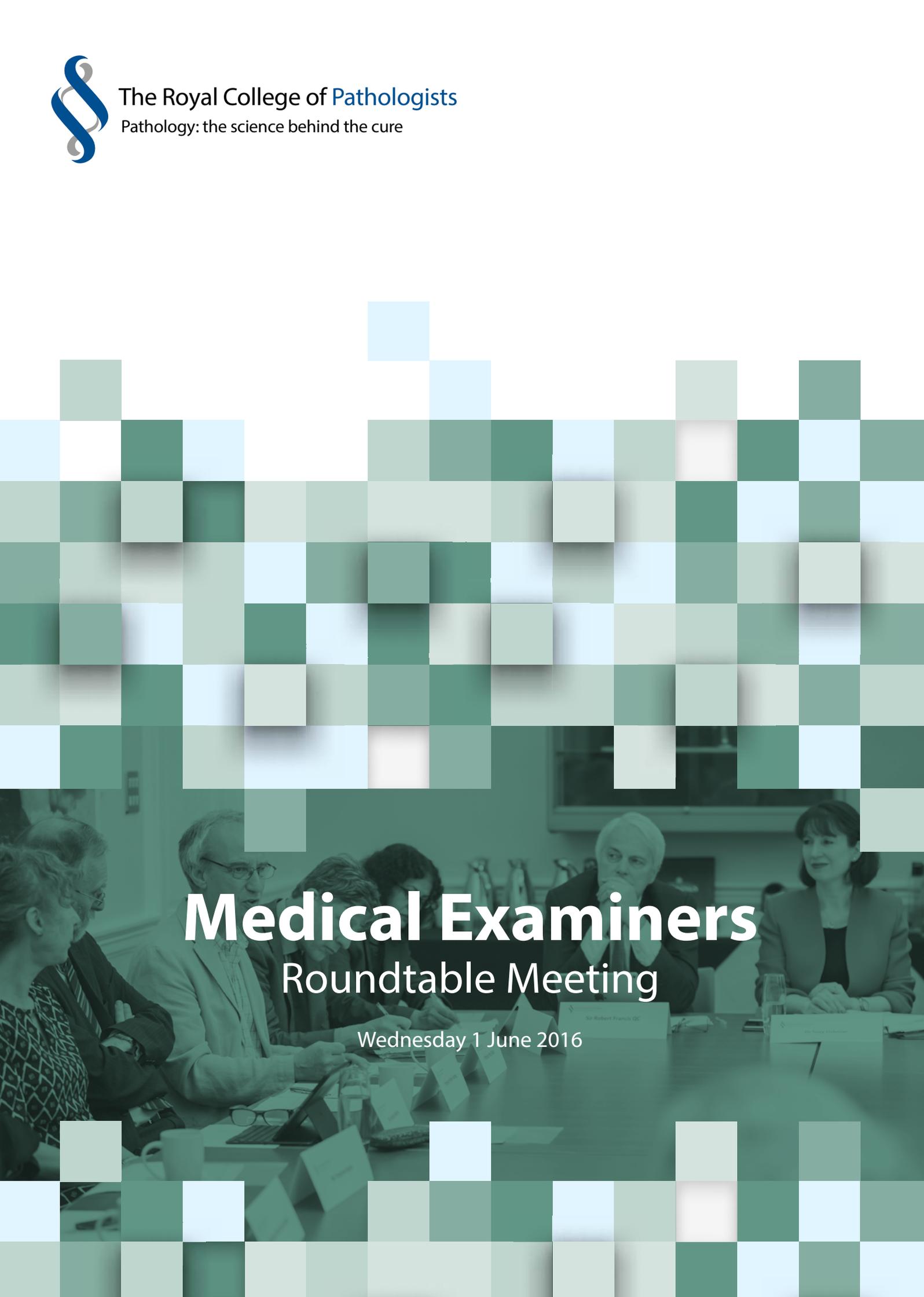




The Royal College of Pathologists

Pathology: the science behind the cure



Medical Examiners Roundtable Meeting

Wednesday 1 June 2016

Convened by

The Royal College of Pathologists at One Birdcage Walk, Westminster, London

Chair

Dr Suzy Lishman, President,
The Royal College of Pathologists

Introductions

Sir Robert Francis QC, Chair of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013

