



The Royal College of **Pathologists**

Pathology: the science behind the cure

Medical examiners

Annual conference report

Wednesday 18 May 2022

Convened by

The Royal College of Pathologists

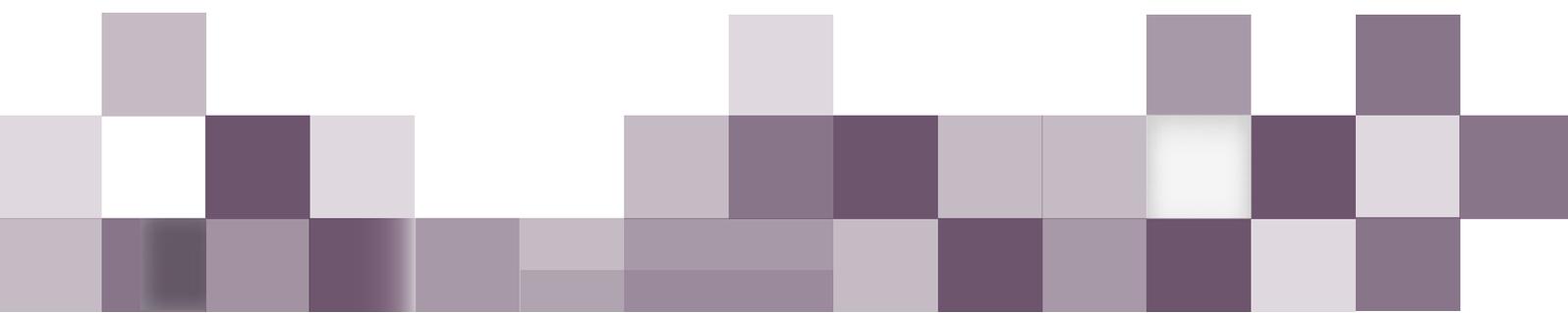
Chair

Dr Suzy Lishman CBE, Chair of the Royal College of Pathologists' Medical Examiners Committee

Introductions

Professor Mike Osborn, President, Royal College of Pathologists

Jane Crossley	Team Leader – Death Certification Reform, Department of Health and Social Care
Dr Alan Fletcher	National Medical Examiner
Dr Aidan Fowler	National Director of Patient Safety, NHS Improvement
Tracy Frisby	Registration Service Manager, NE Lincs Council
Fiona Murphy MBE	Director of Nursing for Corporate Services across Liverpool Foundation Teaching Hospitals
Dr Anup Patel	Medical Examiner, East Kent Hospitals University NHS Foundation Trust
Ms Tanaya Sarkhel	Lead Medical Examiner, Ashford & St Peter's Hospitals NHS Foundation Trust
Dr Jason Shannon	Lead Medical Examiner for Wales
Dr Golda Shelley-Fraser	Regional Medical Examiner, South West
Matthew Smith	Clinical Audit Facilitator, Cwm Taf Morgannwg University Health Board
His Honour Judge Thomas Teague QC	Chief Coroner
William Vineall	Director of NHS Quality, Safety and Investigations at the Department of Health and Social Care
Dr Michelle Webb	Lead Medical Examiner, East Kent Hospitals University NHS Foundation Trust
Dr Esther Youd	Consultant Pathologist, University of Glasgow



Introduction

A national network of medical examiners was recommended by the Shipman, Mid-Staffordshire and Morecambe Bay public inquiries. The Royal College of Pathologists (RCPATH) campaigned for their implementation and continues to play a key role in influencing government's work around implementation of the service.

Medical examiners are part of a national network of specially trained independent senior doctors from any specialty. Overseen by the National Medical Examiner, they scrutinise all deaths that do not fall under the coroner's jurisdiction.

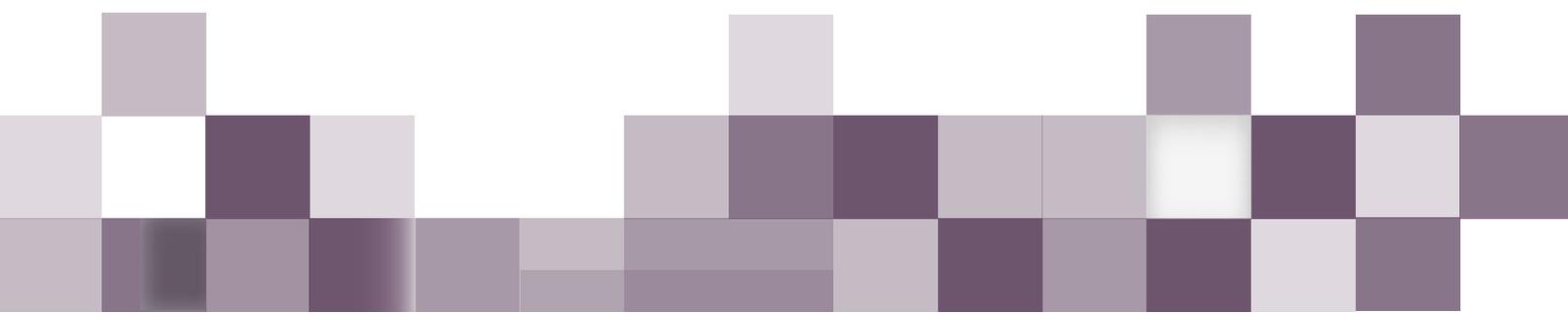
As the lead medical royal college for medical examiners, the College provides medical examiner training, information on setting up a medical examiner system and advice on how to become a medical examiner.

The College hosts the annual medical examiner conference, which provides an opportunity for all those involved in the care of the bereaved to discuss updates on national policy and share experiences and challenges in implementing and running medical examiner services.



