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 Wednesday 20 May 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 Dr Jason Shannon, Lead Medical Examiner for Wales Dame Suzy Lishman CBE, Senior Advisor Dr Amanda Evans, Medical Examiner 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 Bethan Davies, Welsh Government representative Ms Molly Corless, 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)* Ms Emma Whitting, Coroners' Society representative
Absent:	Dr Laszlo Igali, RCPath Vice President for Professional Practice Dr Niall Martin, Medical Examiner Ms Kirsty Lagdon, Welsh Government representative

ME.10/26 **1. Welcome, declarations of conflicts of interest and apologies for absence**

1.1 The Chair welcomed all members to the meeting.
1.2 There were no declarations of conflict of interests.
1.3 Apologies for absence were received and noted above.

ME.11/26 **2. Minutes of the previous meeting**

2.1 The minutes of the meeting held 8 March 2026 were reviewed and approved as a correct record.

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.**

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ME.12/26 3. Updates

3.1 National Medical Examiner

Dr Twamley extended thanks to the RCPath team and Dame Suzy Lishman for their support of the annual Medical Examiner Conference which received positive feedback.

He provided the following National Medical Examiner update:

- The recently published Ministry of Justice statistics demonstrated a positive impact of the medical examiner system, showing reductions in referrals to coroners and a slight decrease in inquests, while a higher proportion of referred deaths proceeded to inquest, suggesting that cases referred for coronial consideration were increasingly those most appropriate for investigation.
- Preliminary Q4 data suggested improved winter resilience, with less impact from various bank holidays and resident doctor strikes compared to the previous year.
- Progress was ongoing on the National Medical Examiner report, which was nearing final edits and would require approval from English health ministers and the Welsh Government.
- Freedom of Information requests had been received from Co-op Care, issued to all 125 Medical Examiner offices in England (excluding Wales), and a separate request from an individual concerning coroner referral within a specific trust.
- The Good Practice series had been distributed for review, with updates and revisions planned.
- Issues raised regarding the performance of an individual medical examiner had prompted a review of assurance standards, including peer review and scrutiny.

Dr Shannon raised a concern regarding wording in the Ministry of Justice report, which stated that only deaths requiring investigation were referred to coroners. He noted that doctors determine whether deaths meet the requirements of the Notification of Death Regulations, while the decision to investigate rests with the coroner. Dr Twamley acknowledged the point and noted that NHS England had not contributed to the report's wording. Mr Hawkins agreed to raise the issue with the Ministry of Justice. The discussion also highlighted the importance of documenting referrals appropriately, the need for improved data on informal discussions with coroners' officers, and variation in referral rates across jurisdictions, including Wales.

3.2 Department of Health and Social Care (DHSC)

Mr Hawkins provided the following Department of Health and Social Care (DHSC) update:

- Ministry of Justice coronial statistics were presented, showing that both the number of deaths reported to coroners and the proportion of registered deaths referred have fallen significantly since 2017. He noted that the Ministry of Justice cited the medical examiner system as a contributing factor, while acknowledging that a range of other reforms, including changes to death certification and the removal of the 28-day rule, were also likely to have influenced this trend.
- Work is ongoing on pandemic preparedness, including a review of legislative provisions to ensure that the statutory death certification and registration system remains operational during any future pandemic.
- DHSC is also reviewing and reinvigorating its digital programme, including the medical certificate of cause of death and case management systems, with the aim of developing a modern, future-proofed solution in collaboration with frontline stakeholders.

- Funding decisions for these initiatives remain a ministerial responsibility; however, DHSC has emphasised the clear need and demand for continued progress.

Dr Shannon noted that the reduction in coroners' referrals likely reflects wider death certification reforms, particularly the removal of the 28-day rule, although Medical Examiner scrutiny also contributes. Dr Evans asked whether there were renewed commitment and funding to progress the digital initiatives. Mr Hawkins confirmed that the programme was being actively reviewed and refreshed, rather than simply resumed, with the aim of delivering a system that meets current and future needs, and that stakeholder engagement would be central to its development.

3.3 Wales

Ms Davies provided an update on behalf of Welsh Government, noting recent political changes in Wales following the formation of a new Welsh Government led by Plaid Cymru. She confirmed the appointment of a new Cabinet Secretary for Health and Care, alongside new Deputy Ministers for Public and Preventative Health and for Social Care, Mental Health and Women's Health. She indicated that initial engagement had begun through written briefings, with a request from Ministers for a proportionate approach during the first 100 days. She also noted that consideration was being given to how best to advise on the National Medical Examiner report during this period. Ms Davies additionally introduced a colleague, Ms Molly Corless, who would be taking over responsibility for policy relating to medical examiners and death certification, with her continuing in a supporting capacity.

