Medical Examiners and Death Certificate Reforms

Dr Huw Twamley,
Medical Examiner LTHTR
Regional M.E. (Northwest)

A statement was made by the government on the 27th April 2023.

I wish to inform the House of the Government's plan for introducing a statutory medical examiner system from April 2024.

Coroners and Justice Act 2009

Medical examiners

(1) [F2 Local authorities] (in England) and Local Health Boards (in Wales) must appoint persons as medical examiners to discharge the functions conferred on medical examiners by or under this Chapter.

(2) Each [F3 local authority] or Board must—

(a) appoint enough medical examiners, and make available enough funds and other resources, to enable those functions to be discharged in its area;

(b) monitor the performance of medical examiners appointed by the [F3 local authority] or Board by reference to any standards or levels of performance that those examiners are expected to attain.

(3) A person may be appointed as a medical examiner only if, at the time of the appointment, he or she—

(a) is a registered medical practitioner and has been throughout the previous 5 years, and

(b) practises as such or has done within the previous 5 years.

Reforms requiring Secondary Legislation

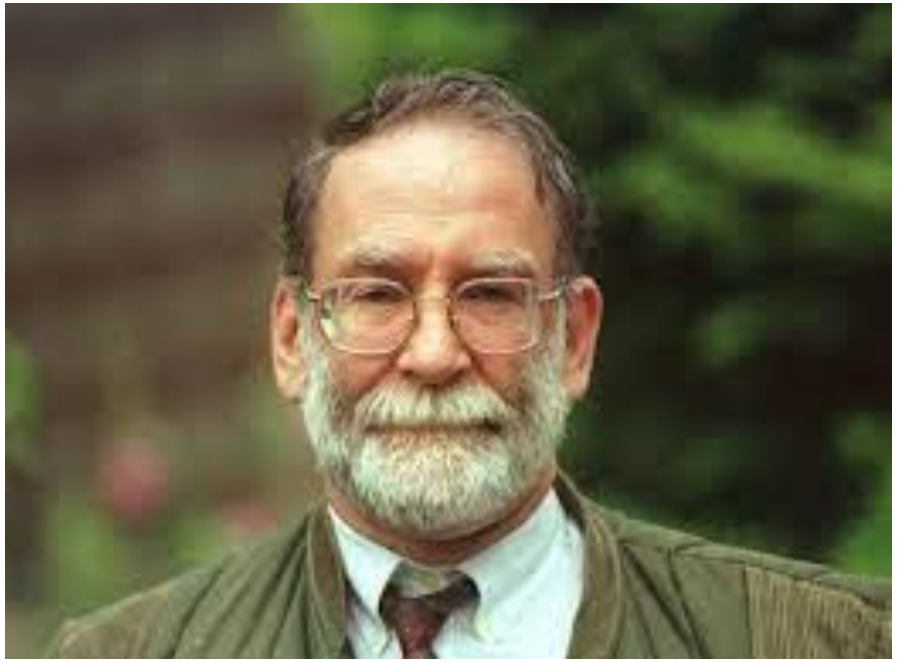
- Medical examiner scrutiny will be a compulsory legal process before a death can be registered
- ME scrutiny will replace Cremation forms
- Medical Crematorium referee system will cease after a transition period.
- Removal of the need for examination of the body for MCCD/Cremation
- Digital MCCD
- Online registration of death (or hybrid)