This report summarises progress in the introduction of a statutory medical examiner service. It includes a strategic update from the Department of Health and Social Care on implementation and the work required to move towards this. The report also highlights the benefits of pilot medical examiner systems through case studies.

The College continues to work with local and national government, stakeholders, charities and patient groups to ensure the successful rollout and to advocate for patients and bereaved families.



200,000+

deaths in England and Wales were independently scrutinised by medical examiners in 2021

19,807
deaths were referred for case record review in England

3,637
of these deaths involved people with a learning disability or severe mental illness

99%
of post mortems in England and Wales are coroner post mortems



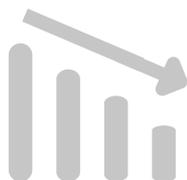
£96.80
The cost of a coroner post mortem in England and Wales



7%
increase in the number of post-mortem examinations requested by coroners in 2021 compared with 2020



5%
decrease in the number of deaths reported to the coroner in 2021 compared with 2020



Training

5

successful joint training events were delivered by the Royal College of Pathologists and the Judicial College in 2021



356

medical examiners attended



215

coroners attended

1,427
senior doctors completed medical examiner training by the end of 2021

330
staff completed medical examiner officer training by the end of 2021



Strategic update from the Department of Health and Social Care

Legislation

The Health and Care Act 2022 received Royal Assent on 28 April 2022, transferring the responsibility for employing medical examiners from local authorities to the NHS. This will facilitate medical examiners' access to patient records, while allowing them to remain independent of the case. Secondary legislation will follow, allowing medical examiners to move to a statutory footing.

Timing

It is the intention that from April 2023 the statutory medical examiner system will be introduced, subject to cross government agreement. This can only be achieved if all parts of the system are ready.

Funding

The statutory medical examiner system in England will be centrally funded. The Ministry of Justice (MOJ), for example, has already taken the steps to permanently remove cremation form 5.

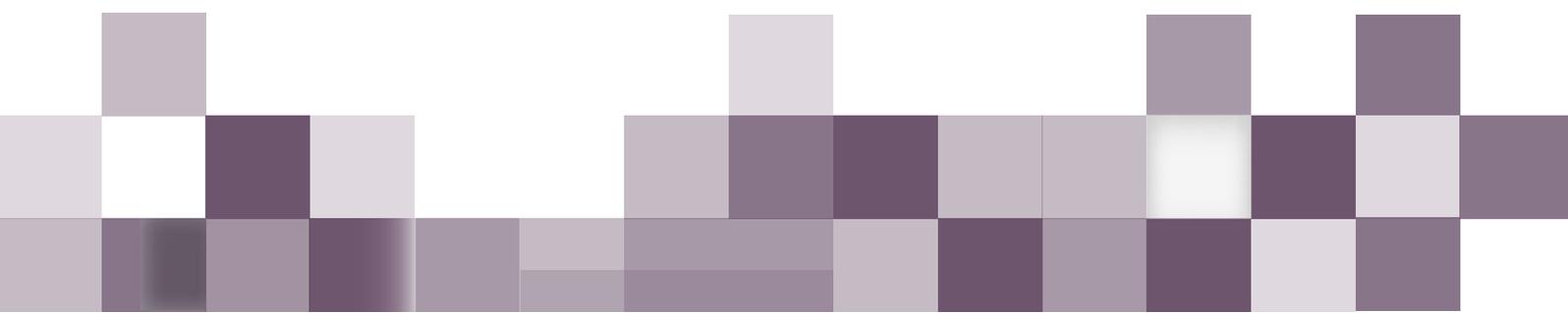
This will allow removal of the associated fee. It is understood that MOJ intends to permanently remove cremation form 4 with the full introduction of the statutory medical examiner system.

System improvements

Learning from the COVID-19 pandemic has led to plans to digitise the Medical Certificate of Cause of Death (MCCD) and review its content. This work is being undertaken by NHS Business Services Authority commissioned by the Department of Health and Social Care (DHSC).

Main changes to the MCCD:

- The digital MCCD will include ethnicity data for the first time, self-declared by the patient and taken directly from the patient record where available.
- The reporting of maternal deaths will be included, bringing the MCCD in line with international standards identified by the Office for National Statistics.
- The presence of medical devices and pacemakers will be recorded by the attending doctor on the MCCD.



- A signature and declaration by the medical examiner that they have scrutinised the case will be added.

The digital MCCD will be rolled out to complement the statutory medical examiner system from April 2023.

The voice of the bereaved

One of the key elements of the death certification reform programme, of which medical examiners form a key part, is listening to the voice of the bereaved so they have the opportunity to ask questions and raise concerns. Listening to the bereaved will inform public health policy and the patient safety agenda going forward.

The government is working with the UK Commission on Bereavement, an independent stakeholder body led by the Right Reverend and Right Honorable Dame Sarah Mullally, the Bishop of London, a former Chief Nursing Officer at the DHSC. They recently ran a call for evidence from individuals and organisations about their experiences of bereavement support. The report is due to be published in autumn 2022.

The government is increasingly aware of the disparities in society that prevent certain groups from accessing support. The National Institute for Health and Care Research will commission

research into the barriers that prevent BAME communities from accessing bereavement support, and to help address health disparities. The bid is backed by £300,000 and the stage 1 call went out on 10 May and closed on 4 June 2022. The results are expected in 2023.

