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

Medical Examiner Officer Training Workbook

Contents

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

Introduction

- The Medical Examiner System
- Role of the MEO

What has been my key learning?

Session 1 - Practical considerations and case management

What has been my key learning?

Session 1 - Scenario discussions

1.1 Doctor on call / going home

The ME office is notified by a death by the on call registrar at 8am on arrival to the office. An elderly Muslim gentleman passed away overnight and the family are eager to get the MCCD as soon as possible. The registrar is known to one of the family and has been asked to write the MCCD. The registrar proposes 1a heart failure, 1b myocardial infarction after being called to the cardiac arrest to the ward.

- Have they attended the deceased in life during the last illness?

- Was this an expected death?

- Should they be assisting with the MCCD if they are related to the family personally?

- Is the cause of death acceptable?

- What may the ME wish to review during scrutiny?

1.2 Limited availability of the QAP

A QAP attends the ME office to write the MCCD. The notes have just arrived and have not yet been reviewed by the ME. The QAP is adamant they need to write the MCCD now as they are in theatre all afternoon and cannot come back later. They are on leave for a week after today and don't have time to do the cremation form. They advise they can issue the MCCD as 1a likely metastatic oesophageal cancer and that there is nothing requiring coroner referral and no concerns raised by the attending team.

- Is the proposed COD acceptable?

- From the discussion with the doctor is there anything that would make you think this may require coroner referral?

- What action would you take to ensure the best use of the QAP and the ME time?

- What would you do if after ME review there was something that required coroner referral?

1.3 Pre emptive advice for expected death

A call is received by a consultant paediatrician from intensive care, they are about to withdraw treatment on a 3 year old child. Both brain stem tests have been completed and the parents wish to permit organ donation and take their child back home as soon as possible after death. The paediatric is going off duty but wishes to write the MCCD before they leave so that donation can occur as soon as possible after ventilation has been withdrawn. She wishes to write:

1a ventilator associated pseudomonas pneumonia

1b Immunosuppression

1c Acute myeloid leukaemia

- Can the paediatrician write the MCCD?

- Is the cause of death acceptable?

- What can you do to ensure that the wishes of the family are facilitated?

- Who else may require information about this case?

1.4 MCCD issued over the weekend without an ME review

You arrive at the office on the Monday morning and discover a MCCD was issued in the early hours for a 78 year old Jewish lady who passed away. According to the bereavement office the death has been registered and the burial taken place. There is no record in the notes about what has been written on the MCCD.

- What would be your first actions?

- Should the MCCD have been issued out of hours?

The cause of death was recorded as

1a Old age and dementia

1c infected pressure sores

1b frailty and immobility

- Is this cause of death acceptable?

- What would you do next?

- What would you do if the ME suggested the MCCD needed to be rewritten?

- What would you do if the ME suggested the case should be reported to the coroner?

- What should you do if the medical examiner feels the MCCD should be left as it is as its 'too much hassle for the family who want a quick funeral'?

- A medical examiner calls the office later in the day to say they spoke with the QAP over the weekend and approved the cause of death above but didn't take any notes. What are your key thoughts?

1.5 Conflict between the wishes of the family and the wishes of the deceased

A 20-year-old man suffered a collapse at work on Wednesday evening. His Glasgow Coma Score is 3 and a CT confirmed extensive subarachnoid haemorrhage. He was taken to intensive care where two successive sets of brainstem death tests showed he fulfilled the criteria for brainstem death. You are contacted by the intensive care consultant at 1600 on the Friday because the family wish to remove his body for a burial over the weekend. He points out that the deceased had a signed organ donor card in his pocket, but the family are insistent on burial without donation. The QAP offers 1a Spontaneous subarachnoid haemorrhage and there is no evidence of trauma or anticoagulation.

- What would you do?

- What actions are needed if the family propose to take the body out of the country?

Session 2 - Putting Patients first

- Putting the bereaved at the heart of the service: Patient Services association
- Meeting the needs of the faith communities – National Burial Council & Board of Deputies of British Jews

What has been my key learning?

