Standards for the Delivery of the Medical Examiner Service

Developed by the Medical Examiners Committee of the Royal College of Pathologists.

It is anticipated that this provisional document will in due course be developed and updated by the National Medical Examiner, when appointed.

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Background

The *Shipman Inquiry's Third Report* (2003)[1] concluded that existing arrangements for death certification are confusing, provide inadequate safeguards and are "open to abuse by a dishonest doctor". This provided added impetus for calls for a reform of the process of death certification in Luce report in 2003[2]. That report itself cited three committees of inquiry, from 1910, 1936 and notably the Brodrick report of 1971[3], which had concluded that there was a need for reform of the death certification process, although no significant reforms had resulted.

The government's response to the Shipman Inquiry was laid out in *Learning from Tragedy, Keeping Patients Safe* (2007)[4]. This proposed that Medical Certificates of Cause of Death (MCCDs), for burials and cremations alike, would be subject to scrutiny by an independent "medical examiner" linked to the appropriate clinical governance team.

Following on from this, *Consultation on Improving the Process of Death Certification* (2007)[5] was published outlining a programme of work to design, pilot and implement a single system of death certification in England and Wales.

The facility to appoint medical examiners were established by the *Coroners and Justice Act* (2009)[6], with duties as set out in the Act and in subsequent regulations and guidance.

It is currently proposed that from October 2014 the causes of all deaths in England and Wales that are not the subject of a coroner's investigation will be subject to scrutiny and confirmation of the cause of death by a medical examiner.

It is important to realise that the aim of this reform is not limited to identifying fraudulent certification of death. It also aims:

- To resolve the well-documented inaccuracies inherent in the current processes of death certification. This is important to society because a more accurate documentation of the diseases and processes that cause death will have a major influence on the planning the delivery of health and social care and in achieving public health benefits.

- To assist clinical governance in the health service, by identifying areas where clinical practice might be improved even if the concerns raised do not justify referral to the coroner. The importance of this is underlined by the inquiry into clinical standards at the Mid-Staffordshire Hospital [7]

- To improve services for bereaved people. The Ministry of Justice's *Charter for Bereaved People who come into contact with a Reformed Coroner System* (2008)[8] highlights the important status of bereaved persons, their rights and responsibilities. The Department of Health's *When a patient dies: Advice on developing bereavement services in the NHS* (2005)[9], although written before the development of the new process of death certification, provides key elements that are pertinent to the medical examiner service.

In addition to proportionate and effective scrutiny of MCCDs, medical examiners will provide medical advice to coroners and advice to certifying doctors. They will work with NHS colleagues to use the information they collect to support clinical governance and they will assist in training doctors and other healthcare professionals on the appropriate certification of death.

Following advice from the Academy of Medical Royal Colleges, the Department of Health invited the Royal College of Pathologists (RCPath) to take on the role of lead college for medical examiners. The president of the RCPath had already chaired a multidisciplinary working group that established a curriculum for training medical examiners.[10] The Royal College of Pathologists accepted the role and established a Medical Examiners Committee with agreed terms of reference.[11]

Pending appointment of the first National Medical Examiner, this document has been developed by the Medical Examiners Committee of the RCPath. It is anticipated that subsequent maintenance of the document will be undertaken by or in close consultation with the National Medical Examiner.

Legislative changes to the method of implementation

The *Coroners and Justice Act* (2009) states that "*Primary Care Trusts (in England) and Local Health Boards (in Wales) must appoint persons as medical examiners…*"

The Health and Social Care Act 2012 makes provision for the abolition of Primary Care Trusts, but that Act also includes measures to transfer the responsibility for the appointment of medical examiners to Local Authorities in England. The responsibility for appointment will remain with the Local Health Boards in Wales. For the purposes of this document the generic term "appointing authorities" will be used to include both systems.

Standards for the Medical Examiner Service

The delivery of a medical examiner service of an acceptable quality will require team effort and collaboration. Medical examiners will have to be competent and diligent, but there are also responsibilities that fall upon the appointing authority, the National Medical Examiner and others. In broad terms, section 2 of this document relates to medical examiners and section 6 to the National Medical Examiner. The other sections may be regarded as being primarily the responsibility of the appointing authority, although there are numerous shared responsibilities, making it inappropriate to consider the sections of this document in isolation from the whole.

1. Requirements for the Recruitment of a Medical Examiner

A medical examiner must be a medical practitioner, registered with the General Medical Council and maintaining a licence to practise by compliance with the GMC requirements for revalidation. The general standards for doctors working within the UK are set by the General Medical Council.[12]

In addition to these a medical examiner must: -

- complete the prescribed components of the e-Learning for Healthcare training programme for medical examiners as a pre-condition of submitting an application for employment as a medical examiner[13]
- complete the rest of the e-Learning for Healthcare training programme for medical examiners before commencing work as a medical examiner
- complete a face to face component of training, as specified by the Medical Examiners committee of the RCPath (or equivalent, as approved by the National Medical Examiner) before commencing work as a medical examiner.