Further information

<https://bereavementcommission.org.uk>

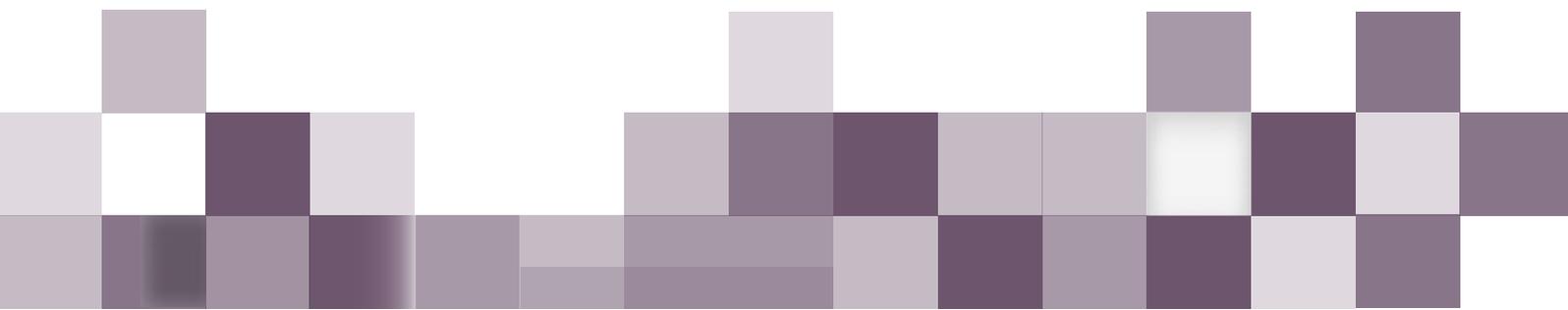
<https://www.nihr.ac.uk>

To volunteer to contribute to the development of the digital MCCD, contact the NHS Business Services Authority.

Details of the ministerial announcement subsequently made on 9 June 2022.

Mr William Vineall

Director of NHS Quality, Safety, and Investigations at the Department of Health and Social Care



Overview of the National Medical Examiner's report 2021

During 2021, the message went out to healthcare providers in both England and Wales to start preparing for medical examiners to provide a universal system of independent scrutiny for all non-coronial deaths. This progress, in the context of the COVID-19 pandemic, is all the more impressive.

Medical examiners reported independent scrutiny of more than 200,000 deaths in England and Wales in 2021. Around 10% of deaths in England (and slightly more in Wales) were referred for a case record review, including more than 3,500 deaths of people with a learning disability or severe mental illness. In nearly 90% of cases where medical examiners requested urgent release of bodies this was granted.¹

The National Medical Examiner, in collaboration with experts and stakeholders, produces [good practice guidelines](#), which are published by the Royal College of Pathologists.

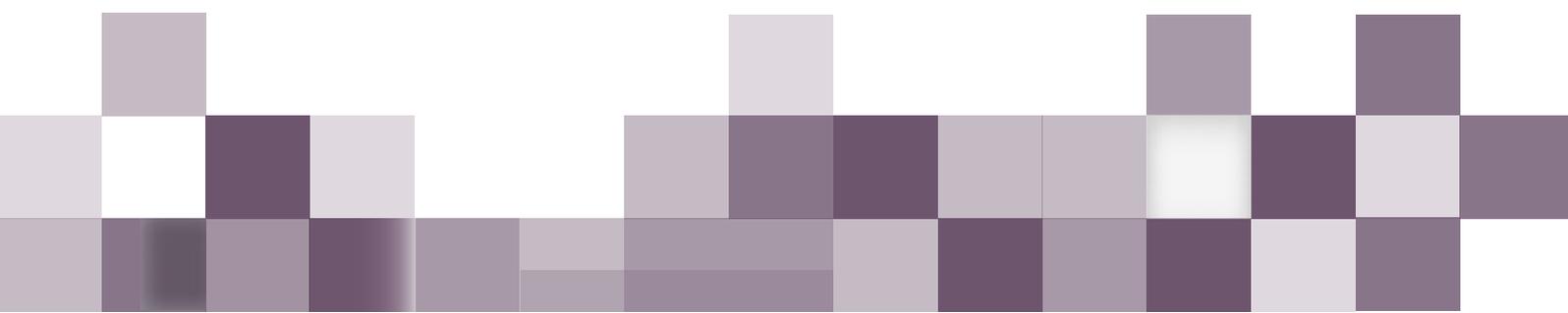
To date, eight documents have been published on subjects ranging from how medical examiners can support families and carers after the death of a person with a learning disability or an autistic person, to facilitating organ and tissue donation.

Dr Alan Fletcher

National Medical Examiner

1. NHS. [National Medical Examiner's report 2021](#).
Published 18 May 2022.

“ I am delighted to have the Royal College of Pathologists' support in promoting good practice. The Good Practice Series will ensure consistency and high standards are maintained and each instalment has the benefit of subject matter expert input.”



The impact of medical examiners on the coronial system

The practical benefits that the medical examiners scheme can bring to the death investigation process are already being demonstrated in Trusts and Health Boards throughout England and Wales.

Medical examiners have been able to provide that extra level of scrutiny and, where appropriate, take difficult decisions to question colleagues, ask for a further look and sometimes refer cases to coroners to consider investigation.

Coroners and medical examiners form complementary parts of the same system of death investigation. In 2021, 195,200 deaths were reported to coroners, the lowest level since 1995 and, down 5% (10,300) compared with 2020. That represents a third of all registered deaths. There were 84,600 post-mortem examinations requested by coroners in 2021, a 7% increase compared with 2020. 32,800 inquests were opened in 2021, up 2% compared with 2020.

