5 Completing the Medical Examiner Referral Form 9

5.6 Patient Safety Team 9

5.6.1 Checking referral form 9

5.6.2 Requesting medication report 9

5.6.3 Submitting referral form 10

5.7 Medical Examiners access to TEWV Electronic Patient Record 10

5.8 Attending Practitioner (TEWV) 10

5.8.1 Attending Practitioner (TEWV) conversation with Medical Examiner 10

5.8.2 Medical Certificate of Cause of Death and registering the death 11

6 Definitions 11

7 How this procedure will be implemented 11

7.1 Implementation action plan 11

7.2 Training needs analysis 12

8 How the implementation of this procedure will be monitored 12

9 References 12

10 Document control (external) 13

Appendix 1 – Guidance for deaths which require reporting to the Coroner 14

Appendix 2 – Medical Examiner Referral Form 15

Appendix 3 – Standard Process Description flowchart 19

Appendix 4 – Medical Examiner Service Information Leaflet 21

Appendix 5 – Approval checklist 22

1 Introduction

The UK Government introduced changes to the process of Medical Certification of Cause of Death in 2019, as a response to longstanding concerns about the previous process, including concerns arising from the third Shipman Enquiry and the Mid Staffordshire NHS Foundation Trust Public Enquiry. This included the establishment of a system of Medical Examiners. These changes were outlined in

- The Medical Certificate of Cause of Death Regulations 2024
- The Medical Examiners (England) Regulations 2024
- The National Medical Examiner (Additional Functions) Regulations 2024

The Medical Examiner system has been in place within acute hospital trusts in England since 2019. From September 9th 2024, there will be a requirement for all NHS organisations to comply with the regulations around Medical Certification of Cause of Death, and the new Medical Examiner system.

The stated purposes of the Medical Examiner system are to:

- provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.

To enable these objectives, Medical Examiners Offices have been established regionally throughout England. The purposes of the Medical Examiners Offices are to:

- agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it
- discuss the cause of death with bereaved people and establish if they have questions or any concerns with care before death

- act as a medical advice resource for the local coroner
- identify cases for further review under local mortality arrangements and contribute to other clinical governance processes.

In Tees, Esk and Wear Valleys NHS Foundation Trust, a small number of patients each year receive end of life care within our inpatient services. Many of these patients will be receiving care within Mental Health Services for Older People, but such a situation could potentially occur in any service.

This procedure applies only to expected, natural deaths of patients who are at the time of death receiving inpatient care in a TEWV inpatient unit. Deaths occurring in the community, or whilst a patient is on leave from a TEWV inpatient unit to an acute hospital site, would not be subject to this procedure as the process of certification of death would then be the responsibility of primary care services or the acute hospital trust respectively. If a patient is a TEWV inpatient but on leave from our inpatient services at the time they die, then as it is an expected death, part of the leave planning should include identifying if TEWV or the GP would be the Attending Practitioner for the purposes of certification.

The requirements for notification of deaths to the Coroner are unchanged, and are set out in

- The Notification of Deaths Regulations 2019 (legislation.gov.uk)

Referral to the Coroner will continue to be required for patients who die whilst detained subject to the Mental Health Act 1983 (as amended), or for all deaths which are unexplained or unnatural (including where there is the possibility of suicide or deaths related to neglect) as is currently the case.

Due to the relatively small numbers of deaths occurring within TEWV services, an agreement has been reached with the South Tees Medical Examiners Office that they will serve as Medical Examiner for all relevant deaths within TEWV inpatient units, no matter where that unit may be located.

This procedure supports Our Journey To Change (OJTC) as set out in End of Life Care Provision and Care After Death Policy.

