National Medical Examiner's report 2020

April 2021

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Foreword

I am delighted to provide my first report for the National Medical Examiner system for England and Wales.

The creation of the new medical specialty of medical examiner and new profession of medical examiner officer is a significant development. That so much progress has been made in a short time is testimony to the commitment of many to providing bereaved people with consistent, independent listening. It remains my resolve to ensure bereaved people are central to the medical examiner system as we continue implementation in the non-statutory phase prior to the advent of a statutory system. The coronavirus pandemic underlines how important this is.

We have much to do, but this report describes our progress and next steps, building the foundations of a medical examiner system that will facilitate reflection, learning and improvement across the entire health system.

Dr Alan Fletcher
National Medical Examiner

Introduction

Implementation of medical examiners began in England and Wales in 2019 with the appointment of the National Medical Examiner and recruitment of national and regional teams. This report summarises progress made during 2020. Some trusts in England set up medical examiner offices during 2019 or earlier, but it was in the final quarter of 2019 that funding arrangements were confirmed. This enabled implementation to start in earnest in England and Wales in 2020 and, despite the coronavirus pandemic, significant progress was made through the year.

Medical examiners are senior doctors who in the immediate period before the death is registered (five days) independently scrutinise the causes of death. Quarterly reporting submissions from trusts in England, and feedback from Wales, evidence that the medical examiner system provides what is needed and is well received by the public and stakeholders. The progress made through the year is remarkable.

In the boxes throughout this report you will find excerpts of feedback that local and regional medical examiners have received, as well as examples of the impact medical examiners are having.

Inevitably, progress in 2020 was impacted by the coronavirus pandemic and the need for healthcare systems to prioritise frontline care for patients. Nevertheless, medical examiners played an important part in the response to the pandemic, and provided a skilled workforce ready to deliver reviews of deaths of health and social care workers from COVID-19 at short notice.

"Getting feedback that the family understood the process and were comforted by our team really helps – it lets us know that when we shift our emphasis to providing a good death, that we achieved that for them and their family." **(intensive care consultant, after medical examiner shared feedback from bereaved family)**

About the National Medical Examiner

Dr Alan Fletcher is the National Medical Examiner for England and Wales, and was appointed to the role in March 2019.

He was previously lead medical examiner at Sheffield Teaching Hospitals NHS Foundation Trust, and has been pioneering the medical examiner role since 2008 as part of the Department of Health and Social Care's (DHSC's) death certification reform; personally reviewing over 22,000 deaths. He has overseen the introduction of the medical examiner system in England and Wales.

Dr Fletcher is national clinical lead for medical examiner e-learning, and is a member of the DHSC Death Certification Reform Strategic Board.

He was Chair of the Royal College of Pathologists Medical Examiners Committee from 2015 to 2019, and maintains his clinical practice as consultant in emergency medicine and general internal medicine at Sheffield Teaching Hospitals NHS Foundation Trust.

The national medical examiner system

The national medical examiner system is being rolled out across England and Wales, initially on a non-statutory basis, and is part of DHSC's Death Certification Reform Programme for England and Wales. It also forms part of the NHS Patient Safety Strategy and the NHS Long Term Plan in England. The all-Wales Medical Examiner Service is a critical part of the long-established mortality review programme.

Throughout 2020, medical examiner offices have been established at acute trusts in England and at regional hubs in Wales, initially providing scrutiny of non-coronial deaths in acute care. This remit is being expanded in 2021 and 2022 to cover non-coronial deaths that occur in other settings such as the community.

A core part of the medical examiner role is to provide bereaved people with clear information about the cause of death, and an opportunity to raise any concerns they may have about the care and treatment provided to the deceased person. Medical examiners also carry out a proportionate review of patient records and discuss causes of death with the doctor completing the Medical Certificate of Cause of

Death (MCCD). They ensure concerns about patient care are identified promptly and referred for further investigation, to improve services and care for all patients.