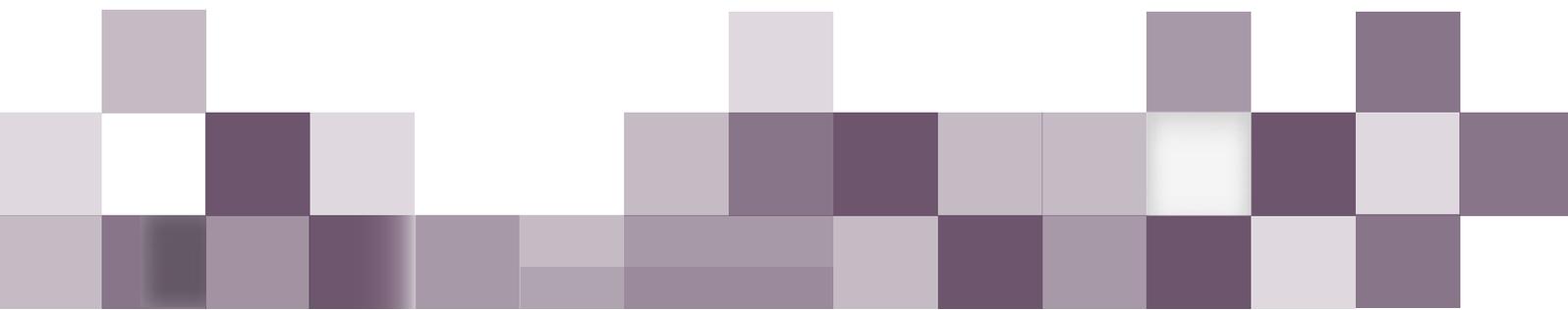
At least part of the reduction in cases reported to coroners, as well as possibly the increase in post-mortem examinations and the modest rise in

the number of inquests, may provide evidence of the medical examiner system in action, with only appropriate cases being referred to the coroner.

Five successful joint training events were delivered by the Royal College of Pathologists and the Judicial College. The feedback was overwhelmingly positive.

His Honour Judge Thomas Teague QC
Chief Coroner

“ I am currently mid-way through a national tour of every coroner area in England and Wales. I always ask whether there is a medical examiner scheme in the local coroner area and, if so, how it is working and what the relationships are like. I have been heartened by the positive feedback that I have received during these visits.



Patient safety

NHS Improvement (NHSI) committed to publishing the *NHS Patient Safety Strategy* and revising it annually. The pandemic delayed this, but the strategy has been published and revised once, with the 2nd revision due in 2022. The aim is to move from a reactive system with reliance on retrospective review of cases with harm, to risk-based mitigation in real time, which will deliver a safer system with greater pace.

“ The medical examiner system is undoubtedly a huge success. The system is still building but is now reviewing the majority of acute deaths.

The COVID-19 pandemic and the issues that arose, and were quickly responded to, have proved that the NHS can work quickly to problem-solve and adapt to ensure safer care. Dr Fowler cited medical examiner contributions to this system during the pandemic – giving the example of improvements in ventilatory support for COVID-19 patients as a direct result of issues picked up and escalated by medical examiners.

Reporting using the National Reporting and Learning System (NRLS) and Strategic

Executive Information System (StEIS) currently captures around 2.4 million patient safety incidents per year. Of these, 10,000 are classed as severe harm or death (around 0.5%), approximately 3% are moderate harm, and the rest are low harm, or no harm (near misses).

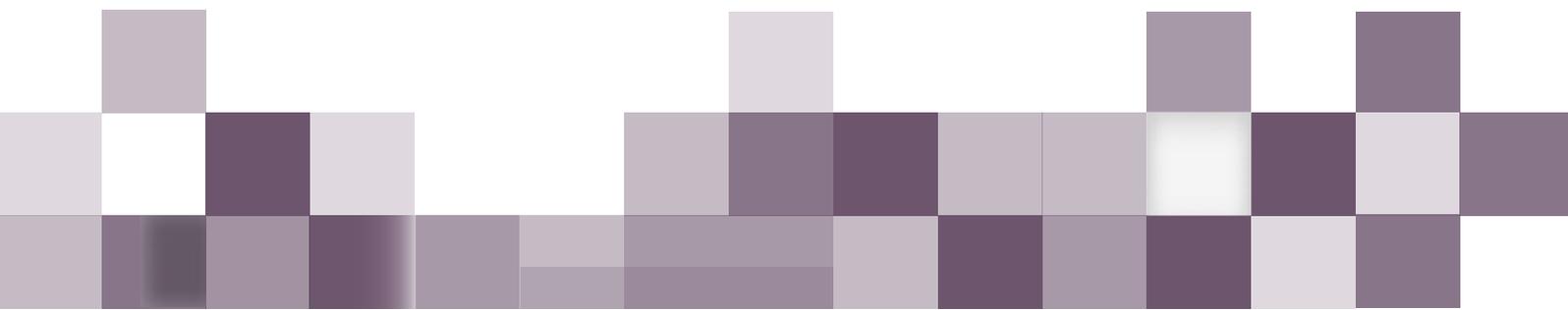
Training modules (NHS Patient safety syllabus) aimed at all NHS staff will enable everyone working in the NHS to have a basic understanding of patient safety, and allow patient safety specialists to be trained to a higher level. This will ensure we act on the learning that is identified in a more systemic and robust fashion.

Over 800 patient safety specialists will soon be in place. By the end of Q1 of 2022/2023 each organisation will have two patient safety partners drawn from the lay public on their quality committees. The patient safety specialist will act as ‘the captain of the team’ and help disseminate the patient safety strategy to organisations.

The new integrated care systems (ICS) will be integral – having oversight of the high-level themes that emerge from the data and working to ensure learning is disseminated. This will help to break down silo working.