Dr Alan Fletcher, Chair,
Medical Examiners Committee,
The Royal College of Pathologists

Professor Dame Sue Bailey	Chair, Academy of Medical Royal Colleges
Ms Francine Bates	Chief Executive, The Lullaby Trust
Mr Simon Bennett	Director of Clinical Policy and Professional Standards, NHS England (on behalf of Sir Bruce Keogh)
Ms Charlotte Bevan	Senior Research and Prevention Officer, Sands, stillbirth and neonatal death charity
Professor Nick Black	Professor of Health Services Research, London School of Hygiene and Tropical Medicine
Mr James Bolton	Policy Officer, Health, The Royal Mencap Society
Mr Noel Evans	Bereavement Services Manager, City and County of Swansea (for Welsh Local Government Association)
Professor Peter Furness	Senior Advisor on Medical Examiners, The Royal College of Pathologists
Ms Veronica Hamilton-Deeley	Senior Coroner, City of Brighton and Hove
Mr Steve Holmberg	Medical Director, Brighton and Sussex University Hospitals NHS Trust
Dr Mark R Howard	Consultant Histopathologist and Medical Examiner, Royal Sussex County Hospital
Ms Brenda Jones	Deputy Head of the Chief Coroner's Office, Judicial Office for England and Wales
Mr Andy Langford	Director of Operations, Cruse Bereavement Care
Ms Alyson Morley	Senior Adviser, Health Transformation, Local Government Association
Ms Sharmila Nebhrajani	Chair, Human Tissue Authority
Mr Glenn Palmer	Joint Head of Coroners, Burials, Cremation and Inquiries Policy Team, Ministry of Justice (for Elizabeth Knapp)
Ms Meena Paterson	Team Leader, Department of Health, Death Certification Reform Programme
Ms Jennifer Sano	Lay representative, Medical Examiners Committee, The Royal College of Pathologists
Dr Kevin Stewart	Clinical Director of Clinical Effectiveness and Evaluation, Royal College of Physicians
Mr Ian Thomas	Head of Healthcare Governance, Welsh Government

Foreword

A national system of medical examiners was first proposed by a parliamentary committee in 1894. More recently, the reports of the Shipman Inquiry (2005), Mid Staffordshire Inquiry (2013), Morecambe Bay Investigation (2015) and Hutton Review of Forensic Pathology (2015) have all recommended that medical examiners be introduced to improve the investigation of deaths with the benefits this brings for both bereaved relatives and future patients.

Primary legislation to introduce medical examiners was passed in 2009 and seven pilot schemes have scrutinised over 30,000 deaths since then. The Department of Health has recently announced that medical examiners will be introduced in England and Wales in April 2018 and published documents for consultation.

As the lead medical royal college for medical examiners, The Royal College of Pathologists has been at the forefront of the campaign to introduce this system and continues to work with other stakeholders to facilitate the smooth delivery of this long-awaited reform.

The pilot studies found that medical examiners improve the accuracy of death certification, provide reassurance and answers for bereaved relatives, identify trends in unexpected causes of death, ensure that the correct cases are referred to the coroner and help foster a culture of openness. This ultimately results in better education of doctors and improvements in the quality of care that future patients receive. More accurate certification also provides invaluable data to inform future prioritisation and resource allocation.

The benefits of medical examiners will be far-reaching and touch the work of numerous agencies. With this in mind we arranged a roundtable with leading representatives of patient groups, charities, local and central government, the coronial and health services to discuss the issues, particularly in relation to the practicalities of implementation.