Dr Shannon provided the following update on Wales:

- Timeliness of the system in Wales remained stable and under control, and had been for a sustained period.
- A previous position regarding the suitability of FY1 doctors certifying deaths had been reversed following further discussion with the GMC and reconsideration of legal advice.
- Access to EMIS Web was being introduced, which would improve access to GP records, reduce workload for GP practices, and support medical examiner work.
- Overall case numbers were lower than the previous year, reflecting system changes designed to ensure appropriate direct referral of clear-cut coroner cases and clearer definition of when medical examiner duties were engaged.
- CPD activity continued, with engagement through the ME/ME Officer hub reported as positive.
- Appraisal and revalidation processes had been strengthened to support compliance with MCCD regulations.
- Work was underway to improve performance monitoring of medical examiners, including active oversight of an individual case, with emphasis on the need for robust evidence to support assurance and decision-making. Dr Shannon indicated willingness to share broader principles from this work with the MEC, subject to maintaining appropriate confidentiality.

3.4 Royal College of General Practitioners (RCGP)

The MEC received and noted the report, which had been policy checked by RCGP.

Dr Cranfield highlighted a number of issues arising from the report, including ongoing tensions in coronial practice and the impact on GPs. She noted reports that GPs were being advised that referrals were inappropriate despite available data not supporting this, and cited examples where coroners had indicated they would refuse referrals for

unknown causes of death, potentially placing GPs in a position where compliance with the Notification of Death Regulations could be difficult. She also referred to concerns about interpretation of guidance on cause of death and associated pressures on GPs, and highlighted potential unintended consequences where Medical Examiner practice aligned with more restrictive approaches to referral. She confirmed RCGP's willingness to contribute to ongoing work on defining attending practitioners, the development of the digital MCCD, approaches to learning from deaths in the community, and feedback from bereaved families. She concluded by requesting advice and help in resolving the issues raised to support a more workable and mutually agreeable position, and thanked colleagues for a successful Medical Examiner conference.

A separate discussion took place regarding feedback from bereaved families in relation to Medical Examiner appraisal and revalidation. The Chair and Mr Langford advised that seeking individual feedback from bereaved families in the immediate period following a death was considered inappropriate due to the sensitivity of timing, and would not be recommended. It was clarified that feedback from bereaved families could be considered in a broader service improvement context, but not as individual case-based feedback within the immediate timeframe of Medical Examiner involvement. Dame Suzy Lishman clarified that Medical Examiners in non-patient-facing roles are not required to obtain patient or bereaved feedback for appraisal or revalidation purposes, and that colleague feedback and appropriate declaration of role context were sufficient.

Action: *The Chair and Mr Langford to draft a short statement for inclusion in appraisal guidance clarifying that Medical Examiners, as non-patient-facing doctors, are not required to obtain patient or bereaved feedback reflecting the agreed position on the appropriateness of seeking bereaved feedback.*

3.5 Coroners' Society

The Chair noted that Ms Whitting had submitted her apologies for absence and was unable to attend the meeting. A written update was received by email.

The update indicated that there were no specific matters to report, but highlighted the recent coroner statistics published by the Ministry of Justice. These demonstrate a positive impact of the Medical Examiner system, including a reduction in the overall rate of coroner referrals and post-mortem examinations. It was further noted that several areas have reported an increase in the number of inquests. This is considered likely to reflect improved identification of deaths requiring investigation, particularly more complex cases, thereby evidencing the effectiveness of the system.

ME.13/26 4. Training

4.1 Medical Examiner training

The Chair expressed thanks to Dame Suzy Lishman and colleagues at the RCPath for hosting a successful annual conference, noting the quality of the speakers and the positive feedback received. Dame Suzy Lishman highlighted that the RCPath Events Team had reduced in size due to financial constraints and expressed her appreciation to Kristen Pontello (RCPath Events Manager) for her significant contribution in supporting the programme.

Providing an update, Dame Suzy Lishman reported that the recent annual conference had been well received, with positive informal feedback, and that formal evaluation feedback would be shared in due course. She advised that a number of the topics and speakers had been suggested by members of the ME/MEO Hub, including occupational COPD and a presentation from Vicky Price on over-treatment and inappropriate

investigations at the end of life. It was noted that Vicky Price would return to deliver a follow-up webinar on 7 December, alongside a patient or relative.

The webinar programme was reported to be continuing to develop, with high levels of engagement and an increasing number of sessions being delivered, including two webinars scheduled in June 2026. Webinars were recorded and made available for later access, with certificates provided to support continuing professional development (CPD), and were recognised as a source of CPD for appraisal purposes.

Training for medical examiners would continue to be delivered fully online, with three sessions per year and approximately 30–35 attendees per session. Over 2,700 medical examiners had been trained to date. The reduction in attendance was attributed to the maturity of the system and revised eligibility criteria, requiring applicants to have been shortlisted for, or to be applying for, a medical examiner role. Feedback from a palliative care consultant following a recent training session had highlighted the need for more patient-centred language within training scenarios, and minor amendments were to be made to improve wording. It was also noted that Mr Langford had agreed to contribute to the patient perspective component of the training, replacing Rachel King.