Dr Aidan Fowler

National Director of Patient Safety, NHSI



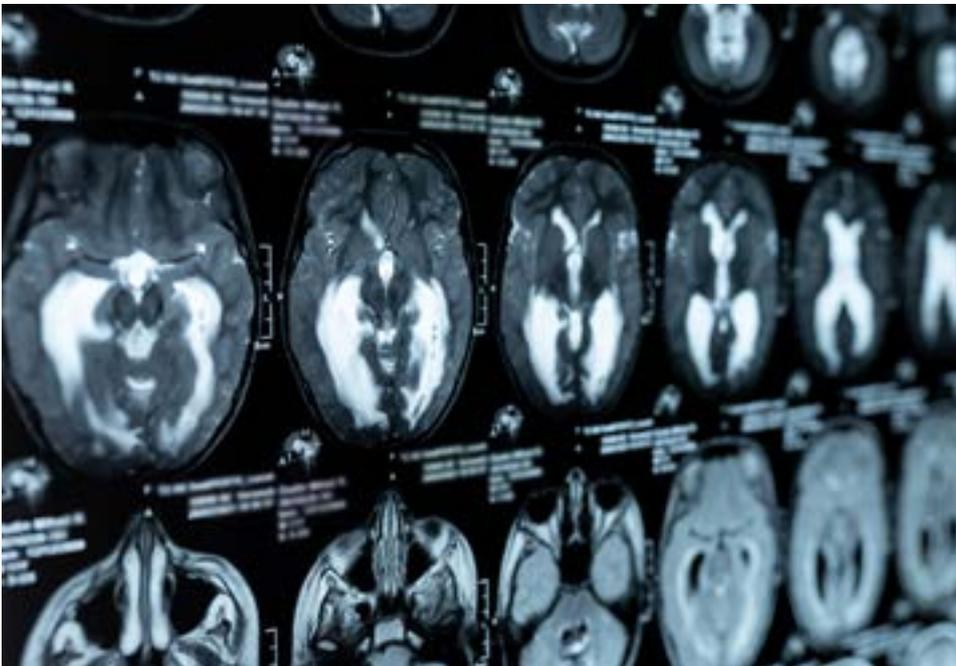
The role of post-mortem examinations

There has been a decrease in the number of deaths reported to coroners in England and Wales over the last five years. This has been mirrored by a decrease in the overall proportion of deaths reported to coroners, but a slight increasing trend of the proportion of deaths requiring a post mortem (up to 43% in 2021).

Coroner's post mortems are the most common type of post mortem, accounting for over 99% of post mortems in England and Wales. This is a legal decision and it has a limited remit to determine the medical cause of death. It costs £96.80.

Forensic pathologists have separate training in the UK, and the cost of the post mortem is thousands of pounds. Consent post mortems (sometimes called hospital post mortems) account for around 1% of post mortems. They are typically requested by a hospital clinician to investigate an aspect of the death, disease process or treatment.

Imaging has long been a part of post-mortem examinations, using plain X-ray, particularly in forensic examinations and paediatric examinations. However, in recent years, cross-sectional imaging (CT and MRI) has been developed for post mortem.



These are not available in many centres, but where available, post-mortem CT scanning can provide an adjunct to or replacement for invasive autopsy. A post-mortem CT costs several hundreds of pounds and the cost is often borne by the family.

Dr Esther Youd
Consultant Pathologist

Benefits of the Welsh national medical examiner service: lessons from the scrutiny of 10,000+ deaths

Wales is the only nation in the world with a single, nationally managed, medical examiner service with staff employed separately from care provider organisations to maximise independence and consistency as well as ensuring sustainability and continuity.

“ For the bereaved, they have an opportunity to be heard and to have any concerns they may have addressed knowing that the death has been reviewed independent of the care provider.

A consistent output has demonstrated benefits for coroners, care organisations and the deceased as well as providing the Welsh government with a reliable source of information.

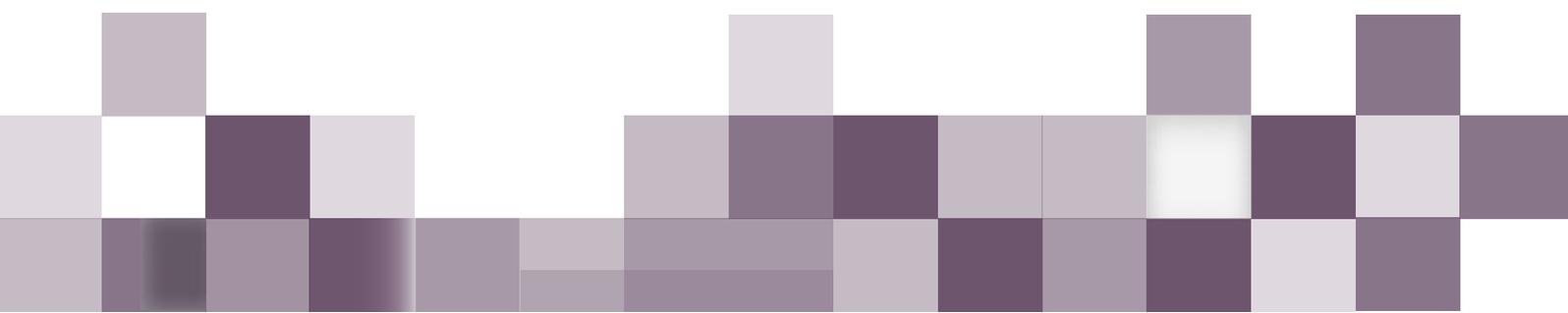
For coroners, there is assurance of oversight over the statutory Notification of Deaths Regulations (2019). They are provided with detailed reports to assist them with their decision-making, including a reliable proposed cause of death. For the bereaved, they have an opportunity to be heard and to have any concerns they may have addressed knowing that the death has been reviewed independent of the care provider.