Despite the event being organised at short notice to meet the consultation deadline, we were delighted by the positive response to the invitation and the constructive discussion that took place. This document summarises the key points discussed at the roundtable event and was submitted to the Department of Health's consultation on death certification reform.

I hope that all involved in the introduction of medical examiners will find the meeting report useful. While it doesn't answer all the questions raised, it demonstrates a commitment to change for the benefit of patients and a willingness to work together to bring about this important reform. There is still work to be done before medical examiners are introduced in 2018 and the College looks forward to collaborating with all stakeholders to support successful implementation.

Dr Suzy Lishman

President, The Royal College of Pathologists



Background

The Royal College of Pathologists (RCPATH) looks forward to the introduction of a national system (England and Wales) of medical examiners in 2018.

Evidence from the seven Department of Health (DH) pilot schemes has demonstrated a number of benefits, including improvements in patient safety, an increase in the accuracy of death certification and a quicker identification of problems with care. Medical examiners were also able to address bereaved relatives' concerns and explain the often technical medical language used on death certificates to them.

In order to support the DH consultation and to support implementation, the RCPATH has produced a policy pamphlet, *Medical examiners*, and convened a meeting of experts from various fields to discuss:

- Where this vital initiative sits within the overall patient safety landscape.
- How improved death certification could better inform public health planning.
- The practicalities of implementation to ensure that this initiative reaches its full potential.

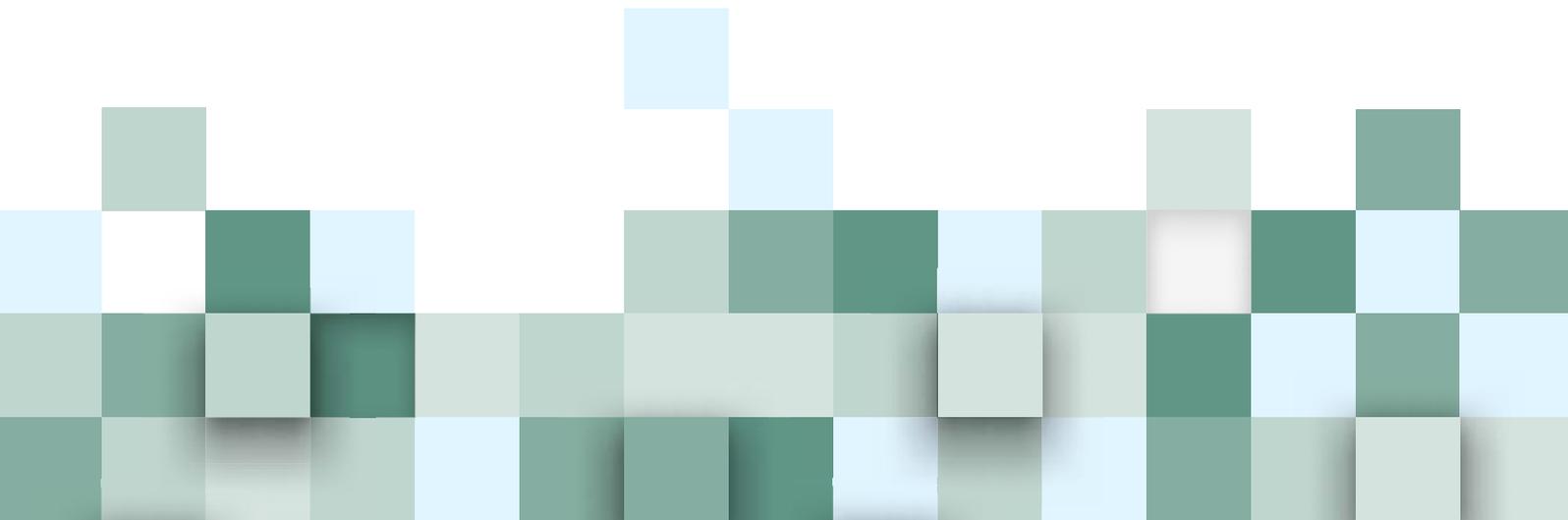
The roundtable provided an opportunity to discuss key strategic issues affecting the scope and implementation of the medical examiner system.