Dame Suzy Lishman reported that she had reviewed all non-mandatory e-learning modules and provided a summary to e-Learning for Healthcare. She advised that almost all modules required minor updates to reflect the statutory system, although many changes were small (for example, references to outdated forms or images), and that this work was now with E-Learning for Healthcare and subject to resourcing.

Updates were also provided on ongoing work, including the letter of good standing and the definition of attendance, both of which were nearing finalisation. A cause of death list was in preparation for initial circulation, and the medical examiner textbook was being updated. A statement was also being prepared in response to recent Ministry of Justice statistics.

4.2 Medical Examiner Officer

Ms Shale was not in attendance and therefore there had been no update.

ME.14/26 5. Death Investigation Committee feedback

Dr Cranfield provided feedback from the most recent Death Investigation Committee (DIC) meeting. She reported that discussions had included the importance of ensuring that time for training was appropriately reflected within job planning, noting that, in practice, insufficient time was often allocated. Discussions had also included portfolio activities, in particular autopsy work, as well as academic activity, delivery of webinars, guideline development, and the review of peers' work, with consideration of how these activities were undertaken within existing job planning arrangements. Workforce considerations for pathologists were also discussed; however, it was observed that this was unlikely to present a significant issue given the high level of interest and existing waiting lists.

She advised that the new Chair, Dr Martin Goddard, intended to review the DIC's terms of reference, including expectations of those who attend, and suggested that the updated terms of reference be brought to the MEC for consideration in relation to representation. She further reported that the meeting had concluded ahead of the allocated time, with a number of items taken forward for work outside of the committee meeting, and that the next meeting would take place in October 2026.

In response, Dr Shannon welcomed the feedback and noted that autopsies remained a recurring topic within training discussions. He highlighted the importance of

understanding the processes leading to autopsy, while recognising that decisions regarding coronial post-mortems rested with the Coroner. He further emphasised that peer review was embedded within current operational processes, enabling shared learning across colleagues. Dr Twamley supported the value of peer review both within and between offices. He raised concerns regarding variation in guidance relating to post-mortems, particularly in relation to maternal deaths, and suggested that greater clarity and consistency were required. He proposed that such issues could be considered by the DIC. Dr Cranfield advised that members of the DIC were involved in national work relating to maternal deaths and that these issues were within the Committee's remit.

ME.15/26 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. It was reported that uptake data indicated a reduction in access from April, likely linked to the annual subscription renewal cycle, and this was being followed up by the RCPath.

Overall feedback on the Hub and webinar provision remained positive, with recognition of strong value for continuing professional development (CPD). It was noted that while live attendance data were available, a significant number of users accessed content on demand, and further consideration of viewing data was suggested.

A query was raised regarding the distribution of webinar notification emails, with concerns that some members were not receiving reminders or links for upcoming sessions. It was noted that this would be followed up and that membership status may be a contributing factor.

ME.16/26 8. Assisted Dying Bill

Dame Suzy Lishman reported that the Bill had not progressed in the House of Lords in April and had subsequently fallen at the end of the Parliamentary session. She further noted that it had not been included in the recent King's Speech and therefore would not proceed in its current form. She advised that this would be the final update and that the item could be removed from the standing agenda.

Mr Hawkins provided clarification on the Parliamentary process, noting that although the Bill had fallen, it could be reintroduced in a future Parliamentary session, including as a private Member's Bill, subject to the relevant Parliamentary procedures.

ME.17/26 9. Private sector record sharing

The MEC discussed record sharing in relation to private sector prescribing.

Dr Evans presented a recent case involving a community death referral in which private prescribing had not been communicated to NHS treating teams or reflected in shared records. She reported that medical examiner scrutiny had been undertaken prior to full awareness that police and coronial involvement were already in place in relation to the case. She highlighted that privately prescribed medication was only identified subsequently and that the lack of information sharing between private and NHS services created a significant patient safety and governance concern. She described this as a "hidden risk", particularly where private clinicians do not routinely share information with NHS services.

Dame Suzy Lishman advised that private clinicians would usually seek patient consent to share information with NHS GPs; however, where consent was withheld, information may not be shared, resulting in incomplete records. She noted that increasing use of private and online GP services was likely to make this issue more prevalent and

contribute to fragmentation of information between systems. Dr Twamley advised that he had discussed the issue with national colleagues, including Aidan Fowler, and that it would be raised further at national level with relevant stakeholders in relation to safeguards and access to prescribing information across systems. Dr Cranfield advised that issues relating to governance and standards in private practice were recognised and remained under discussion within the RCGP, with representation from private GPs on Council.

ME.18/26 **10. Any other business**

None.

ME.19/26 **11. Date of next meeting:**

The next meeting is scheduled for Monday, 2 September 2026 at 10:00am for a duration of 2 hours via MS Teams