Dr Jason Shannon

Lead Medical Examiner for Wales

Matthew Smith

Clinical Audit Facilitator, Cwm Taf Morgannwg University Health Board



Working with registration services

Registration services can support the work of medical examiners, but effective communication between all services is vital to ensure the best possible outcomes.

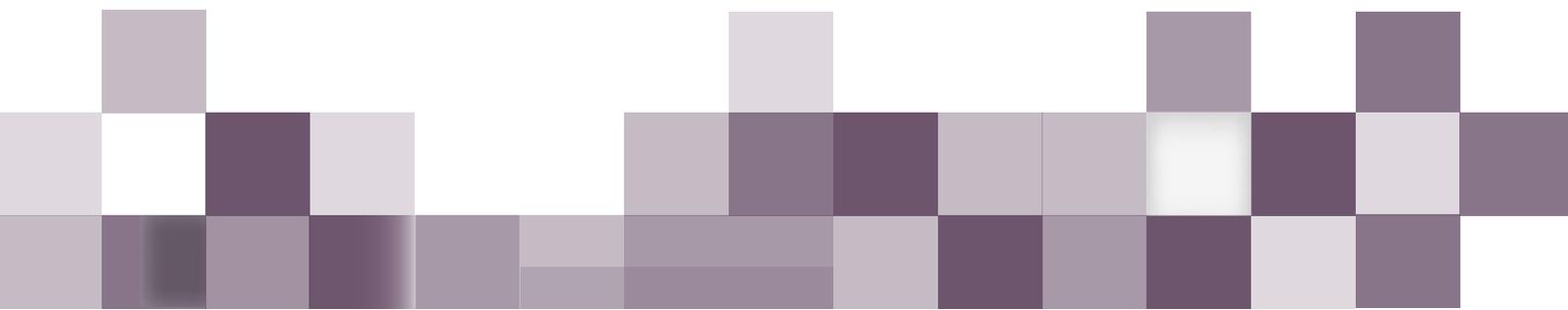
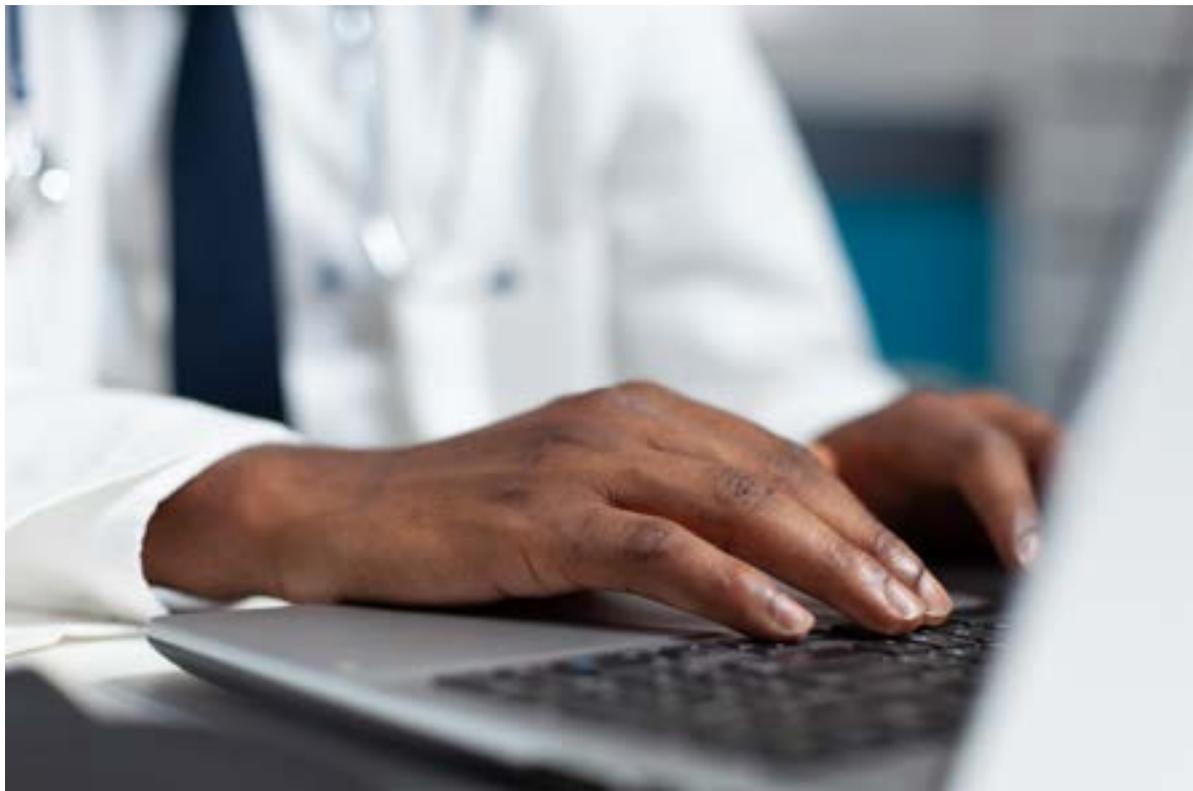
There has been a significant reduction in the number of MCCDs being rejected following review by a medical examiner. There has been an increase in the number of Form 100As issued this year (2022), in the context of the absence of a doctor who could qualify as having attended in the last 28 days of life. This seems to have been related to the tail end of the pandemic and expiry of the Coronavirus Act 2020.

