The Royal College of Pathologists
Pathology: the science behind the cure

Medical Examiners Committee (MEC)

A meeting of the Medical Examiners Committee was held on Tuesday 8 March 2026 from 10:00am – 12pm via MS Teams

Professor Sarah Coupland
Registrar

Minutes

Present:	Dr Golda Shelley-Fraser, Chair Dr Frances Cranfield, Royal College of General Practitioners Ms Emma Whitting, Coroners' Society representative Dr Jason Shannon, Lead Medical Examiner for Wales Dr Suzy Lishman CBE, Senior Advisor Dr Yasmin Kapadia, Medical Examiner Mrs Daisy Shale, RCPath Lead Medical Examiner Officer Professor Carol Seymour, Faculty of Forensic and Legal Medicine Mr Simon Hawkins, Department of Health and Social Care Dr Huw Twamley, National Medical Examiner Ms Kirsty Lagdon, Welsh Government representative Ms Bethan Davies, Welsh Government representative Mr Andy Langford, Clinical Director, Cruse Bereavement Support
In attendance:	Ms Louise Mair, Governance and Committee Services Officer
Apologies	Mr Stephen Rainbird, RCPath Member Engagement and Support Manager Shelaine Kissoon, Governance and Committee Services Officer *(minutes)* Dr Amanda Evans, Medical Examiner
Absent:	Dr Laszlo Igali, RCPath Vice President for Professional Practice Dr Niall Martin, Medical Examiner

ME.01/26 1. Welcome, declarations of conflicts of interest and apologies for absence

1.1 The Chair welcomed all members to the meeting and extended a particular welcome to Mr Langford, Clinical Director at Cruse Bereavement Support, who was attending as the new lay representative. Introductions were made.

1.2 There were no declarations of conflict of interests.

1.3 Apologies for absence were received and noted above.

ME.02/26 2. Minutes of the previous meeting

2.1 The minutes of the meeting held on Monday, 8 December 2025, were reviewed and approved as a correct record, subject to the following amendment:

Under ME36/25 (8), the sentence:
"She further noted that health professionals, including MEs, would have the option to opt out of involvement in assisted dying cases, and should the Bill pass." should be amended to read as: *"She further noted that health professionals would have the option to opt out of involvement in assisted dying cases should the Bill pass."*

2.2 There were no matters arising not already covered on the agenda.
2.3 The action log was reviewed, and the following updates were noted:

ME.39/23 *Letter of Good Standing for Appraisal:*
The letter of good standing for appraisals is in working progress**. Action remains in progress.**

ME.03/26 3. Updates

3.1 National Medical Examiner

Dr Twamley provided an update on National Medical Examiner activity and reported on a College webinar delivered on 7 March 2026, at which he presented an introduction to the role of the National Medical Examiner. The session was recorded and will be made available to the ME/MEO Hub.

He updated members on engagement with national inquiries, including submissions to the Stillbirths Inquiry and the Thirlwall Inquiry. He confirmed that clarification had been provided that there is no specialist paediatric Medical Examiner role, as all Medical Examiners are non-specialists.

He noted responses to recent House of Lords comments regarding turnaround times and advised that revisions to the Good Practice Series would shortly be issued to regional Ms and MEOs. He further reported on the ongoing work on a time-limited survey relating to death certification amendments, pandemic resilience planning, and the development of a communications strategy in response to recent media coverage.

Finally, he outlined wider strategic priorities, including standardisation across Medical Examiner offices, development of digital systems (Manage My Caseload and electronic death certification), and exploration of research and academic opportunities.

3.2 Department of Health and Social Care (DHSC)

Mr Hawkins provided a report and first thanked colleagues for their work over the winter period, noting that, from a departmental perspective, death certification and registration processes had functioned well. He advised that the digital Medical Certificate of Cause of Death (MCCD) remained paused, with no further update available. He reported ongoing work with the Office for National Statistics (ONS) on analysis of death certification reforms and noted that feedback had been provided on forthcoming publications to ensure focus remained on the original policy intents. He outlined plans to strengthen communications activity in response to recent media coverage and parliamentary discussion, including engagement with parliamentarians to improve understanding of the ME system.