Some participants at the meeting were speaking as individuals and not on behalf of their respective organisations.



Key conclusions of the meeting

1. All those present were strongly in favour of the implementation of death certification reform and the introduction of medical examiners.
2. Most of those present were concerned about funding the system on the basis of a fee for bereaved relatives and would prefer central funding from government. Some participants felt strongly that the new system should be government-funded.
3. Overall, participants felt implementation on the basis of a fee would be preferable to failure to implement the reform.
4. Concerns were raised about the logistical difficulty of full implementation throughout England and Wales in 2018. It was suggested that trusts (particularly in acute secondary care) could implement local schemes based on funding from cremation form fees. Brighton and Birmingham provide successful examples of this approach. Any trust wishing to set up a pilot or shadow service is advised to do so in partnership with their local authority, which will be responsible for running the medical examiner service.
5. There was considerable scepticism about whether the proposed fee of £80 to £100 per death would be adequate to cover costs. Participants urged that the analysis behind this proposal should be subjected to independent review. Implementation with inadequate resource could lead to the system being discredited before it is allowed to establish itself.
6. There was concern about the effect that the system of medical examiners would have on already-stretched local authorities in terms of resources to implement and run the system and the practicalities of collecting the fee.
7. There was concern about the effect on the coronial workload, which is not yet clear. However, the suggestion that the coronial workload might be reduced by allowing medical examiners to scrutinise Deprivation of Liberty Safeguards (DoLS) cases was welcomed.
8. Some attendees called for independent evaluation of the pilot schemes, particularly those which had not been continued when central funding ceased. However, any evaluation must happen concurrently with the process and not delay implementation.
9. The suggestion that the remit of medical examiners should be extended to cover stillborn babies was discussed. It was felt that this may be desirable but it would be preferable to extend the role only once medical examiners were fully established.



Meeting Notes

Meeting introduced by the Chair, Dr Suzy Lishman

Dr Lishman opened the meeting with an explanation of the history and the aims of death certification reform and the role of the RCPATH as the lead college for medical examiners.

Introductory remarks by Sir Robert Francis QC

Sir Robert gave two examples of unexpected deaths where there was a breakdown of trust between the bereaved relatives and the hospital. In both cases, the families were extremely distressed by the process surrounding the investigation of their loved one's death. In one case, this involved a protracted coroner's inquest. Medical examiners would have answered relatives' questions at a much earlier stage and may have been able to prevent escalation of concerns.

Sir Robert then described an audit undertaken of practice in the Mid Staffordshire NHS Trust, which found that in 22% of cases the cause of death on the Medical Certificate of Cause of Death (MCCD) differed from the information in the case notes. In 27% of deaths that were certified as due to natural causes, referral to the coroner would have been appropriate.

'It is absolutely clear to me that medical examiners are the best route to assist coroners, and they are not going to cost a great deal of money. Though I would advise the College to not rest on its laurels until they are implemented,' Sir Robert concluded.

Introductory remarks by Dr Alan Fletcher

Dr Fletcher explained that, so far, the medical examiner pilots had examined over 30,000 deaths in England and Wales which resulted in:

- More timely and accurate referral to coroners
- Improved accuracy of death certification
- Early detection of clinical governance issues such as infection outbreaks.