The digitisation of the MCCD is a welcomed development, but registrars will still have to ask the prescribed questions to the person registering the death.

Training for all those involved in death certification should be promoted, especially for medical professionals early in their careers. The growth of local, regional and national networks should be encouraged to foster the highest standards and support improvements.

Tracy Frisby

Registration Service Manager, NE Lincs Council



Access to primary care records: a national update



Proportionate review of medical notes is a key component of the medical examiner scrutiny process. The National Medical Examiner team made a submission to the Confidentiality Advisory Group, which was approved to put beyond doubt the legal basis for health organisations to share patient records for medical examiner scrutiny. This addresses the legal basis for accessing medical records for the purposes of medical examiner scrutiny rather than the day-to-day practicalities.

The National Medical Examiner team and DHSC are currently working with NHS Digital and NHSX on a digital solution for a single point of access for medical

examiners to GP electronic records for the purposes of medical examiner scrutiny.

GP Connect is currently considered to be the best option for a national digital solution. It is a hidden application that enables access to GP records via different systems. NHS Digital have mapped out the level of readiness of all acute trusts for GP Connect.

Regional teams are currently working with digital transformation leads and lead medical examiners to verify the data. Other methods currently being used include:

- direct access to GP electronic patient record systems
- access via Shared Care Records
- national referral systems
- cloud-based systems.

Dr Golda Shelley-Fraser

Regional Medical Examiner, South West

Case studies

Establishing a community medical examiner service

Ms Tanaya Sarkhal

Lead Medical Examiner, Ashford & St Peter's Hospitals NHS Foundation Trust

The ICS consists of four acute trusts. There is a hub and spoke model, so often a patient's last illness will consist of visits to more than one acute trust. There are 104 GP practices in the ICS and the development of Shared Care Records is currently underway. However, this does not give medical examiners enough information to scrutinise a case adequately.

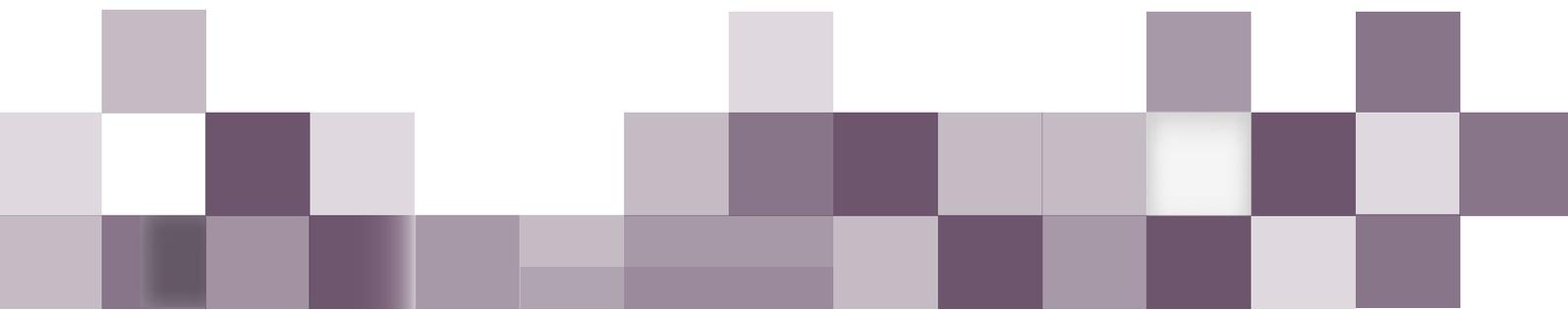
The ICS have worked towards a simple one-button approach to notification of a community death and are using the NHS e-referral system – the e-RS platform. The e-RS referral form auto-populates, attaches the last six months of GP records and is sent directly to a medical examiner office of the GP's choosing along with a scanned copy of the MCCD. Feedback received so far from the two hospices and the GP pilot sites has been positive.

Dr Michelle Webb

Lead Medical Examiner, East Kent Hospitals University NHS Foundation Trust

Dr Michelle Webb described the East Kent model where they are approximately 8,200 deaths per year. Dr Webb liaised with her local Clinical Executive GP Clinical Commissioning Group lead and together they formed the Medical Examiner Community Death Implementation Steering Group. Membership of this group includes representation from the local hospice, community hospitals, Clinical Director of the primary care network, crematorium medical referees and Chair of the Local Medical Committee.

Dr Webb stressed the importance of key engagement from the beginning of the process with the local medical committee (LMC). The recruitment of GPs to become medical examiners has also been very helpful with GP engagement. As has explaining the culture of the medical examiner role as 'two heads are better than one'.



Establishing a community medical examiner service (continued...)

The rollout of the community pilot commenced with community hospitals, hospices and then GP pilot sites. The area is fortunate that all practices are on the EMIS electronic note system. To date, they have 42 practices enrolled and a further nine joining in the near future.

The ability to provide feedback is proving useful for Care Quality Commission (CQC) information and, so far, 164 compliments and seven concerns have been feedback to the practices. The GP completes the MCCD, which is then sent with the automated patient tracking list (PTL) referral to the medical examiner office. In 95% of the proposed causes, the medical examiner is in agreement with the GP. Often numerous conditions are included in part 2 and the medical examiner feeds back any conditions that should be removed from the MCCD to the GP.

“ The recruitment of GPs to become medical examiners has also been very helpful with GP engagement. As has explaining the culture of the medical examiner role as ‘two heads are better than one’.