He provided an update on pandemic preparedness work, including consideration of existing legislative powers under the Coroners and Justice Act 2009 and potential new powers through forthcoming primary legislation to support continuity of Medical Examiner services during future pandemics. He also reported on the Manage My Caseload system, noting that development remained paused, and outlined plans to engage with Medical Examiner offices to better understand user requirements and inform future decisions.

Dame Suzy Lishman reported on recent media coverage relating to Medical Examiners, noting that she had submitted responses on behalf of the RCPath to articles in *The Times* and *The Daily Telegraph* which contained inaccuracies, although these had not been published.

3.3 Wales

Dr Shannon provided an update on Wales and reported that the service remained stable and resilient following the winter period. He reported that ME processes had functioned well, although delays had been experienced in other parts of the system, including QAPs, health boards and GP practices.

He noted that case numbers had reduced, which was not fully explained by overall death rates, and suggested that process changes implemented previously had contributed to improved efficiency. These included clearer expectations regarding referral of cases to the coroner. He also highlighted ongoing work to improve the quality of death certification, including addressing incomplete or inaccurate data entry.

He advised that internal training and CPD activity remained well established, alongside engagement with wider training opportunities. He further outlined ongoing work to improve process efficiency, including digital handling of documentation. He reported that the service continued to operate effectively, with few escalations from families or funeral directors, and that performance data was being used to support service improvement and provide insights to care providers.

3.4 Royal College of General Practitioners (RCGP)

The MEC received and noted the report, which had been policy checked by RCGP. Dr Cranfield noted continued support from the RCGP for the Medical Examiner system and highlighted a number of areas where further advice and clarification were required.

She raised concerns regarding the interpretation of the standard of proof for cause of death, noting variation in practice and recent instances in which GPs had been challenged in coronial settings. She advised that discussions had taken place with the Chief Coroner, but that uncertainty remained regarding the relationship between “best of knowledge and belief” and the balance of probabilities, and the consistency of its application across settings. She also highlighted ongoing uncertainty regarding the definition of “attending practitioner”, particularly in relation to telephone consultations, and requested clearer national guidance to support consistent application in practice.

She noted the RCGP’s willingness to engage in discussions relating to Learning from Deaths in the community and raised a further query regarding approaches to obtaining bereaved feedback for appraisal purposes, following a request from a lead appraiser in Gloucester. She advised that she had not previously encountered this process and suggested that the matter be considered at a future meeting.

Dr Twamley and Dame Suzy Lishman commented on these issues. Dr Twamley noted that GPs generally act in good faith and in the context of clinical uncertainty, and emphasised the importance of a supportive approach within the Medical Examiner system. He highlighted that medical certification is a shared process involving multiple professional safeguards, and that variation in coronial practice can influence clinician confidence. He noted the importance of clarity in the role of the attending practitioner and the need for appropriate guidance and training, and emphasised the importance of respecting professional judgement where clinicians feel unable to certify cause of death.

Dame Suzy Lishman noted that there is variation in interpretation and application of the “best of knowledge and belief” standard and emphasised that clinical practice involves professional judgement in the context of uncertainty rather than certainty. She highlighted that guidance is not always read or consistently applied in practice, and that there is

variation in understanding and application across clinical and coronial settings. She emphasised the importance of clear guidance while recognising its limitations and the need to support clinicians in exercising professional judgement.

Mr Langford offered support in relation to approaches for gathering bereaved feedback, drawing on relevant experience.

3.5 Coroners' Society

Dr Whitting provided an update on the Coroners' Society. She noted that coroners operate with judicial independence and therefore make individual decisions, and emphasised the importance of maintaining effective local working relationships between coroners, Medical Examiners, and clinicians. She highlighted the role of Medical Examiners in supporting decision making where cause of death is uncertain or where post-mortem examination is being considered, particularly in cases involving elderly patients with comorbidities and where family preferences are a factor. She advised that coroners require sufficient clinical information, including relevant past medical history and a clear rationale where clinicians are unable to certify a cause of death, to support appropriate decision-making.

She reported positive feedback from coroners' induction training, particularly scenario-based learning, and indicated that similar approaches may be beneficial in wider training. She also confirmed that providing specific examples of issues would support escalation through national coronial forums, including the Chief Coroner's training event.