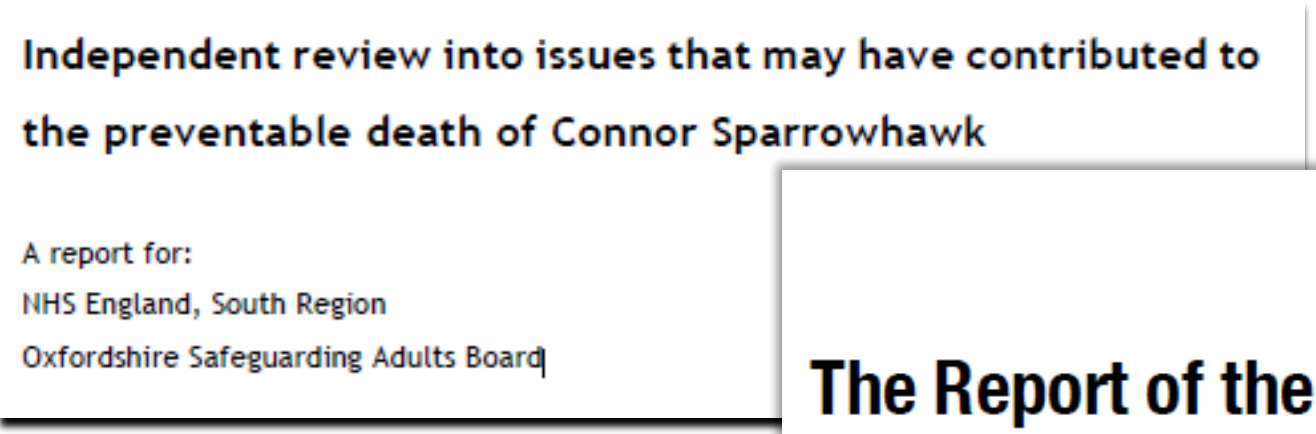
THE
SHIPMAN INQUIRY

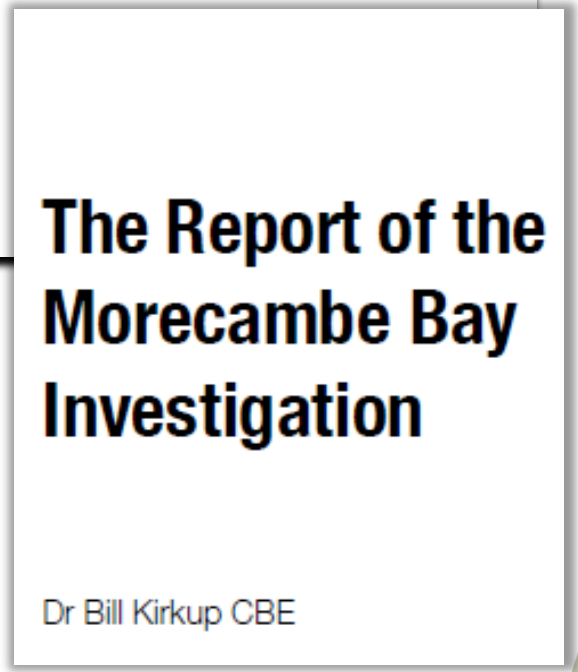
Chairman: Dame Janet Smith DBE

Third Report

Death Certification and the
Investigation of Deaths by Coroners




Independent review into issues that may have contributed to the preventable death of Connor Sparrowhawk
A report for:
NHS England, South Region
Oxfordshire Safeguarding Adults Board


The Report of the Morecambe Bay Investigation
Dr Bill Kirkup CBE


Gosport War Memorial Hospital
The Report of the
Gosport Independent Panel
June 2018