Session 2 - Scenario discussions

2.1 Scenario: Allegations from angry and distressed relatives

The ME reviewed the death of a 58-year-old woman with a long history of chronic obstructive pulmonary disease, known lung cancer and extensive co morbidities. The ME had raised no concerns on their review and the QAP did not raise any issues when asked about the case. When you call her husband, he is very angry and upset, claiming that she hadn't received full treatment and had died because the hospital had 'left her to die'.

- What are your first thoughts and what would you do?

On further enquiry it would appear that her COPD had deteriorated despite having a home nebuliser, antibiotics and regular visits from her GP. Her blood gases were very poor but ITU declined to admit her for ventilation based on her existing co morbidities as they felt she would not respond well to ventilation or be able to be weaned from it.

- What would you do next?

The husband responds to your explanation with surprise and acceptance; he explains that he had not been given that explanation. He had merely been told his wife's lungs were "shot to pieces from too much smoking" and they were stopping treatment.

- What would be your response?

2.2 NoK have concerns regarding pre hospital care

68 year old man with T2DM, hypertension and obesity presents to the ED with chest pain. He is seen on arrival and diagnosed as a late presenting MI with a new diagnosis of IHD. Shortly after arrival he arrests in the ED department and resuscitation is unsuccessful. After review by the medical examiner the cause of death is agreed as 1a Myocardial infarction and 1b Ischaemic heart disease. On discussion with the daughter she has no concerns with the care at the hospital and accepts the cause of death after some explanation but is concerned that her dad had gone to the GP several times over the last few weeks and is worried that his heart problems could have been detected sooner and his heart attack prevented.

- What would be your response?

- Would this need discussion with the coroner?

On review of the medical records it appears that the patient had visited the GP for general fatigue, breathlessness and palpitations. The GP had sent him for an ECG and it had been recorded by the cardiology department that it was normal. On inspection the ECG showed ischaemic changes.

- What would you tell the daughter?

2.3 NoK have concerns regarding medical care

An elderly lady with longstanding diabetes developed pneumonia and was admitted to hospital but died six days later. The clinical team proposes a death certificate with pneumonia in part 1a and old age and frailty, and type two diabetes mellitus in part 2. The ME agreed this as a cause of death and neither the QAP or ME raised any concerns. During your contact with the family, the son is very unhappy with the overall standard of care in hospital. Specifically, he claims that the day after admission she fell out of bed; he had not been present, but she subsequently complained of pain in her left hip but this was never investigated but he believes that she broke her hip.

- What would you do?

The ME re-reviews the case notes and determines that they make no mention of this incident and the hip was not X-rayed. The ME is concerned as it would appear a significant event has not been acted up on and suggests referral of the case to the coroner for further investigation. When you call the son back he is horrified by this proposal, specifically because they anticipate that it will require a post-mortem examination and it will delay funeral arrangements. The son then changes

his story, denying that she ever fell out of bed and withdrawing all complaints about the standard of care. He 'forbids' you to discuss your conversations with the coroner and states you would be breaching confidentiality if you ignored his request.

- How would you respond to this?

2.4 NoK have concerns regarding the cause of death

A 46-year-old man dies of liver failure due to a documented history of alcohol excess over many years although he had been abstinent for the last 10 years. He was well known to the Hepatology department and had been under their care for some time. His cause of death is agreed between the QAP and the ME as 1a alcoholic liver disease. His next of kin is his 23 year old daughter who has had limited contact with her father and only recently got back in touch with him. During discussion about the cause of death she is shocked at the cause of death and strongly contests that he ever had an alcohol problem as he was a driver by occupation. She reports that he had told her he had liver cancer.

- What are your thoughts?

- She is offended at the word alcoholic on the MCCD and asks for it to be removed – how would you respond?

You receive a call back from the daughter a few days later. She is clearly upset and is contesting the cause of death again as she has found a life insurance policy that is void if her father died of alcohol related disease. She demands that the cause of death is changed as she needs to collect the life insurance to pay for the funeral as she has no other way to pay for it.

- How would you respond?

2.5 NoK raised concerns regarding the ME system

On contacting a relative regarding the apparently natural death due to a pre existing lung cancer you are challenged on the role of the ME office and accused of covering up events in hospital. The relative states that they never gave the ME permission to view the records and will be taking this up with their local MP as the service is corrupt and in league with the NHS in falsifying records.

