

Useful links for MEs

RCPath guidance

One page summary of death certification reform changes Cause of Death list (The COD List will be updated in 2025 to reflect the changes in the statutory system.) <u>RCPath ME website homepage</u> <u>Role of the ME, including model job description</u> <u>Role of the MEO, including model job description</u>

National Medical Examiner publications

National Medical Examiner homepage <u>The National Medical Examiner's Guidance for England and Wales</u> Essential for setting up and running an ME service.

The National Medical Examiner's Annual Reports

<u>The National Examiner's Good Practice Series</u> Providing focused information on relevant topics.

Contact details for ME offices in England

DHSC guidance

Guidance for medical practitioners completing the MCCD

Referring to the Coroner

Notification of Death Regulations 2019 When to refer a death to the Coroner.

MoJ guidance to accompany notification of deaths regulations



Membership Engagement and Support





Touche v HM Coroner

Case in which an otherwise natural death is found to have been unnatural as it resulted from failure to provide adequate monitoring and treatment i.e. an act of omission.

Chief Coroner guidance no 31 (death referral and medical examiners)

Chief Coroner guidance no 32 (postmortem examinations)

Chief Coroner guidance no 45 (stillbirth and live birth following TOP)

Chief Coroner Guidance no 47 (the death certification reforms)

All Chief Coroner guidance (includes links to the above)

Cremation Guidance

<u>Guidance for applicants, funeral directors, crematorium managers and medical referees, and cremation forms</u>

Structured Judgement Reviews

Using the SJR method - a clinical governance guide to mortality case record reviews

Using the SJR method – a guide for reviewers

Implementing SJRs for improvement