INDEPENDENT REVIEW OF THE LIVERPOOL CARE PATHWAY
MORE CARE, LESS PATHWAY
A REVIEW OF THE LIVERPOOL CARE PATHWAY


The Royal Liverpool Children's Inquiry
Report


THE SHIPMAN INQUIRY
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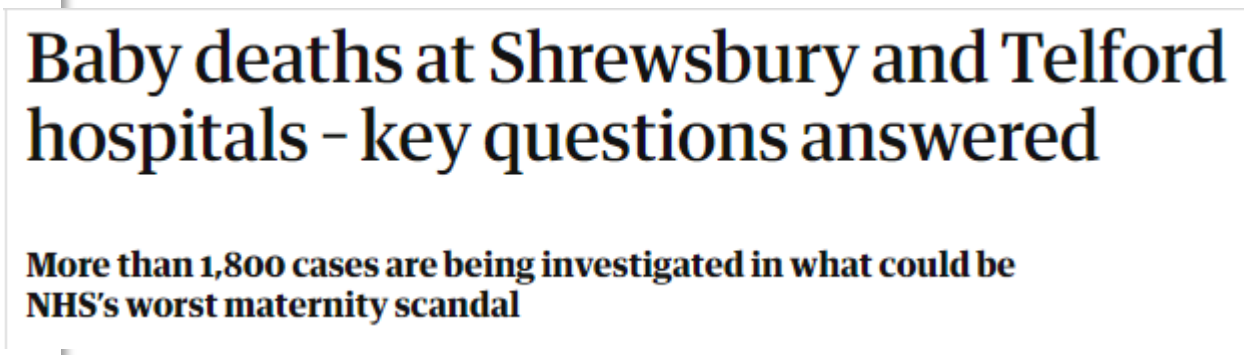
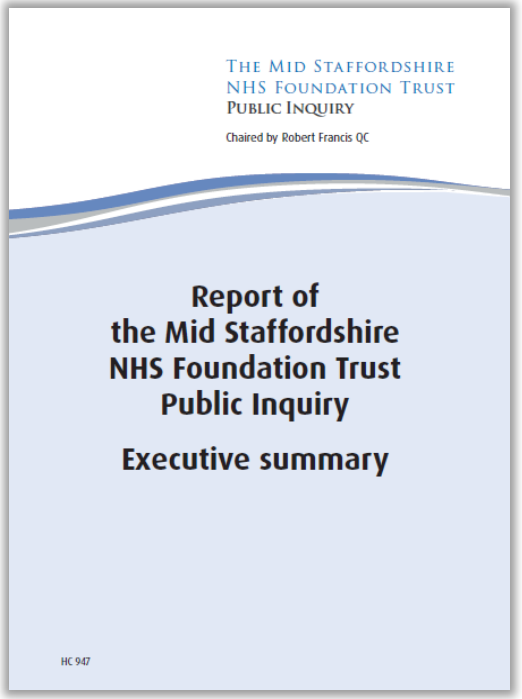
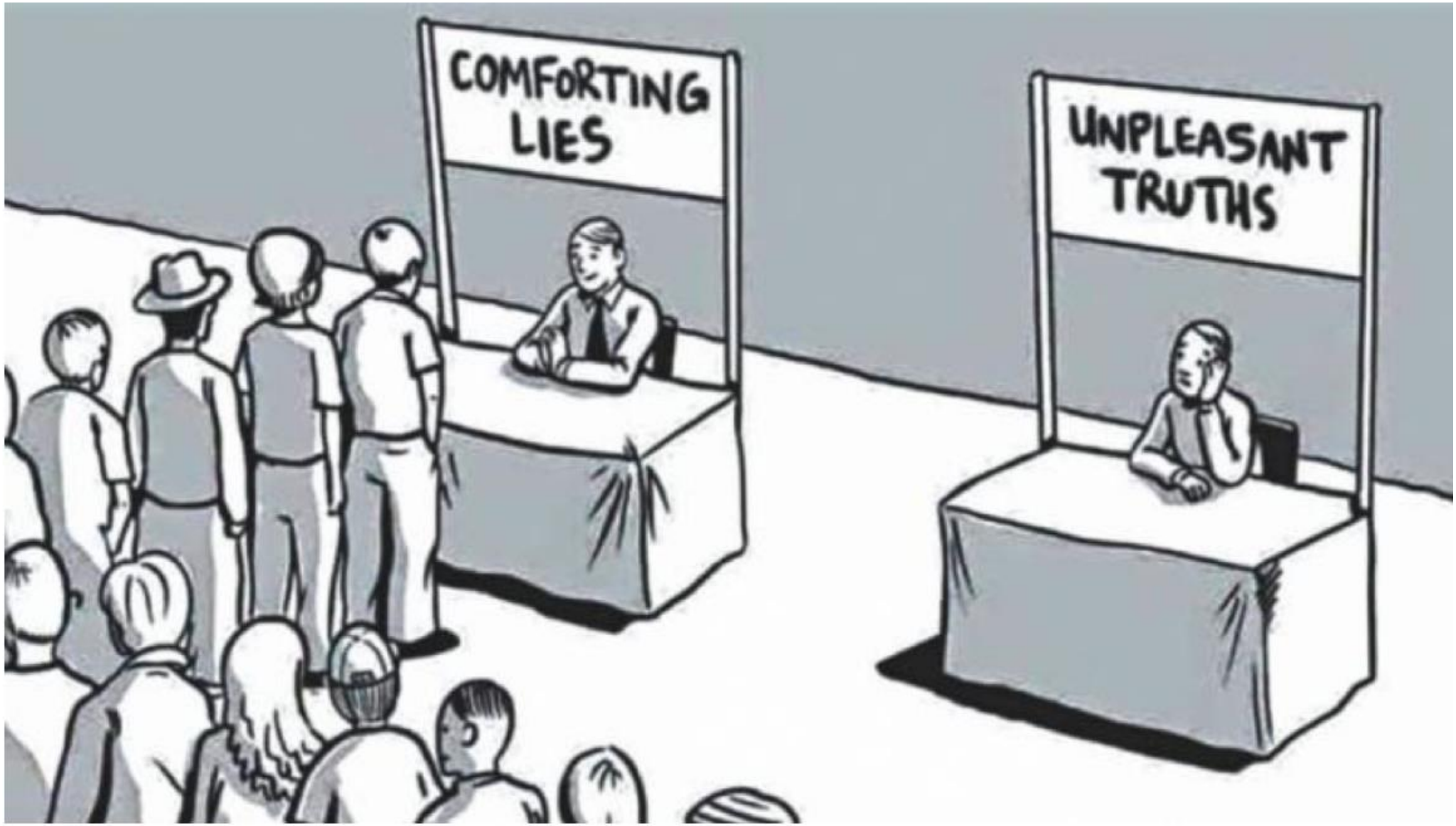
Death Certification and the Investigation of Deaths by Coroners