- How would you respond?

During conversation it becomes apparent that he disputes the diagnosis of lung cancer and feels that the hospital and GP are making this up to cover up the real cause of her death which he believed was as a result of the GP not coming out to see the his mother every day and leaving it to the palliative care nurses. He feels that was inappropriate and given how ill his mother was the GP should have visited every day. He feels that his mother was admitted in extremis as a result, and that the hospital clinicians had failed to treat the condition properly, had just “left her to die” and now everyone is involved in a ‘cover-up’.

- What would be your next action?

The available documentation and your discussion with the ME provide nothing to support the son's concerns. The hospital clinicians feel that there was nothing to be gained by a consent PM. The coroner refuses to be involved. The son becomes increasingly suspicious that this is a closing of ranks, and demands a 'private' PM.

- Can you do anything further?

2.6 Concerns raised some time after death has been registered

An 88 year man is admitted to hospital and dies of pneumonia and age related frailty 7 days after admission. The MCCD is issued to the next of kin and the death is registered. Two weeks after death a nurse involved in his care contacts the medical examiner's office to ask what the coroner's decision had been. Records show that the case was not reported to the coroner at the time.

The nurse then informed the MEO that there were two Incident reports submitted by two specialist nurses on the day of the patient's death, both reports expressing concern relating to the patient's care and also reporting that a member of the hospital staff had been witnessed making changes to the patient records after the patient's death relating to care two days before the patient had died. The Safeguarding Adults team were notified at the time.

- What would you do?

On review there is nothing documented in the medical notes to indicate that the death meets the coroner referral criteria and the medical examiner raises no concerns at re-review. The medical team and the bereaved had no concerns when the MEO discussed the circumstances and care with them.

- Do you need to do anything else?

Session 3 - Working with stakeholders

- Overview of working with others

What has been my key learning?

Session 3 - Scenario discussions

3.1 QAP disagreement with ME suggested cause of death - Change or order

The ME and the QAP have a difference in option in the order of the cause of death, the ME had suggested 1a Congestive cardiac failure and 2 Chronic obstructive pulmonary disease. The QAP has suggested 1a Chronic obstructive pulmonary disease and 2 Congestive cardiac failure. No concerns were raised by the ME or QAP.

- Is the QAPs suggestion acceptable?

- What can the ME do to assist with this type of enquiry?

3.2 QAP disagreement with ME suggested cause of death - Change of wording

The ME suggested 1a sepsis due to Proteus urinary tract infection, 1b Dementia, the QAP wishes want to put 1a multi-organ failure with sepsis 1b urinary tract infection 1c Alzheimer's disease.

- What would you do?

3.3 QAP disagreement with ME suggested cause of death – Change of part 1

A QAP contacts the office about a 45 year old man who died soon after admission to the respiratory ward. He has known COPD with home oxygen and recurrent admissions to hospital with exacerbations of his COPD which have been managed with steroids and antibiotics in the past. He was admitted with a further exacerbation and managed in the ED on arrival with non-invasive ventilation. When he was transferred to the ward he vomited into his mask and suffered a fatal cardiac arrest. The team propose a cause of death of 1a Gastrointestinal haemorrhage 2 Chronic obstructive pulmonary disease

- Is the QAP suggested cause of death acceptable?

- Are there any other elements of the case you think the ME may wish to consider?

After the ME discussion with the QAP cause of death is agreed as 1a chronic obstructive pulmonary disease. Shortly after you receive a call from the consultant who raises issues with the management of care in the ED and has flagged this with clinical governance for investigation. He never met the patient but has been told about events from the on call medical registrar who saw the patient overnight.

- What would you do?

3.4 QAP disagrees with ME suggested reason for referral – concerns with care

A 64 year old man with known peripheral vascular disease and cellulitis of the left leg became unwell on the Saturday morning – NEWS 10. The nursing staff failed to ask hospital at night to review but repeated his observations done every 3 hours and the NEWS was persistently >10. The patient was not seen by a doctor until he arrested 35 hours later on the Sunday evening.

The ME has suggested the cause of death to be 1a sepsis 1b cellulitis of the left leg 1c neuroischaemic foot ulcer due to peripheral vascular disease and suggested referral to the coroner and SJR / LfD review due to a failure to escalate abnormal observations on the ward over the weekend. They feel earlier escalation may have altered the outcome as there was no limit to care and no DNACPR in place.