Medical examiners must meet the essential requirements of the Person Specification and comply with the duties set out in the Job Description for medical examiners, as laid out by the Department of Health's Medical Examiners Task Team.[14] [15] Many of those requirements are included in or are relevant to the quality standards set out below.

2. Duties of a Medical Examiner

Scrutiny of Medical Certificates of the Cause of Death

It is important that any delay caused by the process of scrutiny is kept to an absolute minimum but without compromising the integrity of the process. *

Medical examiners must: -

- refer deaths where the coroner may need to investigate directly to the coroner as soon as that need becomes evident, without undertaking further investigation themselves

* It is anticipated that more specific guidance on the speed of delivery of the service will be issued by the National Medical Examiner and will be reviewed as experience of delivering the service accumulates.

- provide advice to certifying doctors, on request, on how best to set out the cause of death in any specific case, or whether to refer the death to the coroner
- scrutinise deaths in a way that is proportionate and involves conscientious appraisal of documents and circumstances of death, as explained in the e-Learning for Healthcare training programme for medical examiners [16]
- provide advice and scrutiny in the most effective manner possible without causing any unnecessary delay*
- have a discussion, with a relative, carer or other appropriate person, about every death under scrutiny (in person, or through a Medical Examiner's Officer acting on their behalf) regarding the circumstances and causes of death and ensure that careful consideration is given to any concerns raised
- see and approve the final MCCD (or a copy) before confirmed causes of death are notified to the registrar, and comply with the legal and procedural requirements associated with the current processes of certification, investigation and registration of deaths
- be aware of specific provisions in respect of the reporting of deaths in children and facilitate the work of other groups with a duty to investigate such deaths
- maintain an up to date knowledge of clinical causes of death, together with death certification requirements and processes. They must demonstrate this during an annual appraisal process that covers their work as a medical examiner, in support of medical revalidation as prescribed by the General Medical Council
- facilitate, as far as appropriate scrutiny permits, processes for organ and tissue retrieval for transplantation and other altruistic purposes
- maintain a specified 'distance' from the death under scrutiny. In particular medical examiners are not permitted to scrutinise the death of a person: -
    - who is a relative, personal friend or close associate
    - to whom they have provided any recent care or treatment related to the cause of death
    - who has been cared for, or received treatment from, any relative personal friend or close associate
    - with whom they, or any relative, personal friend or close associate, has (or may have as a result of death) any direct or indirect fiduciary relationship
- work with colleagues, appointing authorities and the public to improve and sustain the quality of the certification of causes of death.

Clinical Governance

Medical examiners are expected to use any information they obtain in the course of their work to assist clinical governance systems in the health service to identify problems and to correct problems as quickly as possible. To that end, medical examiners must:

- have knowledge of local clinical governance systems and have appropriate routes of communication with each local unit delivering health and social care

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- discuss issues raised by relevant medical directors, clinical governance departments, and public health departments
- act proportionately to ensure that any sub-standard clinical performance or behaviour identified during the medical examiner's work is reported. If subsequent experience indicates that such problems have not been corrected, then reporting of the problem must be escalated appropriately
- work with colleagues responsible for clinical governance and public health surveillance to assist the identification of local issues, trends and unusual patterns of death.

Interaction with Coroners, Registrars and others

Medical examiners are expected to provide appropriate and timely advice, within the expected area of expertise of a medical examiner, to coroners, registrars, local Bereavement Office staff, medical examiners' officers, mortuary staff, health service staff and any others whose work impacts on the proper investigation, certification and registration of death.

Such advice may be oral or in writing, as is appropriate to the circumstances and the complexity of the request. It should be delivered with reasonable speed.[*] If a medical examiner is uncertain how to answer a question then further advice should be sought, as would be the practice with any form of medical referral.

Medical Examiners may receive requests for information to support activities that are beyond their primary responsibility, such as for research purposes or specific audit projects. It is recognised that such additional requests for information may incur work that has to be funded by the individual making the request, but medical examiners should facilitate the provision of such information as far as is practicable and in the best interests of society, while complying with all relevant requirements of confidentiality, research ethics scrutiny and probity.

Interactions with the bereaved

Medical examiners must avoid acting in any way that might suggest disrespect for the deceased or the bereaved. They should seek to minimise, as far as is compatible with fulfilling their role, the distress suffered by the bereaved persons with whom they come into contact.

Medical examiners must give an opportunity for the person discussing the death to raise any concerns, whether about the cause of death or the care provided before or after death.

Medical examiners must show awareness of equality and diversity issues within the community and demonstrate an understanding of the requirements of diverse faith groups and individuals, notably in respect of the urgency of release of the body

The medical examiner or medical examiner's office should ask whether the bereaved persons with whom they come into contact understand the stated cause of death and whether they have any questions about the care which the bereaved received. If they are not personally qualified to answer such questions they should refer the questioner to other professionals or sources of

[*] It is anticipated that more specific guidance on the speed of delivery of the service will be issued by the National Medical Examiner and will be reviewed as experience of delivering the service accumulates.

information, as appropriate. This may include a consultation with a doctor who was responsible for the care of the deceased.