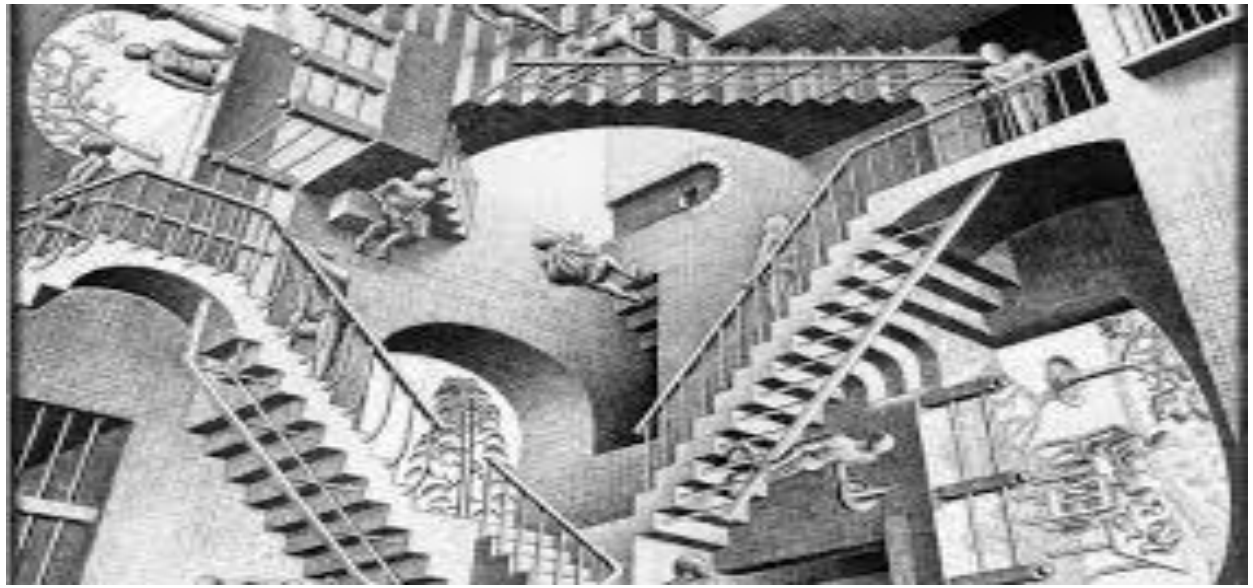

Baby deaths at Shrewsbury and Telford hospitals - key questions answered
More than 1,800 cases are being investigated in what could be NHS's worst maternity scandal

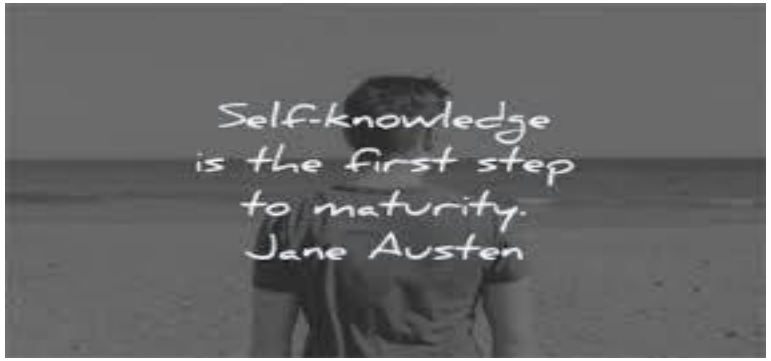

The Mid Staffordshire NHS Foundation Trust
Public Inquiry
Chaired by Robert Francis QC
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
Executive summary
HC 947


