The Royal College of Pathologists

Pathology: the science behind the cure

Medical examiners

Introduction

A national system of medical examiners was first proposed in 2005 following the Shipman Inquiry (the report produced following the investigation into the activities of the GP and serial killer Harold Shipman). It was subsequently legislated for in the Coroners and Justice Act 2009 and will provide independent scrutiny of all deaths not referred to the coroner.

Dr Suzy Lishman, President of The Royal College of Pathologists, said:

'Understanding why people die provides valuable statistics about the health of the nation, helps families understand what happened to their loved ones and enables health professionals to improve care for the living.

'Pilot schemes have shown that medical examiners work closely with families and health professionals to answer questions, address concerns and identify problems with care at an early stage so action can be taken to safeguard patients in the future.

'No other patient safety initiative can provide these benefits in such a timely and truly independent way.'

What is a medical examiner?

Medical examiners will be part of a national network of specifically trained independent senior doctors (from any specialty). Overseen by a National Medical Examiner, they will scrutinise all deaths across a local area that do not fall under the coroner's jurisdiction.

What is the role of The Royal College of Pathologists?

The Royal College of Pathologists is the lead medical royal college for medical examiners and has long campaigned for their introduction. The College has established a committee to oversee the introduction of medical examiners and has developed a job description and person specification for the role.

A multidisciplinary committee established by The Academy of Medical Royal Colleges has produced a curriculum for training medical examiners.

Why is reform needed?

Currently, when someone dies of natural causes, a doctor who attended the person during their last illness will sign a medical certificate of the cause of death. This is then used to register the death and a Certificate of Registration of Death is provided.

This process for certifying a death has changed little since the nineteenth century.

There is no need for an external examination of the body (unless the body is to be cremated) and there is no formal opportunity for relatives to raise concerns.

The certification of death is usually delegated to junior doctors and is often not done well. There is evidence that up to ten per cent of death certificates are completed to a poor standard and just over half (55%) could be improved. A recent study by the Office for National Statistics found that if the death certificate is checked by a medical examiner, the underlying cause of death is recorded differently in 22% of cases.

If there is any suspicion that 'unnatural causes' (such as accident, neglect, industrial disease, self-harm or link to a medical procedure) may have contributed to a death, or if the cause of death is unknown, the death must be reported to the coroner as currently happens, who may investigate and hold an inquest.

The Shipman Inquiry, chaired by Dame Janet Smith

In January 2000, GP Harold Shipman was convicted of murdering 15 of his patients. It is likely that he killed over 200. Harold Shipman signed the death certificates of the patients he murdered.

In 2001, an independent public inquiry was established by Parliament. In the third report from the inquiry, ***Death certification and the investigation of deaths by coroners***, Dame Janet Smith noted that recommendations for reform arising from previous inquiries and reports (Luce 2003, Broderick 1971) had been ignored. The inquiry also pointed out it is unsafe to have a single doctor certifying that a death is due to natural causes with no independent scrutiny.

Dame Janet's criticisms contributed to the passage (with all-party political support) of the **Coroners and Justice Act 2009**, which made provision for the introduction of medical examiners.

Medical examiners have subsequently also been recommended by other independent inquiries into failings in the NHS.

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Sir Robert Francis QC (Francis Report, February 2013)

The Inquiry heard evidence that suggested that the cause of death included in certificates relating to deaths occurring at the trust were often inaccurate or incomplete. The report said, ***'Such deficiencies are unacceptable because they mislead the family of the deceased and the coroner. They are also a significant impediment to the reliability of mortality statistics, which, for all the difficulties of interpretation are, and will remain, an important indicator of the effectiveness of care and treatment.'***

The report recognised the need for improvements in the accuracy of the certified cause of death and the identification of cases to be referred to the coroner. It strongly supported approaching families and responsible doctors after a hospital death to establish if they had concerns relevant to the cause of death, including the quality of care received by the deceased.

A medical examiner could have played a vital role as a conduit for relatives' concerns, identifying problems earlier and acting as an agent for change at Mid Staffordshire.

The Report of the Morecambe Bay Investigation, chaired by Dr Bill Kirkup CBE (Kirkup report, 2015)

Covering January 2004 to June 2013, the investigation report found 20 instances of significant failures of care at Furness General Hospital, associated with three maternal deaths and the deaths of 16 babies at or shortly after birth. Different clinical care in these cases would have been expected to prevent the outcome in one maternal death and the deaths of 11 babies.

The report called for the immediate introduction of medical examiners and recommended extending their scope to review stillbirths. The College supports this extension of the role of medical examiners.

A review of forensic pathology in England and Wales: submitted to the Minister of State for Crime Prevention by Professor Peter Hutton, March 2015

In a letter to the Home Office accompanying his review, Professor Hutton wrote: ***'There is an opportunity to do this (improve the death investigation system) through the Medical Examiner system which was part of the Coroners and Justice Bill 2009, but which has never been implemented.'***

Why are medical examiners needed and what will they do?