2 Purpose

Whilst the delivery of specialist End of Life (EoL) care is not the main clinical purpose of TEWV NHS Foundation Trust, it is acknowledged that TEWV Trust staff may be required to care for

patients who have life threatening or life limiting conditions - whether this be a form of cancer or non-cancer related physical and/or mental health diagnoses (i.e. dementia, frailty, heart failure, chronic obstructive pulmonary disease (COPD) etc.). As people live longer, there are an increasing number of patients who have comorbid physical and/or mental conditions, some of which are advanced long-term conditions that may require complex, skilled interventions and require delivery of care within mental health in-patient settings.

Often, if a person is nearing the end of their life whilst an inpatient with TEWV, they will be discharged in a planned process to another setting which can better meet their care needs, such as an acute hospital, hospice, care home or their own home. Sometimes though a person might have comorbid mental health needs which can only appropriately be managed in TEWV inpatient care, or there may be a decision made between the person and/or their loved ones and TEWV inpatient staff, concluding that the best interests of the person lie in remaining on a TEWV unit. On rare occasions therefore, this will mean that a person will naturally reach the end of their life while they are receiving care within a TEWV inpatient unit.

The purpose of this procedure is to

- ensure that TEWV is meeting its statutory obligations with regard to medical certification of cause of death, for people who come naturally to the end of their lives whilst within our inpatient services
- provide appropriate guidance for clinical and non-clinical staff who are involved with the process of certifying death
- ensure that we are providing accurate and timely information to bereaved relatives and loved ones, regarding the process of certification of death
- ensure that any opportunities for learning relating to the death or to the provision of end of life care are identified

3 Who this procedure applies to

This procedure applies to all healthcare professionals working within TEWV NHS Foundation Trust inpatient services. Key roles and responsibilities are outlined in Section 3.1 Roles and Responsibilities.

Consideration has also been given to those who may be affected by the aims and objectives of this procedure to ensure that the document content aligns to the Trust's values, so that people who may be affected are treated with compassion, respect and responsibility.

Respect

- Listening
- Inclusive
- Working in partnership

Compassion

- Kind
- Supportive
- Recognising and Celebrating

Responsibility

- Honest
- Learning
- Ambitious

3.1 Roles and Responsibilities

Role	Responsibility
Medical Director	• Ensure that all Medical Staff are aware of this procedure, and other policies, guidance and procedures which relate to this procedure. • Ensure that adequate training is given to allow Medical Staff to implement this procedure. • Responsible for the development, review and monitoring of this procedure.
Chief Nurse	• Ensure that all Registered Nursing Staff are aware of this procedure, and other policies, guidance and procedures which relate to this procedure. • Ensure that adequate training is given to allow Registered Nursing staff to implement this procedure.
Medical and Registered Nursing Staff	• Ensure that they are aware and familiar with the contents of this procedure, and other policies, guidance and procedures which relate to this procedure. • Promptly notify the Patient Safety Team in the event of an expected, natural death. • Promptly complete the Medical Examiner Referral Form (Appendix 2) • Participate in the process of consultation with the Medical Examiner as set out in this procedure. • Complete all relevant documentation, including Medical Certificate of Cause of Death, in accordance with the advice given by the Medical Examiner. • Be able to sensitively explain the process to bereaved relatives and loved ones, and be able to signpost effectively for further support if required. • Inform Senior Management where the procedure is not being implemented appropriately.

Team Leaders, Ward and Unit Managers	• Be fully aware of the contents of this procedure and other policies, guidance and procedures which relate to this procedure. • Ensure that staff read and have an awareness of the procedure. • Ensure that staff undertake training appropriate to their role.
Patient Safety Team	• Be fully aware of the contents of this procedure and other policies, guidance and procedures which relate to this procedure. • Support the relevant inpatient team and Medical Examiner, by acting as a point of coordination if required. • Promptly send completed Medical Examiner referral forms to the Medical Examiner, following a death.
Pharmacy Team	• Support the assessment of the Medical Examiner by promptly producing a report from the Electronic Medication Prescribing and Administration system, detailing the recent prescription and administration of medications to the deceased.
Chaplaincy	• Support service users, fellow patients, family/carers, and staff with spiritual, religious and/or cultural needs.