Dr Shannon noted variation in coronial practice across regions and emphasised the importance of clear statutory boundaries between clinicians and coroners in relation to death notification and investigation processes. He highlighted the need for appropriate and complete clinical information to support coronial decision-making and reduce uncertainty. Dr Cranfield raised concerns regarding variability in coronial engagement and communication with clinicians and Medical Examiners, and suggested that improved multidisciplinary engagement, including roundtable discussions, could help strengthen consistency and understanding across systems. Dame Suzy Lishman noted that while effective working relationships exist in many areas, there remains variability in the interpretation and application of guidance across coronial practice, including in relation to cremation processes, leading to inconsistency.

ME.04/26 4. Training

4.1 Medical Examiner

The Chair formally congratulated Dame Suzy Lishman on her inclusion in the New Year's Honours List, in recognition of her significant contribution and commitment to the development of the Medical Examiner system over a number of years. Dame Suzy Lishman thanked members and noted that the award recognised the Medical Examiner service, alongside recognition of Professor Alan Fletcher (OBE), and reflected the progress made in establishing the system nationally.

Dame Suzy Lishman then provided an update on ME training, noting that 32 participants attended the January session, bringing the total number of trained Medical Examiners to over 2,700. She reported that only 18 participants were currently booked for the May 2026 session, reflecting a slowdown in recruitment and appointments, with a further session planned for September.

She reported that a review of e-learning materials had been undertaken, noting that while core modules had been updated for the statutory system introduced in July 2024, the

majority of non-core modules require updating to reflect current practice. This work is being progressed with e-learning providers. She outlined a programme of forthcoming webinars, including topics such as neglect, genetics and genomics, and prevention of future deaths. She also provided an update on the annual conference, which is booking well and will include sessions on national updates, death certification reform, NHS Resolution learning, end-of-life care, and occupational COPD.

Dame Suzy Lishman confirmed ongoing work on updates to the cause of death list, the definition of attending practitioner, and the good standing document. She also noted her forthcoming contribution to the Amos Inquiry, alongside colleagues, and ongoing engagement with the Royal College of General Practitioners and media outlets.

4.2 Medical Examiner Officer

Ms Shale provided an update on Medical Examiner Officer (MEO) training. She reported that face-to-face training is being maintained alongside two virtual sessions per year, although attendance is declining as all existing MEOs have now been trained. Future provision will focus on new entrants, with the number of sessions kept under review and a potential reduction to one session per year depending on demand.

She outlined the development of additional training modules covering paediatrics and neonates, organ donation cases, and Medical Certificate of Cause of Death (MCCD) processes, with consideration being given to a further module for senior/lead MEOs covering leadership, governance, audit and service management responsibilities.

She also presented draft performance and development review (PADR) guidance to support consistency across organisations, aligned with NHS, professional, and regulatory frameworks. She emphasised the importance of ongoing continuing professional development (CPD) beyond initial training and advised that work is underway to explore digitisation of the CPD portfolio within the College system.

Finally, she noted that the Medical Examiner Oversight Group is considering work on MEO wellbeing, including resilience, burnout, retention and career development.

ME.05/26 5. Death Investigation Committee feedback

None reported.

ME.06/26 6. ME/MEO Hub update

The MEC received and noted the paper prepared by Mr Stephen Rainbird, which provided an update on the ME/MEO Hub, including revised membership fees, in particular a reduced fee for Medical Examiner Officers. It was reported that four new MEO members had joined following the introduction of the revised fee structure. It was noted that membership trends across both the College and the Hub appeared to be plateauing; however, it was anticipated that the revised fee structure may support future growth in membership. The MEC also noted the continued success of the Hub's webinar series and the forthcoming programme of activity, which was welcomed.

ME.07/26 8. Assisted Dying Bill

The Chair confirmed the Assisted Dying Bill would remain a standing agenda item. Dame Suzy Lishman provided a brief update, noting that the Bill remains in the House of Lords with timing for its return to the Commons still uncertain. She reported that her evidence to a House of Lords Select Committee had been referenced during recent debate in the House of Lords. She clarified that there had been a minor misunderstanding in relation to her comments on "unexpected deaths" and confirmed that she had provided clarification in correspondence.
She noted that the Bill continues to progress through the parliamentary process and

highlighted ongoing discussion regarding its scrutiny in the House of Lords.

ME.08/26 **10. Any other business**
None.

ME.09/26 **11. Date of next meeting:**
The next meeting is scheduled for Wednesday, 20 May 2026 at 10:00am for a duration of 2 hours via MS Teams