A national system of medical examiners will:

- **Improve safeguards for the public** by providing robust and independent scrutiny of the circumstances and cause of deaths by apparently natural causes. A medical examiner will scrutinise all medical certificates of cause of death prepared by the attending doctor; medical examiners will also have the discretion to undertake or arrange an external examination of the body.
- **Ensure that the right deaths are referred to a coroner** and confirm the medical cause of all deaths not investigated by the coroner. They will provide a statutory notification to a registrar to allow authorisation of burial or cremation.
- **Improve the quality of certification** by providing expert advice to the certifying physician. This will usually be the doctor who cared for the patient during their last illness (who may be a GP or hospital consultant), who has a duty to ensure that the death is properly certified or referred to the coroner.
- **Offer an opportunity for relatives to ask questions** about the medical circumstances and cause of death and to raise any concerns they might have.
- **Feed information to the quality assurance systems** of healthcare providers in cases where, although the death did not need to be investigated by the coroner, there are grounds to suggest that the quality of care should be improved. For example, if a high incidence of pressure sores is identified at a particular healthcare provider, which would raise issues of quality of care.
- **Provide general medical advice to coroners**, if requested, in relation to specific cases, to assist with the coroner's decision on whether to conduct an investigation.
- **Collate and share statistical information** on causes of death, with more accurate statistics informing health policy and planning. The role could be extended, for example, to include recording of the number of deaths due to antimicrobial resistance.

What are the benefits of a national system of medical examiners?

Seven pilot schemes in Sheffield, Gloucester, Powys, Leicester, north London, Brighton and Hove, and Mid Essex have scrutinised over 23,000 deaths since 2008 when they were established with funding from the Department of Health.

Evidence from the pilot schemes has demonstrated a number of benefits:

- **Improved accuracy of death certification.** Medical examiners advised on the best wording to explain the cause of death accurately and with the detail needed. In discussion about the cause of death, they would ensure that important information was included, for example, that the underlying cause of pneumonia was immobility caused by a stroke.
- **Helped avoid unnecessary distress for families** by listening to concerns and providing reassurance to the next of kin that can result from unanswered questions about the cause of death. Bereavement support groups involved in the pilots were universally supportive and the medical examiner service was valued by families.
- **Families felt reassured after consulting the medical examiner about the language used on the death certificate** as they often found the medical terminology difficult to understand.
- **Identified trends in unexpected causes of death.** For example, medical examiners triggered investigations that identified problems with post-operative infections.
- **Ensured that the right deaths were referred to a coroner for further investigation.** When the certifying doctor was unsure of the need for coronial referral, a discussion with the medical examiner normally clarified the position.
- **Close working relations between medical examiners and the local coroner's office** were established in all the pilots. Coroners welcomed the improved quality of medical information they received.
- **Immediate referral of avoidable deaths (those that could have been avoided if the care or treatment had been delivered differently) to the coroner.** This made coronial investigation more straightforward and helped lessen the anguish of the grieving relatives.
- **Helped foster more openness in the NHS** as health professionals who raised concerns felt supported knowing that they were protected by the authority and independence of the medical examiner. Medical examiners were often able to discuss and 'defuse' potential complaints. In one pilot, there was a substantial fall in medical litigation costs.

Will medical examiners increase the number of deaths referred for coronial investigation?

If a death requires investigation by the coroner, prior discussion with a medical examiner is not mandatory. However, in both the main pilot sites (Sheffield and Gloucester) it rapidly became normal practice to discuss all deaths with a medical examiner before referring appropriate cases to the coroner.

Overall, the pilots have demonstrated a reduction in the total number of cases referred to coroners. This is due to a large reduction in the number of unnecessary referrals. However, scrutiny by medical examiners also resulted in a smaller number of additional deaths being referred to the coroner, where a doctor had incorrectly thought that death was due to natural causes or that further investigation was not necessary.

In summary

The isolation that families often feel after the death of a loved one can be compounded by a healthcare system that quickly moves on to caring for the living. While this is understandable in an NHS facing increasing and competing demands, bereaved families should be listened to and deserve answers to their questions from an independent and authoritative source.

Medical examiners will be able to provide prompt independent feedback to those responsible for health care. This provides a crucial opportunity to identify inadequate standards of care in hospitals, care homes or in the community, helping to avoid future harm. Understanding the cause of death is essential to our understanding of disease, its prevalence and, longer term, how we find ways to prevent or treat illness.

The Royal College of Pathologists has strongly advocated for these benefits to be delivered through the establishment of a national network of independent medical examiners. Their introduction will be integral to delivering a high quality health service which prioritises patient safety, clinical effectiveness and patient experience.

What happens next?

In March 2016 the Secretary of State for Health announced a package of measures to improve safety and transparency within the NHS. He confirmed that, from April 2018, independent medical examiners will scrutinise and confirm the cause of all deaths not subject to investigation by a coroner.

The Department of Health has started its consultation (which runs until 15 June 2016) on the proposed reforms.

info@rcpath.org
020 7451 6700

4th Floor, 21 Prescot Street,
London E1 8BB

www.rcpath.org

May 2016