4 Related documents

This procedure should be read in conjunction with the following Trust policies & procedures:

- End Of Life Care Provision and Care After Death Policy CLIN-0100
- Information Governance Policy CORP-0006

5 Procedure for Referral to the Medical Examiner Service

5.1 In event of an expected death in a TEWV inpatient setting

In the event of an expected death in a TEWV inpatient setting, the Patient Safety Team are to be notified immediately via completion of a report using the InPhase system. This can be done by any member of the clinical team who has the required knowledge to complete the form, but the Ward Manager or nurse in charge of the ward is responsible for ensuring that it has been done.

5.2 Identify a member of the ward medical staff who will be the Attending Practitioner

The ward medical team and multidisciplinary team will identify a member of the ward medical staff who will be the Attending Practitioner, for the purposes of certification of death. This can be any member of the ward medical team who is able to complete the Medical Certificate of Cause of Death (MCCD), not necessarily the consultant or Responsible Clinician. The Attending Practitioner must be a fully registered and licensed medical practitioner and must have attended the deceased during their life. In an out of hours situation if an on-call doctor attends to confirm death of a patient on the ward and they aren't the doctor that is usually part of the medical team on the ward they cannot be the "Attending Practitioner" and as such will not be able to complete the MCCD.

5.3 If Coroner required

The ward MDT and medical team should decide whether referral to the Coroner is required (using the criteria set out in Appendix 1) If referral to the Coroner is required, this should be done as soon as possible to the Coroner's Office covering the location where the person has died.

5.4 If Coroner not required

If referral to the Coroner is not required, the Attending Practitioner will complete the Medical Examiner Referral Form (Appendix 2). This will require a review of the clinical case including relevant medical records. On the Medical Examiner Referral Form, the Attending Practitioner should suggest what they think is the likely cause of death, to the best of their knowledge and belief. This should refer to a cause of death, not a mode of dying (one which does not explain "why"). Guidance produced by the Royal College of Pathologists can be referred to at G199-Cause-of-death-list.pdf (rcpath.org). The Attending Practitioner should briefly explain their rationale for suggesting the likely cause of death in the relevant section of the referral form.

5.5 Completing the Medical Examiner Referral Form

- The Attending Practitioner should complete their personal and contact details as part of the referral form, as the Medical Examiner will need to contact them to discuss the cause of death. Phone numbers should be mobile / direct line. The initial contact from the Medical Examiner will generally be made via email. Consideration should be given to the availability of the Attending Practitioner for a discussion with the Medical Examiner – in situations such as imminent planned leave from work, it may be necessary to identify an alternative or additional Attending Practitioner.

- The Attending Practitioner should note on the referral form any concerns or problems with care which had been identified, relevant to the deceased.

- If the deceased or their family have any religious or cultural requirements for urgent release of the body, these should be noted on the relevant section of the referral form, so that the Medical Examiner service is aware of the possible urgency of the referral.

- Once the referral form is complete, the Attending Practitioner will email it to the Patient Safety Team, copying it to the Ward Manager and Associate Director for the service.

5.6 Patient Safety Team

5.6.1 Checking referral form

- Upon receiving the Medical Examiner Referral Form, the Patient Safety Team will check that all sections of the form have been completed.

5.6.2 Requesting medication report

- The Patient Safety Team will contact the Trust Pharmacy Team TEWV.pharmacyadmin@nhs.net requesting that an urgent report be produced from the

Electronic Prescription & Medicines Administration (EPMA) system, detailing the medicines prescribed and administered to the deceased during the final two weeks of life. Once produced, the Pharmacy Team will return this report urgently to the Patient Safety Team, via email as a PDF document.

5.6.3 Submitting referral form

- The Patient Safety Team will submit the Medical Examiner Referral Form to the South Tees Medical Examiner service via secure email at stees.meo@nhs.net . Attached to the email should be the EPMA medication report PDF document.