> "In one case the bereaved felt greatly helped, as they had been reassured by the medical examiner there was nothing they could have done to predict the deterioration or help their relative, but up to that point they had felt a sense of guilt." **(medical examiner)**

Example of medical examiner impact: A frail elderly patient with a known heart condition was admitted and then transferred to a specialist hospital for invasive investigations. They died shortly after arrival at the second hospital. The medical examiner discussed this with the family who raised concerns about the care and the appropriateness of the transfer. As a result the trust changed their end of life process.

Implementation

Throughout 2020 there has been outstanding work across England and Wales to establish local medical examiner offices and national and regional support systems.

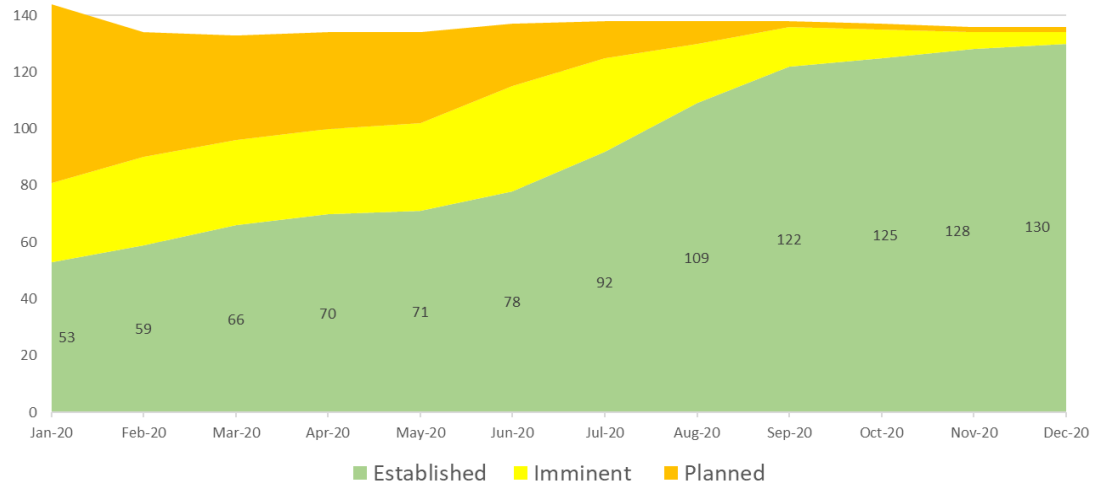
In Wales, the service is being implemented by NHS Wales Shared Services Partnership (NWSSP), an independent mutual organisation, owned and directed by NHS Wales. NHS England and NHS Improvement started to implement medical examiners in England in 2019 by establishing national and regional teams to support the programme. DHSC confirmed the detailed funding model for the non-statutory system in December 2019 and with this, trusts in England have been able to plan local implementation with confidence from January 2020.

At the start of 2020, 48 acute trusts in England had established medical examiner offices[1] and by the end 130 trusts[2] had done so, leaving five still to implement their

[1] This means trusts had appointed medical examiner(s) and commenced scrutiny of some non-coronial deaths. As medical examiners are a completely new initiative, it is recognised that host organisations require time to recruit, build capacity and establish processes.
[2] The number of expected medical examiner offices in England has varied through implementation with some trusts merging, and others deciding to join existing medical examiner offices.

plans. In addition, a few specialist trusts continued to consider whether to establish their own medical examiner office.

Figure 1: Number of acute trusts in England with established medical examiner offices



In Wales, four hub sites covering all health board areas have been established.

To accompany the establishment of medical examiner offices, the National Medical Examiner team introduced quarterly reporting arrangements for medical examiner offices in England. The first full reporting submission was made in February 2021, though some trusts were unable to complete full submissions as a result of the pressures caused by the coronavirus pandemic.

Trusts reported that feedback from members of the public was overwhelmingly positive. In England and Wales, medical examiner offices have also reported improved working with coroners and register offices, with registrars rejecting fewer MCCDs and more appropriate notification of deaths to coroners.