COMFORTING LIES
UNPLEASANT TRUTHS

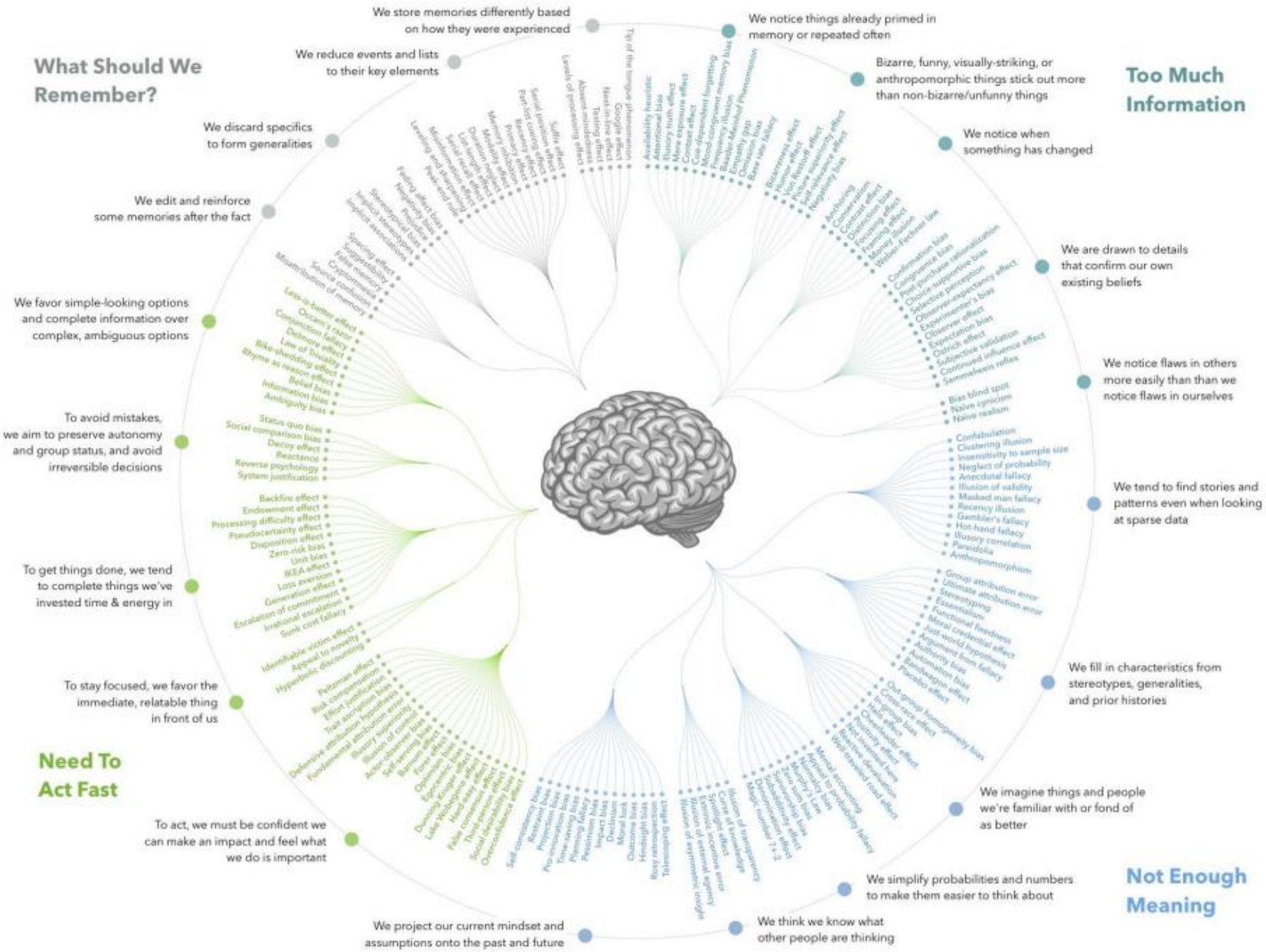
Illusions

- Illusion of Superiority
- Illusion of Optimism
- Illusion of Control

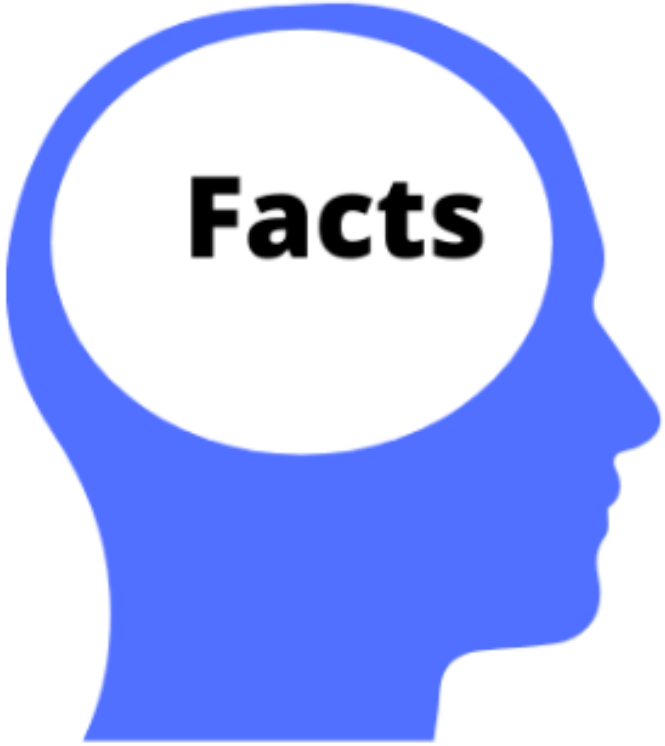




COGNITIVE BIAS CODEX



Cognitive Dissonance



Parliamentary and Health Service Ombudsman has found evidence of systematic cover-ups by the NHS in dealing with instances of substandard patient care and inquiries into it.