- The Medical Examiner office operates from 08.00 to 16.00, Monday to Friday. Once the referral has been received, the Medical Examiner will consider the information given in the referral form. As part of their processes, they will need to access the TEWV Electronic Patient Record (CITO) in order to scrutinize the clinical record. They will also contact the deceased's relatives to discuss the cause of death and to give them the opportunities to raise any questions they have about this.

5.7 Medical Examiners access to TEWV Electronic Patient Record

- Read-only CITO access has been agreed for the Medical Examiners, to support this role. As a contingency, in the event of any technical reason why the Medical Examiners are unable to access CITO, it is possible for the Attending Practitioner to provide guided access to CITO during their scheduled discussion with the Medical Examiner, using the screen-sharing function of Microsoft Teams.

5.8 Attending Practitioner (TEWV)

5.8.1 Attending Practitioner (TEWV) conversation with Medical Examiner

- The Medical Examiner will need to hold a conversation with the Attending Practitioner in order to discuss the case, and the cause of death. It is suggested that these discussions take place via Microsoft Teams, though this is not mandatory if an alternative means of discussion is mutually agreeable to the Attending Practitioner and the Medical Examiner. The Medical Examiner will usually contact the Attending Practitioner initially via email to agree a time and date for the discussion. TEWV Attending Practitioners must prioritize this meeting as far as is reasonably possible, because any delay in this process could result in a delay to the bereaved relatives being able to register the death and to proceed with funeral arrangements.

- During the discussion between the Attending Practitioner and the Medical Examiner, the Attending Practitioner should be prepared to offer guidance to the Medical Examiner on where any required specific information in the CITO record can be located. It is likely that most or all of the

relevant information will be found within the Progress Notes, however. It may be helpful to use the screen sharing function of Microsoft Teams to assist with this, if needed.

5.8.2 Medical Certificate of Cause of Death and registering the death

- Following discussion with the Medical Examiner, a cause of death will be agreed. The Attending Practitioner should then complete the Medical Certificate of Cause of Death accordingly.

- The Attending Practitioner will then scan and email the Medical Certificate of Cause of Death to the Medical Examiners Office, with copy to the Patient Safety Team.

- The Medical Examiners Office will arrange for the deceased's family to register the death.

- The Patient Safety Team will upload the copy of the Medical Certificate of Cause of Death to CITO.

6 Definitions

Term	Definition
n/a	•

7 How this procedure will be implemented

- This procedure will be published on the intranet and on the Trust website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.

7.1 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
n/a				

7.2 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
n/a			

8 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	tbc	Frequency = Method = Responsible =	
2		Frequency = Method = Responsible =	
3		Frequency = Method = Responsible =	

9 References

- The Medical Certificate of Cause of Death Regulations 2024

- The Medical Examiners (England) Regulations 2024
- The National Medical Examiner (Additional Functions) Regulations 2024

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	03 September 2024
Next review date	03 September 2027
This document replaces	N/A - New document
This document was approved by	Executive Clinical Leaders Group
This document was approved	21 August 2024
This document was ratified by	Executive Directors Group
This document was ratified	03 September 2024
An equality analysis was completed on this policy on	pending
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
1	03 Sept 2024	New document	Published

Appendix 1 – Guidance for deaths which require reporting to the Coroner

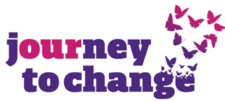
Briefly, a registered medical practitioner has a duty to notify a death to the Coroner if any of the following circumstances apply:

- poisoning
- exposure to a toxic substance
- use of a medicinal product, controlled drug or psychoactive substance
- violence
- trauma or injury
- self-harm
- neglect, including self-neglect
- the person undergoing a treatment or procedure of a medical or similar nature
- an injury or disease attributable to any employment held by the person during the person's lifetime
- the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances above
- the cause of death is unknown
- the person died in custody **(including whilst subject to detention under the Mental Health Act)**
- there is no attending medical practitioner to sign the death certificate
- the deceased cannot be identified.