> "…the fullness of your report, and the depth, decency and honesty of your opinions … was hugely appreciated. It has immediately given 'closure' …they will be able to focus on the future, while remembering the past." **(feedback from bereaved family to medical examiner office)**

The coronavirus pandemic

Progress in 2020 was made despite unprecedented pressures caused by the coronavirus pandemic. NHS England and NHS Improvement declared a level 4 incident on 30 January 2020 and on 17 March 2020 issued guidance to NHS organisations on the coronavirus response. Pandemic responses in Wales were similar, with routine treatments scaled back to accommodate the need to treat patients with coronavirus.

Medical examiners played an important role in the pandemic response. Some with frontline clinical skills provided acute care instead. Others used their enhanced training in causes of death certification processes to become full-time certifiers. This released frontline doctors from an administrative task so that they could prioritise frontline caring duties.

DHSC and other government departments, with input from the National Medical Examiner, drafted clauses in the Coronavirus Act for England and Wales. The resulting adjustments to the death certification processes facilitated the contribution of medical examiners described above.

Working with stakeholders including the Ministry of Justice, Chief Coroner's Office, Home Office (General Register Office) and Office of National Statistics, the National Medical Examiner team published excess deaths guidance for all medical practitioners and contributed to updated guidance on MCCD completion in England and Wales.

As the first wave of the pandemic passed, in June 2020 the National Medical Examiner asked trusts in England to recommence their implementation plans for the establishment of medical examiner offices. We commend trusts for their response; the number of established offices quickly increased. In Wales, recruitment to the remaining hub site was completed in July 2020, with duties starting in August 2020.

> "Medical examiners played a pivotal role in the COVID-19 pandemic by highlighting cases that need investigating through trust mortality processes, ensuring that resources were used effectively to learn from deaths." **(medical director, acute trust)**

Deaths of health and social care workers with COVID-19

The safety of NHS and social care staff was paramount as they risked exposure to the virus in caring for patients.

In England, an independent process was established in July 2020 for medical examiners to scrutinise the deaths of health service and adult social care staff who die after contracting COVID-19. This involves medical examiners considering whether there is a reason to suspect the death was a result of the person being exposed to COVID-19 at work, and reporting their conclusions to the National Medical Examiner's office. Where appropriate, employers are asked to consider their obligation under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) to report to the Health and Safety Executive. The process will remain in place for as long as it is required.

In Wales, separate processes that do not involve medical examiners were in place to ensure employers discharged their obligations under the RIDDOR requirements.

Guidance and publications

Guidance and resources to support organisations in establishing their medical examiner offices and medical examiners in their roles were added to the National Medical Examiner's webpage during 2020.

Good practice guidelines

In January 2020, the National Medical Examiner published Good practice guidelines for medical examiners, with input from a range of stakeholders. This consolidated previous guidance and provided a framework for a consistent national model and approach to scrutiny of deaths by medical examiners.

> "The medical examiner team have gone above and beyond to help us and have fought for measures to help us and our patients. We are immensely grateful and pleased that the Medical Examiner's Office is set up for the longer term. Thank you!" **(excerpt from junior doctors' nomination)**

National medical examiner updates

The National Medical Examiner has written a regular update bulletin to provide information and news for medical examiners and stakeholders. Six bulletins were published in 2020, with distribution growing to more than 1,500 individuals representing a range of stakeholders.

National Medical Examiner's good practice series

To provide focused information for medical examiners on topical matters, the National Medical Examiner in partnership with subject-matter experts and key stakeholders is producing a series of brief good practice documents, designed to be easily digested by busy frontline staff, with links to further reading, guidance and support.

The first considers how medical examiners can support people of Black, Asian and minority ethnic heritage and their relatives and was published by the Royal College of Pathologists in February 2021. Forthcoming subjects include responding to requests for urgent release of bodies; learning disabilities and autism; child deaths; and organ and tissue donation.

Example of medical examiner impact: Medical examiners identified several cases with safeguarding concerns that had not been raised by clinical teams. These were notified to the coroner and patient safety leads. This prompted improvements in awareness, training and process for clinical staff.