In cases where the deceased's illness may have implications for other members of the family, whether due to genetic, infective or other factors, the medical examiner should ensure that family members are aware of those implications and what actions they can take to mitigate them.

Training others

Medical examiners are expected to give advice to certifying doctors, as noted above, but they may also be asked to provide more formal training sessions for doctors and other members of health service staff. Some medical examiners within one area may choose to take a lead in training others while others may wish not to be involved, but within each area there must be a system for delivering such training.

3. Record-keeping

- Record keeping must comply with standards laid down in the *Caldicott Report* (1997)[17] the *Data Protection Act* (1998)[18] and the *Records Management: NHS Code of Practice* (2006)[19] and by the General Medical Council. [20]
- Records of all deaths scrutinised must be comprehensive and well maintained in a manner to be specified by the National Medical Examiner and that will allow ease of analysis.
- Information must be provided to the National Medical Examiner as requested and locally for clinical governance purpose as required.
- Records must be stored securely for a duration which complies with national guidance as provided through the office of the National Medical Examiner.

4. Availability, management and organisation of the service

The structure of the Medical Examiner Service is not yet fully determined and is likely to vary according to local demands, but the quality of service should be broadly similar. Appointing authorities will be guided by local need, the requirements of the National Medical Examiner and adherence to agreed quality standards.

Appointing authorities will need to work closely with the medical examiner service to ensure that quality is maintained.

The following standards are laid down in the *Coroners and Justice Act* (2009)[5].
Appointing authorities must:

> *appoint enough medical examiners, and make available enough funds and other resources, to enable their functions to be discharged in its area;*
> *monitor the performance of medical examiners appointed by the Trust [Local Authority] or Board by reference to any standards or levels of performance that those medical examiners are expected to attain.*

By extrapolation:

Appointing authorities must, in agreement with the National Medical Examiner and with local medical examiner services: -

- Provide adequate facilities for the delivery of the service, including office space and equipment, records storage, IT and communications equipment. There must be a facility to allow confidential uninterrupted meetings to take place between Medical Examiners or Medical Examiners Officers and relatives of the deceased or other informants
- work with local medical examiners to ensure that the medical examiner service is available at times appropriate to the needs of the local population and agreed by the National Medical Examiner. For some communities this may include the provision of the service beyond normal office hours
- publicise the office hours of the Medical Examiner service and how it can be contacted
- publicise information about how the medical examiner service works (this may be done largely by reference to relevant national publications, but additional local information will also be necessary)
- publicise a route by which complaints about the medical examiner service may be lodged
- make available translation services that are relevant and proportionate to the needs of the local community
- work with local medical examiners to arrange cover for holidays and other periods of absence
- arrange for cover to be available to ensure that there is no conflict of interest between the medical examiner and the death being scrutinised
- ensure that medical examiners working within the same or neighbouring areas (where there are cross border issues) communicate and collaborate so that the needs of the service are satisfied
- ensure that the service is well managed, including human resources management, payroll, finance and information technology.
- work with colleagues to facilitate and deliver education for certifying doctors and others
- make provision, including appropriate paid study leave, for medical examiners to undertake Continuing Professional Development, to keep their service up to date and to comply with the requirements of medical revalidation
- ensure that there is a mechanism to receive and respond appropriately to any complaints about the service, with documentation of the complaint and the response
- ensure that the quality of the service is assessed by appropriate audit processes, as a minimum to provide compliance with guidance from the National Medical Examiner and to satisfy the requirements of medical revalidation
- put in place mechanisms to ensure that the quality of the service remains in compliance with the standards set out in this document
- ensure that all medical examiners have appropriate indemnity insurance

- put in place contingency plans to ensure the continued availability of a death certification service even during emergency situations which cause a sudden and unpredicted increase in the death rate.

5. Health and Safety

In the course of their duties medical examiners may be required to examine the deceased. This may pose certain risks related exposure to infection and to manual handling.

Appointing authorities must ensure that mortuary facilities comply with the requirements of the licensing system imposed by the Human Tissue Act 2004[21].

When undertaking or making arrangements for the external examination of a body, medical examiners should follow guidance set out by the National Medical Examiner, paying particular attention to minimise any risks of harm from infectious or other causes to themselves or others involved in caring for the deceased or in the vicinity.

Appointing authorities and the medical examiner service must comply with all relevant safety and clinical directives in a timely way and ensure the implementation of procedures for recording and auditing compliance and variance from any relevant directive.

6. The National Medical Examiner

The National Medical Examiner is expected to issue further guidance on the appropriate delivery of the medical examiner service. Appointing authorities and medical examiners are expected to comply with such guidance. If for any reason it is temporarily impossible to comply with such guidance the National Medical Examiner must be informed and a discussion should be initiated to determine how and when the problem will be rectified.

Appointing authorities and medical examiners are also expected to comply in a timely manner with reasonable requests to provide information for use by the National Medical Examiner and other national authorities, within the limits of guidance to be issued by the National Medical Examiner.

If the National Medical Examiner becomes aware of a problem with the delivery of the medical examiner service that is not corrected within a reasonable time, the National Medical Examiner will take appropriate steps which may include formally informing the relevant Secretary of State.

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