(2015)

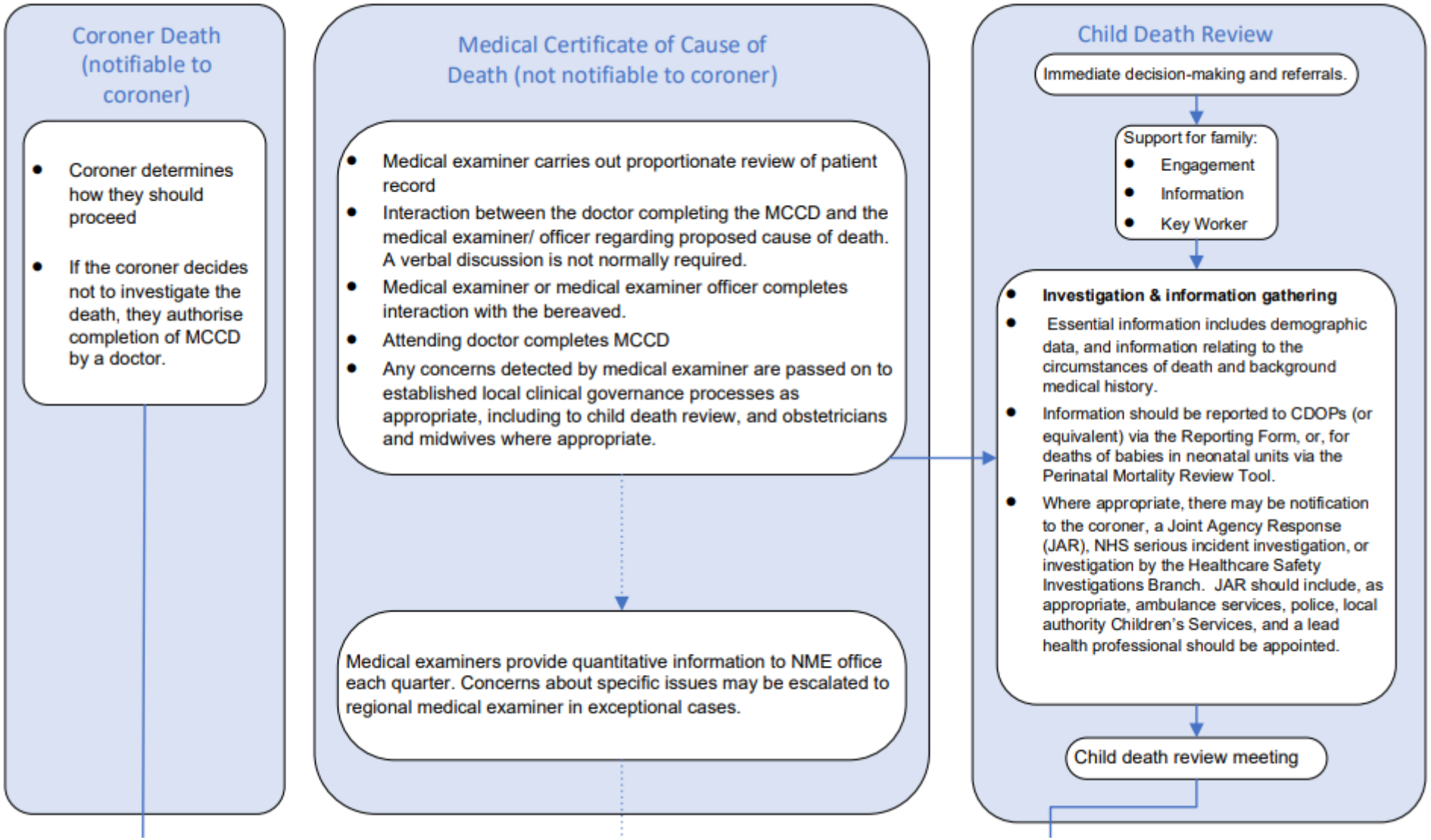
- 75% of cases showed no evidence of failings where in fact serious errors occurred
- 52% of cases were investigated by a colleague of the clinician being investigated
- Significant lack of records, interviews or other investigations
- Families met with “Wall of silence”