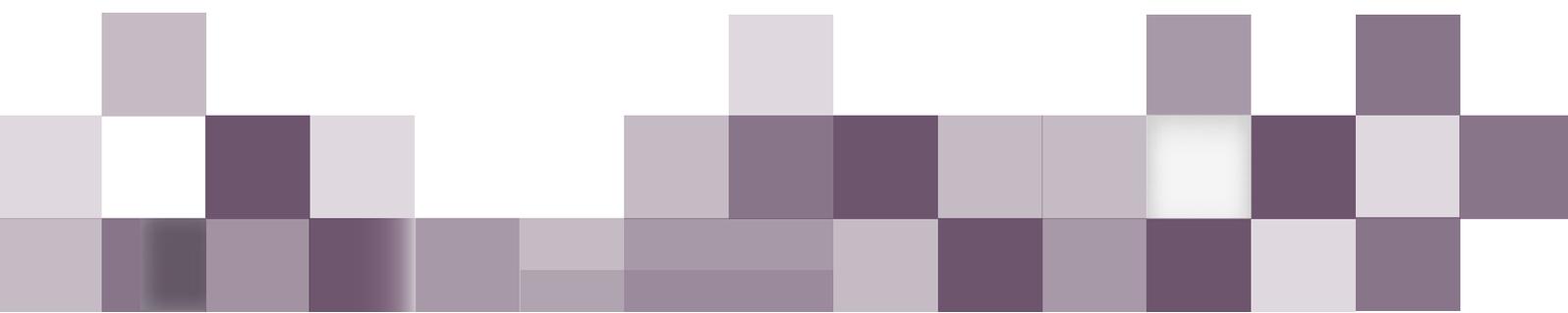
Dr Anup Patel

Medical Examiner, East Kent Hospitals University NHS Foundation Trust

Dr Anup Patel is a GP medical examiner at East Kent. He works in a rural practice in Ashford, Kent, which looks after 7,000 patients. The practice has been a pilot site since November 2021. Initial concerns were raised by the administration staff about extra workload, but the process is now well embedded, and the administration staff do not feel it causes any extra work.

The GPs have found it useful to discuss causes of death with an expert – previously they would have had informal discussions with their colleagues. GP registrars have also found the process beneficial as they approach the end of their training.

The practice previously struggled to receive honest feedback from bereaved families. With its rural setting, the practice looks after many members of the same family and, therefore, relatives have not been keen to give negative feedback. The introduction of an independent service has empowered bereaved relatives to give feedback via the medical examiner system.



Improving end-of-life and bereavement care

Bereavement care is an explicit part of end-of-life care, which should extend to those caring for the dying and the dead. Quality bereavement care should ensure that patients, families and significant others are supported in any circumstance – from the diagnosis of dying, irrespective of place or mode of death.

In the majority of NHS organisations, end-of-life support is offered to patients and families of those expected to die. However, offering bereavement support to families of patients dying suddenly or unexpectedly is a challenge and one that the majority of care settings do not meet.

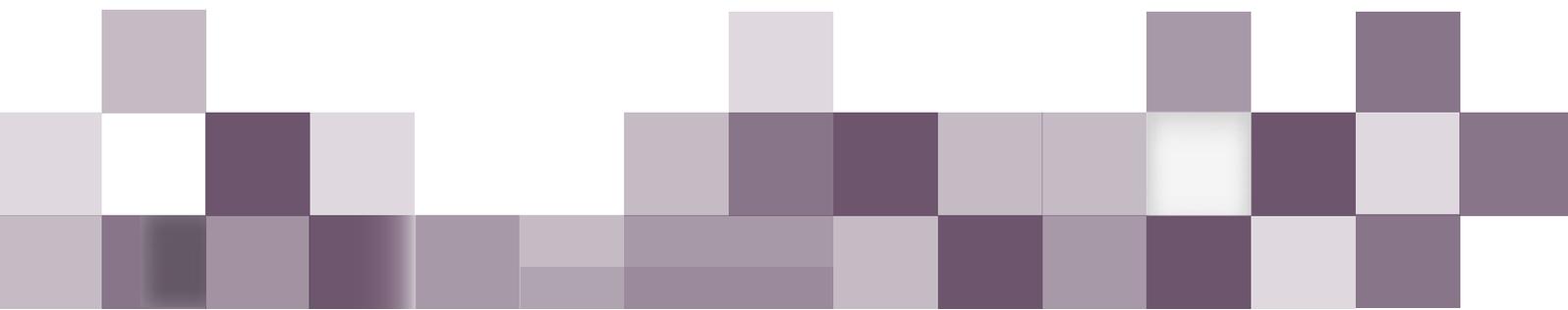
Fiona Murphy created the SWAN model of end-of-life care in 2012 to improve provision of end-of-life care to allow a 'good death'. This empowered all staff to make small changes that make a big difference to families. For example, free car parking, kindness and understanding on the ward, and helping to make last wishes possible, such as Christmas in September, a birthday party or death bed weddings.

SWAN stands for signs/words/actions/needs and allows healthcare workers to identify patients who are at the end of life in a clear but discrete way by using a swan sign.

The SWAN team and Bereavement Services Officer (BSO) nurses work closely together, as well as with the medical examiner service, to share information, provide support and ensure information and processes for the medical examiner service flow smoothly to enable a seamless service for the bereaved.

Fiona Murphy MBE

Director of Nursing for Corporate Services across Liverpool Foundation Teaching Hospitals





The Royal College of Pathologists

Pathology: the science behind the cure

The Royal College of Pathologists is a professional membership organisation with more than 13,000 fellows, diplomates and affiliates worldwide. We are committed to setting and maintaining professional standards and promoting excellence in the teaching and practice of pathology, for the benefit of patients.

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