The team offer 1a ischaemic heart disease and infected foot ulcer due to peripheral vascular disease in part 2. The FY1 who has come to do the MCCD has been told by his registrar that the coroner does not need to be involved. The FY1 last saw the patient on the Friday on ward round.

- What would you do first?

- What would you do if the team recognised the failure to escalate the patient but said 'it always happens on this ward, the nurses don't tell us when the patient has become unwell'

- What would you do differently if the observations had been escalated but the ME had raised concerns about the junior doctor's lack of assessment and escalation and this junior doctor was the one who attended to write the MCCD?

3.5 QAP disagrees with ME suggested reason for referral - Recent operation

A 62 year old patient on cardiac care unit died of pneumonia. The Consultant wishes to record this in 1a and valvular heart disease in part 2 on the MCCD. On discussion the patient underwent an aortic valve replacement 3 weeks ago during this admission. The review by the ME had suggests 1a pneumonia, 1b valvular heart disease (operated). On further discussion between the MEO and the team, the consultant strongly disagrees that a referral to the coroner is needed as the surgery went well and he was recovering well when he developed a pneumonia. The consultant feels that the surgery was unrelated to the death and that it does not meet the new regulations to report to a coroner.

- After discussion with the QAP do you feel this still needs reporting?

A decision was made to report the case to the coroner and a form 100A was issued. When the family arrive at the bereavement office they voice that they are unhappy with the surgery and state they were never 'told of the risks' or that he could die. The coroner's office is notified and they explain that the consultant gave a reasoning that the family have been 'rather difficult' throughout and simply refused to accept how unwell their father had been. The coroner has accepted that the patient had a high mortality rate and could have died at any time without the surgery but that the patient did not his family to know how serious his heart condition was.

- What would your actions be?

3.6 QAP disagrees with ME suggested reason for referral - QAP wishes to discuss the case with the coroner's office for advice

A doctor arrives to discuss a case. A 98 year old man admitted from his home with a pneumonia on a background of mild COPD. He is managed with antibiotics and correct escalation but then deteriorates more rapidly with SOB and hypoxia. The team are unsure if there was a PE at the end to explain the rapid deterioration and want to discuss the case with the coroner to ask if they should put PE or pneumonia in 1a.

- What would you suggest to the QAP?

3.7 Family continue to raise concerns despite form A issued

A 63 year old man with known metastatic renal cell cancer under palliative care for end of life care fell out of bed on ward and sustained a pathological neck of femur fracture. Given his terminal phase this was managed conservatively with analgesia and not operated on. A DATIX was completed and duty of candour undertaken at the time. The medical records document discussions with the family who apparently have no concerns regarding the fall and injury. The patient dies 6 days later. The medical team offer 1a metastatic renal cell carcinoma and say 'what's the point of ref to the coroner as it's not going anywhere, as investigations have been done and the family are satisfied'. They feel that referral to the coroner will bring it all up again for the family and that this is inappropriate. The medical examiner has not yet seen the case.

- What would you do and what are your first thoughts?

A decision is taken to report the case to the coroner, the QAP reports the case and writes to the coroner's officer that all investigations have been done and the family were satisfied. A form A is later issued with a note on the death report stating that the family have no concerns with the care or cause of death. You are contacted by the bereavement office the next day as the family have come to collect the MCCD but have mentioned that they remain very unhappy with the fall and fracture and that they can't understand how a bed bound man could 'fall out of bed'.

- What would you do with this new information?

- What would you do if the coroner still feels this is not something that they need to investigate?

Suggested documentation / reading for MEOs

- Coroners Courts – A guide to law and Practice 3rd Edition. Mr C P Dorries
- ONS completion of the death certificate
- List of prescribed diseases
- CQC report into how the NHS investigated serious incidents

Suggestions for other training

- SAGE & THYME communication training
- Bereavement loss and care training
- Care of the dying patient – end of life care
- Advanced Medical terminology
- Visits to clinical areas within the Trust
- Visits to areas involved in death certification: HMC, Funeral directors, crematoria, registrar office