The Medical Examiner Office

- Predominantly acute trusts, the office may serve more than one trust
- Medical Examiners
  - Lead Medical Examiner
  - Part time, consultants or GPs
  - Specific on-line and face-to-face training
  - 1 WTE per 3000 annual deaths
- Medical Examiners Officers
  - Lead Medical Examiner Officer
  - Support Medical Examiners
  - 3 WTE per 3000 annual deaths

Present Situation

- Around 250,000 deaths were scrutinised in 2022
- Over half a million deaths scrutinised in total since introduction
- Offices established in all Acute Trusts
- Nearly 2000 Medical Examiners trained.
- 72% of all deaths (Acute and Non acute settings)


Coroner Death (notifiable to coroner)
Coroner determines how they should proceed
If the coroner decides not to investigate the death, they authorise completion of MCCD by a doctor.
Medical Certificate of Cause of Death (not notifiable to coroner)
Medical examiner carries out proportionate review of patient record
Interaction between the doctor completing the MCCD and the medical examiner/ officer regarding proposed cause of death. A verbal discussion is not normally required.
Medical examiner or medical examiner officer completes interaction with the bereaved.
Attending doctor completes MCCD
Any concerns detected by medical examiner are passed on to established local clinical governance processes as appropriate, including to child death review, and obstetricians and midwives where appropriate.
Medical examiners provide quantitative information to NME office each quarter. Concerns about specific issues may be escalated to regional medical examiner in exceptional cases.
Child Death Review
Immediate decision-making and referrals.
Support for family:
Engagement
Information
Key Worker
Investigation & information gathering
Essential information includes demographic data, and information relating to the circumstances of death and background medical history.
Information should be reported to CDOPs (or equivalent) via the Reporting Form, or, for deaths of babies in neonatal units via the Perinatal Mortality Review Tool.
Where appropriate, there may be notification to the coroner, a Joint Agency Response (JAR), NHS serious incident investigation, or investigation by the Healthcare Safety Investigations Branch. JAR should include, as appropriate, ambulance services, police, local authority Children's Services, and a lead health professional should be appointed.
Child death review meeting

- Medical examiner carries out proportionate review of patient record
- Interaction between the doctor completing the MCCD and the medical examiner/ officer regarding proposed cause of death. A verbal discussion is not normally required.
- Medical examiner or medical examiner officer completes interaction with the bereaved.
- Attending doctor completes MCCD
- Any concerns detected by medical examiner are passed on to established local clinical governance processes as appropriate, including to child death review, and obstetricians and midwives where appropriate.

Contact with family

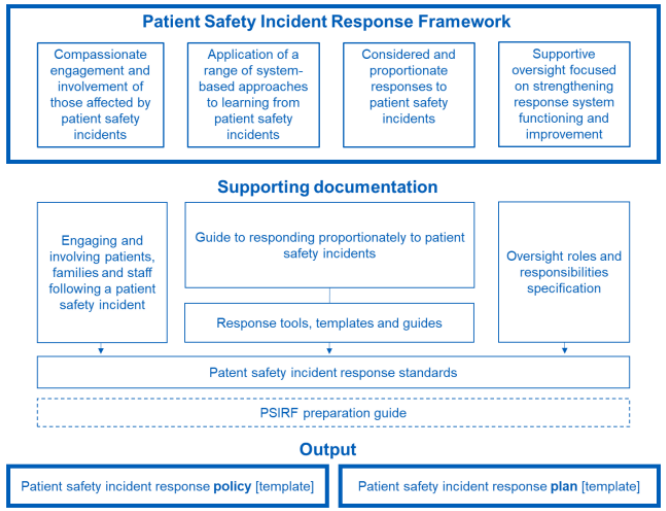
- Can lessen the impact of grief
- Reduces complaints
- Reduces litigation
- Added layer of assurance

“My Priority is the Living not the Dead”

The overall cost of clinical negligence in England rose from £582 million in 2006 to 2007 to £2.2 billion in 2020 to 2021, representing a significant burden on the NHS. For all claims, legal costs have increased more than fourfold to £433 million since 2006 to 2007.

All NHS Written Complaints: (Hospital and Community Health Services and Primary Care)

- The total number of all reported written complaints in 2020-21 was 170,013.
- This was equivalent to 300.6 complaints per 100,000 head of population.
- The proportion of complaints being fully upheld are 33.8% for primary care and 26.8% for HCHS.