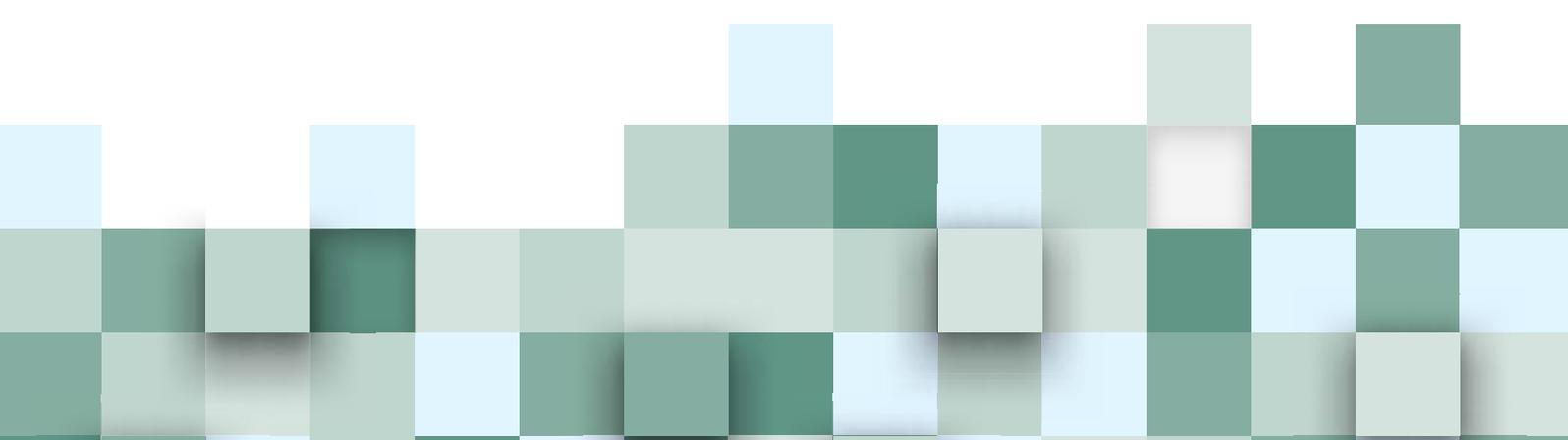
Additional benefits included:

- Education of doctors in how to complete MCCDs
- Establishment of a database of information collated from cases reviewed by medical examiners which supports research and helps to audit patterns and trends of causes of death
- There are indications that there may have been some reduction in bereaved families resorting to litigation as they were able to gain answers to their questions from an independent doctor at an early stage.

Dr Fletcher said there are many experienced clinicians keen to take on the medical examiner role and appointing the right person with the right skills is key.

'Medical examiners are the last piece of the jigsaw of ensuring patient safety when someone dies; their role is not to investigate but to detect and pass on,'

Dr Fletcher said.



All those involved in the pilot sites were overwhelmingly supportive of the reforms. It was notable how much bereaved families welcomed the support of a senior doctor after a death of a loved one, answering questions and giving them the opportunity to raise any concerns they might have.

Dr Fletcher stressed that the way the medical examiner system works is complementary to other forms of review, such as the Retrospective Case Records Review and the systems involved in the investigation of child deaths. As scrutiny by a medical examiner takes place very soon after death, their findings are able to be fed into these processes. The medical examiner is often not in a position to identify problems unequivocally, but is well placed to ask questions and to pass a case on to the appropriate body for definitive investigation and corrective action.

Dr Fletcher concluded that we now have extensive experience of the system, and it works.

Dr Alan Fletcher

These positive views were reinforced by contributions from representatives of the Brighton medical examiner system. This was initially DH funded but has subsequently been supported largely by funds from the fees payable for the completion of Form 5 of the cremation forms.

In Brighton medical examiners review 25-30 cases per week on average. Five medical examiners are on a rota system with one on-call every day. Now that the scheme has been running for five years, families in Brighton have experience of deaths both before and after the introduction of the pilot and it has received universal approval. Dr Mark Howard, Consultant Histopathologist and Medical Examiner based at the Royal Sussex County Hospital said, *'There is a huge emotional and psychological benefit to the bereaved.'*



Open discussion

Sharing and alignment of data

Professor of Health Services Research at the London School of Hygiene and Tropical Medicine, Nick Black, said that he was in favour of implementing medical examiners. Clarity would be needed about how they interface with other death investigation systems, such as confidential inquiries, national retrospective case-note review programmes and the various systems for investigating childhood and neonatal deaths. He said that if duplication can be avoided and communication can be established, there is considerable potential for synergy.