If there is uncertainty as to whether a death ought to be reported to the Coroner, this should prompt a discussion with the Medical Examiner or the Coroner responsible.

Appendix 2 – Medical Examiner Referral Form

Please see over the page



If urgent: Response required by:
Reason:

Reference number:
(To be completed by medical examiner's office.)

Medical Examiner Referral Form

This form is to be completed and emailed to the relevant Medical Examiner Service, or HM Coroner (if required) as soon as possible following a death.

Key information about the deceased person			
Name		Gender	
NHS Number		Paris / CITO number	
Date of Birth Age		GP Practice	
Address		GP Address GP Practice email	
TEWV ward & contact number		Practice bypass telephone no.	

Occupation or last occupation if retired or not in work at the date of death

Details of death	
Date & time of death	
Was death expected?	
Place of death	
Persons present	

Proposed cause of death	
1a	
1b	
1c	
2	

Reasons for concluding cause of death
(From your medical notes, and the observations of yourself and others immediately before and at the time of the deceased's death, please describe the symptoms and other

conditions which led to your conclusions about the cause of death)

Any problems identified with care given? Any suggested learning?
Has there been any discussion with a coroner's office about the death of the deceased?
☐ **Yes** ☐ **No** *If yes, please state the coroner's office that was contacted and the outcome of the discussions:*

Relevant contact details (including phone numbers)	
Attending Doctor(s) able to write a MCCD *(Must be qualified to certify)*	**Name** **Telephone** **Email** **Date patient last seen alive by certifying doctor:** **GMC no. of certifying doctor:**
Usual GP *(or alternative GP at practice)*	
Next of kin *(preferred contact expecting call from Medical examiner and relationship to deceased)*	**Name** **Relationship to deceased** **Aware of death?** ☐ **Yes** ☐ **No**
Person responsible for nursing or care before death	
Person who verified fact of death **(Full name and occupation)**	

Hospital consultant responsible for care *(if patient died within a community inpatient unit or virtual ward)*	

Further Notes

Appendix 3 – Standard Process Description flowchart

Please see over the page

Standard Process Description

Procedure for referral to the medical examiner in the event of a natural death for a patient

Nurse in charge of the ward/MDT

When: Immediate / as soon as practicable

Ensure that the patient's next of kin or nominated contact is informed that they have died, in accordance with care plan if applicable.

When: If not done immediate call, done during follow up contact

When making contact with the patient's relatives (if appropriate), explain the process of death certification and Medical Examiner's role. Inform relatives that they will be contacted by the Medical Examiner to discuss the death.

When: Immediate or as soon as practicable

Determine whether death is notifiable to the Coroner, using Appendix 1 of the policy.

Refer death to Coroner if the criteria are met.

When: Same shift

Report death of patient to Patient Safety Team via InPhase. (include whether its notifiable to coroner)

Attending Practitioner
A registered medical practitioner, who has attended the patient during their life

When: as soon as practicably possible but must be by end of working shift / day

Complete Medical Examiner Referral Form (Appendix 2) and send to Patient Safety Team via secure email at tewv.patientsafetyteam@nhs.net

When: No timescale but likely within 1-2 working days

Engage in a discussion with Medical Examiner (when contacted) about the circumstances and cause of death. Discussion suggested to be held via MS Teams.

- TEWV certifying doctor should be able to access relevant CITO record & share screen with Medical Examiner.

When: Same working day as discussion with ME

Doctor accesses Medical Certificate of Cause of Death (MCCD) book and completes MCCD with cause of death as per the Medical Examiner's opinion.