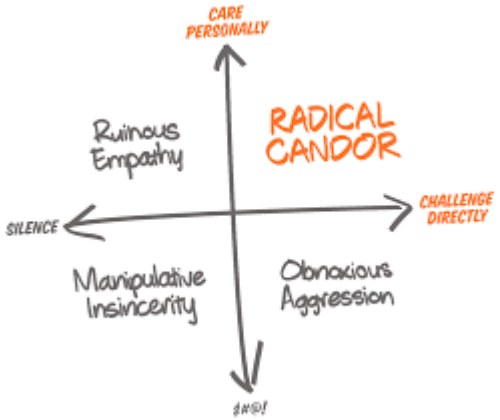


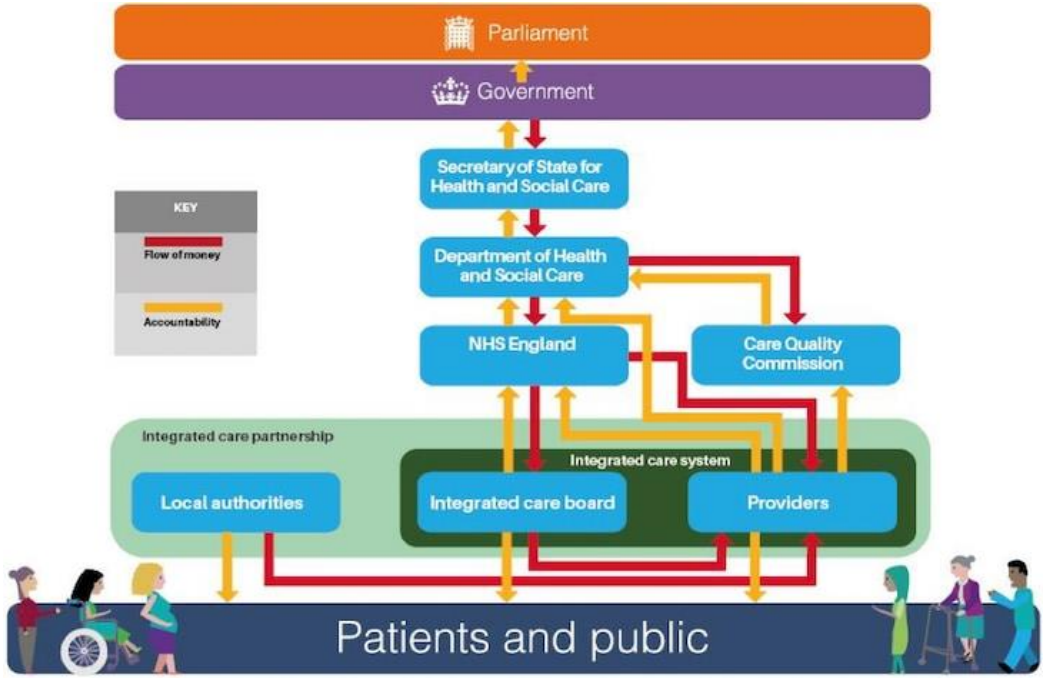
Royal College of Physicians | National Mortality Case Record Review Programme

Using the structured judgement review method
A clinical governance guide to mortality case record reviews

we are your

PALS | Patient Advice & Liaison Service





PMRT
Supporting high quality local perinatal reviews

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

lancashire safeguarding adults board

Lord Sugar @Lord_Sugar · 10m

which one is the dad . Anyway happy birthday

LunchBox Head @POTNOODLEFRINGE

@Lord_Sugar My dads a big fan Alan how about a retweet for his birthday, would really make his day. You're Fired Lol

End of Life Themes

- Vast majority of families very grateful for care received
- Praise for compassionate and caring staff despite clinical pressure
- Loved one dying with dignity and humanity

St John's Hospice

St Catherine's hospice care

End of Life Themes

- Delayed recognition of EOL
- Lack of advanced planning in chronic conditions
- Unable to achieve fast track discharge
- Overtreatment/investigation during EOL
- Overtreatment/investigation not proportionate to patient condition
- Missed/delayed diagnosis or lost to follow up.

Key Points

- Immediate advice and quality improvement for Medical Certificate Cause of Death
- Feedback from bereaved early after death
- Early opportunity to respond to concerns
- Proportionate review of notes before registration of death
- Assurance function independent of hosting Trust
- In addition to current assurance processes rather than replacement.

Thank you

Any Questions?