Dr Kevin Stewart, Clinical Director of Clinical Effectiveness and Evaluation, The Royal College of Physicians, highlighted it was important the medical examiner process aligns with the work on mortality case record review (which the Royal College of Physicians is leading) to avoid duplication and improve learning. The review will be launched in England in late 2016/2017.

Evaluation of pilots

Professor Black called for an independent evaluation of the medical examiner pilot site data to establish wider operational feasibility. This was supported by some attendees.

Such an evaluation should take place before national implementation and include a robust economic evaluation, a realistic evaluation of staffing and infrastructure requirements, the practical difficulties encountered by pilot sites and an understanding of the effects of the pilots on other areas, such as coroners' workload.

Ms Sharmila Nebhrajani, Chair of the Human Tissue Authority (HTA), added that it would be helpful to hear from primary care regarding the impact of the introduction of medical examiners. The HTA said it is important that mortuary capacity is considered. Any delay in the release of bodies as a result of a medical examiner's enquiries may result in a shortage of capacity.

Ms Sharmila Nebhrajani



Gradual roll-out versus 'big-bang'

Dr Howard suggested that, being 18-24 months away from full implementation, increased momentum is needed. Consideration should be given to gradual implementation instead of imposing compliance in all places on a particular date. Ms Meena Paterson, Team Leader for the Death Certification Reform Programme at the Department of Health, commented that several hospitals have adopted the system and have self-funded as there will be no funding available until medical examiners are introduced in 2018. Professor Furness, RCPATH Senior Advisor on Medical Examiners, said that his own hospital is running a system and the issue of finance was difficult.

Although some local early adoption was possible, the need for secondary legislation means that there has to be a specific 'go live' date for the full implementation of the new system. It was suggested that trusts should be encouraged to explore partial implementation to establish schemes in secondary care funded by the fees for cremation forms. This has been successful in Brighton and other early adopter sites. This would help establish relevant local experience before the date of national mandatory implementation. Mr Steve Holmberg, Medical Director at Brighton and

Sussex University Hospitals NHS Trust, said their local medical examiner system was 'hugely beneficial' and, if funds from cremation form fees were insufficient to completely cover the cost of early adoption, trusts should consider covering the shortfall because the clinical governance benefits are well worth the cost. Dr Howard also suggested that current medical examiners could visit trusts who are interested in setting up a medical examiner system to share their experience.

Concern was expressed about early implementation in primary care, which would be more difficult to resource from current cremation form fees.

Dr Fletcher stated that the Sheffield pilot had enrolled 26 primary care practices; the key to successful uptake was personal contact with each practice, exploring how the reforms could be made to work for them. He said that the time taken from death to confirm the MCCD should be less than 24 hours during the working week, apart from a few cases where contacting the relevant doctors or relatives proved problematic. His fastest recorded time from confirmation of death to the release of a medical certificate to relatives was 22 minutes.

Skill and expertise of medical examiners

The importance of employing medical examiners with the right skills and experience was stressed and concerns were raised around the recruitment process. Professor Furness described his recent experience in recruiting medical examiners: in a trust with about 3,000 deaths per year needing at least seven part-time medical examiners, a single advertisement had resulted in 24 expressions of interest. Fifteen doctors had completed the training. They were drawn from almost all hospital specialties. Recruitment was not attempted from recently retired doctors or from primary care. Professor Furness believed that recruitment was unlikely to be an issue, as long as medical examiners are not expected to take a reduction in pay when taking on the role.

It was suggested that each local authority should have a part-time 'lead' medical examiner in post several months before full implementation to assist the implementation process and to adapt it to local circumstances.