Attending Practitioner scans MCCD and emails this to Medical Examiner Office with copy to TEWV Patient Safety Team. Tewv.patientsafetyteam@nhs.net and stees.meo@nhs.net

Patient Safety Team

When: Next working day

Request past two weeks of medication prescription and administration record from Trust pharmacy department

TEWV.pharmacyadmin@nhs.net

Pharmacy Team

When: Within 1 working day

Export data from EMPA covering last two weeks of medication prescription and administration record, and email securely to Patient Safety team as PDF attachment.

When: Concurrent to pharmacy request

Check all fields of Referral Form are completed. Check that Attending Practitioner(s) contact details and availability are included in the form.

When: Within one working day of receipt of pharmacy info

Send completed Referral Form to South Tees Medical Examiners Office by secure email at stees.meo@nhs.net.

Attach EPMA report as PDF attachment.

Copy email to ward manager, Matron, nominated certifying doctor, Associate Medical Director and the Associate Director of Nursing.

When: Within 1 working day

If not received within 5 working days contact the attending practitioner

Once the MCCD is received, the Patient Safety Team will upload a copy of this to the CITO record under correspondence/letters.

Appendix 4 – Medical Examiner Service Information Leaflet

South Tees Medical Examiner Service

Changes in paperwork and process after your loved one has died.

Why is the process changing?

The death certification system in England and Wales has been the same for over 50 years. The government is making changes so that all deaths are reviewed by either a Medical Examiner or a Coroner.

The South Tees Medical Examiner Service is an independent service, hosted by South Tees Hospitals NHS Foundation Trust. The office is located at the James Cook University Hospital.

Who is the Medical Examiner?

Medical Examiners are senior medical doctors who have completed extra training. Most work in the Medical Examiner Service in addition to their other clinical duties.

What does the Medical Examiner Service do?

When a death occurs, a Medical Examiner will read the recent medical notes and discuss with medical staff involved in the final illness, with the aim of:

- Reviewing the care that was provided during the last illness.
- Providing an opportunity for bereaved people to give feedback.
- Making sure that the cause of the death on the death certificate is accurate.
- Deciding whether there should be further investigation by the coroner.

What this means for you:

The Medical Examiner Service is informed of deaths by the hospital or GP practice. If you are the person listed as ‘next of kin’:

- You will be contacted by the Medical Examiner team shortly after the death.
- You will be given the opportunity to discuss the cause of death, and the care provided during the last illness.
- You will also be asked about the funeral arrangements. This information is required to ensure the correct paperwork is issued.
- You will be informed whether the death needs to be referred to the coroner for further investigation.
- The Medical Examiner Service will let you know how to arrange to register the death.

The South Tees Medical Examiner Service is open from 08:00 - 16:00 hours Monday to Friday.

Telephone: 01642 850850 extension 57163 or 53837, Email: stees.meo@nhs.net

Appendix 5 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Y	
Is it clear whether the document is a guideline, policy, protocol or standard?	y	Procedure
2. Rationale		
Are reasons for development of the document stated?	Y	
3. Development Process		
Are people involved in the development identified?	Y	
Has relevant expertise has been sought/used?	Y	
Is there evidence of consultation with stakeholders and users?	y	With patient safety team
Have any related documents or documents that are impacted by this change been identified and updated?	n/a	
4. Content		
Is the objective of the document clear?	Y	
Is the target population clear and unambiguous?	Y	
Are the intended outcomes described?	Y	
Are the statements clear and unambiguous?	Y	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Y	
Are key references cited?	Y	
Are supporting documents referenced?	Y	
6. Training		

Have training needs been considered?		Pending
Are training needs included in the document?		Pending
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?		Pending
8. Equality analysis		
Has an equality analysis been completed for the document?		Pending
Have Equality and Diversity reviewed and approved the equality analysis?		Pending
9. Approval		
Does the document identify which committee/group will approve it?	yes	
10. Publication		
Has the policy been reviewed for harm?	Yes	No harm
Does the document identify whether it is private or public?	yes	Public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Y	
Do all pictures and tables have meaningful alternative text?	Y	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	y	