Ms Veronica Hamilton-Deeley, Senior Coroner, City of Brighton and Hove, underlined that the choice of person for the role is crucial. Medical examiners need to be articulate with excellent standards, both professionally and personally. She added that there is huge value in having a medical examiner system, particularly with regard to hospital deaths where something has gone wrong. Hospital doctors are often so busy that they cannot communicate in the same way as a coroner or medical examiner. In many inquest cases, families have fed back that *'if someone had told me that earlier we wouldn't be here now'*.

Funding

A discussion of funding then took place, with several speakers expressing the opinion that the suggested £80 to £100 per death would not be sufficient to fund a service of acceptable quality. Recruiting good quality doctors will be expensive. The figures in the DH Impact Assessment were questioned; it was explained that the impact assessment is part of the consultation process and could be challenged. A call was made for a rigorous and independent review of the information available on the likely cost of the service.

It was explained that the National Medical Examiner will have a duty to evaluate the quality of the service and, if the funds available are not sufficient to run a service of adequate quality, they would be expected to make representations to that effect. A risk was identified that if there is inadequate resourcing at the outset the system could be discredited before it has time to be established.

Several of those present expressed a clear preference for the system being funded centrally, from general taxation, rather than by a fee. It was argued that this would be more equitable and also more efficient, as the cost of collecting a fee might be considerable. Mr Andy Langford, Director of Operations at Cruse Bereavement Care, raised the issue of 'funeral poverty'. Some families have great difficulty in funding funeral expenses and finding funds for any extra costs would be an additional burden. In response it was pointed out that the fee would be less than the current cremation form fees so the majority of people would pay less than under the current system. Furthermore, although there would be a new fee for burial, burials are considerably more expensive than cremation so anyone wanting to minimise costs would be likely to choose the latter.

The group agreed that it was essential to look closely at the practicalities of introducing medical examiners, particularly the collection of fees.

Positive views of the bereaved

The extremely positive view of the benefits of the reforms for bereaved families was reinforced by all subsequent speakers. Representatives from organisations working with bereaved people were strongly supportive of implementation, largely on the basis of the positive effect in providing support for the bereaved. It was stressed that explanations given immediately after death had occurred could prevent a great deal of distress.

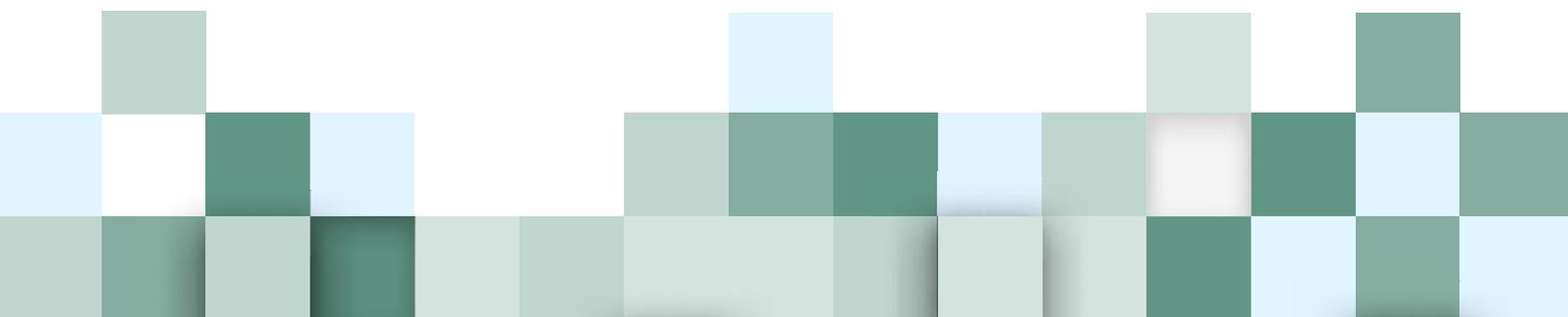
Another potential benefit of the medical examiner system could be a shift in culture so healthcare providers continue to consider the views of families after the death of a patient. This continuity of care after death was welcomed.

Mr James Bolton, Policy officer at Mencap, raised the issue that the families of people with learning disabilities often struggle to find answers about why their relative had died. While a medical examiner system would help, he had concerns about whether medical examiners would be sufficiently trained to deal with issues around learning disabilities and the Mental Capacity Act.

Jennifer Sano, Lay representative, RCPATH Medical Examiners Committee, asked whether medical examiners would investigate military deaths. Both representatives from the sites in Sheffield and Brighton said that they had not reviewed any military deaths.

Religious sensibilities

A question about the effect on religious groups who traditionally bury the dead was raised. Experience from the small pilots in Leicester (large Muslim population) and North London (large Jewish population) had not resulted in concerns being expressed; indeed, the Board of Deputies of British Jews has written to Jeremy Hunt encouraging implementation.



Implications for coroners

The effect on coroners was discussed. It was acknowledged that in correctly identifying deaths that should be referred to the coroner, medical examiners are likely to increase complex inquest workload. This would be partially offset by a reduction in the number of deaths inappropriately referred to the coroner. In due course, the facility for medical examiners to certify natural deaths where there is no other doctor in a position to sign an MCCD should also reduce coronial workload. The pilots have produced varying results on the size of these changes. Overall it is anticipated that the coronial workload will increase, but the size of the change is not known. This is causing considerable concern amongst coroners, who seem mistrustful of promises of an 'additional burden' assessment by DH 18 months after implementation.

Coroners are currently struggling with an increased workload due to the requirement to conduct an inquest in Deprivation of Liberty Safeguards (DoLS) cases and the recent increase in the numbers of people with DoLS in place. The meeting was informed of a recent proposal from the Law Commission that medical examiners should carry out the scrutiny of such deaths, passing cases to the coroner only if they found some cause for concern. The meeting welcomed this. It will require further legislation, but there might be time to legislate by the time medical examiners are introduced in 2018. This would result in a welcome reduction in coronial workload.

Dr Fletcher said that most DoLS cases in primary care are palliative and straightforward. Medical examiners are in a good position to identify DoLS cases and can provide a screening and filtering process for coroners.

Medical examiner independence

There was a discussion of the independence of medical examiners. Independence is regarded as important by representatives of the bereaved. Sir Robert expressed concerns about independence and impartiality of medical examiners. This was based on his observation during the Mid Staffordshire Inquiry that staff members at all levels of seniority had been afraid to speak out. Ms Hamilton-Deeley also expressed concerns about the potential independence of medical examiners. It was explained that the draft regulations and the medical examiner training programme provide instruction on when a medical examiner should declare a conflict of interest and employment by local authorities is also specifically intended to provide independence. Medical examiners will also be in a position to express concerns through the National Medical Examiner, although the National Medical Examiner will have limited powers and may pass such concerns on to other relevant authorities.

Neonatal deaths and stillbirths

There was a brief discussion about medical examiner scrutiny of neonatal deaths and stillbirths. Stillbirths do not currently fall under the remit of the coroner or medical examiner. It is sometimes difficult (and potentially controversial) to determine whether or not a baby showed signs of life after birth. There have been several high-profile cases where parents did not get the explanation they wanted after the death of a stillborn baby.

A suggestion was made that medical examiners might be given a role in the scrutiny of stillbirths, but this was not extensively discussed. It might be an issue to consider after the medical examiner service has been established and settled in.

Meeting concluded

The meeting came to a close and the Chair asked Professor Peter Furness to give a brief summary of the discussions held. This can be found in the *Key conclusions of the meeting* section on page five of this document.



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June 2016

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*L-R - Professor Peter Furness, Sir Robert Francis QC,
Dr Alan Fletcher, Dr Suzy Lishman*