Training

For the medical examiner programme to succeed. medical examiners and medical examiner officers must have the appropriate knowledge and skills. To support this, the Royal College of Pathologists has been leading the delivery of medical examiner training.

At the start of 2020, 410 had completed face-to-face medical examiner training. The coronavirus pandemic meant this training was suspended in spring 2020, and the Royal College of Pathologists introduced virtual training in September 2020 for both senior doctors and medical examiner officers. This proved a great success and by

the end of 2020, 870 senior doctors and 141 medical examiner officers had completed this training. The college is continuing to provide these training programmes through 2021, adding to the available workforce.

Stakeholders

Many stakeholders have an interest in death certification processes, ranging from the Welsh Government, other national government departments with responsibilities in death certification, such as the Home Office (General Register Office), Ministry of Justice; others with statutory responsibilities, such as the Chief Coroner; and leaders of faith communities. The National Medical Examiner has devoted significant time to establishing and building relationships with these groups, and they have been active in shaping the implementation of medical examiners.

The Lead Medical Examiner in Wales has led on national and local engagement with all relevant stakeholders in Wales. In England, lay representatives have also been appointed to the implementation group to ensure contributions reflect the interests of patients, the public, families and carers (see Annex).

The excellent working relationship established with stakeholders proved particularly important during the coronavirus pandemic when healthcare and other public services were called to work together rapidly to prepare for and cope with the resulting pressures.

> “Medical examiners have substantially improved the quality of referrals to the coroner’s service.” **(senior coroner)**

The National Medical Examiner actively encouraged medical examiner offices to develop positive relationships with stakeholders locally, particularly coroners and registrars, and also with other parts of the health service such as mortuary and bereavement services.

Example of medical examiner impact: A medical examiner identified issues with endoscopy services and the trust made immediate improvements.

Increasing the number of scrutinised non-coronial deaths

In a typical year in England and Wales, there are approximately 550,000 deaths. A reasonable assumption is that in due course medical examiners may scrutinise up to 490,000 non-coronial deaths each year. About half these will occur in hospital and half in other settings, meaning at present medical examiners could potentially scrutinise about 250,000 hospital deaths a year, an average per quarter of slightly more than 60,000.

In England, the response to the pandemic constrained the increase in deaths scrutinised between April and September 2020. It was not until October to December 2020 that the number of deaths scrutinised began to reflect the additional capacity.

Figure 2: Number of deaths scrutinised by medical examiners in England in 2020 (trust reported numbers)

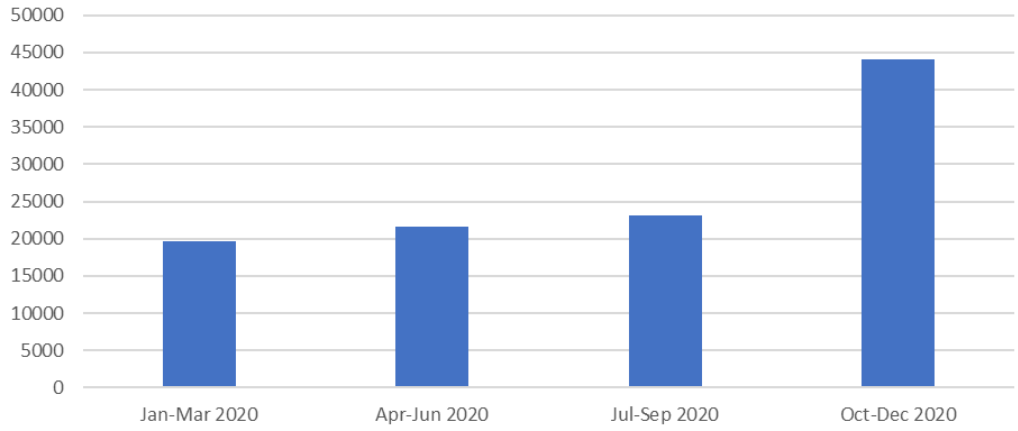
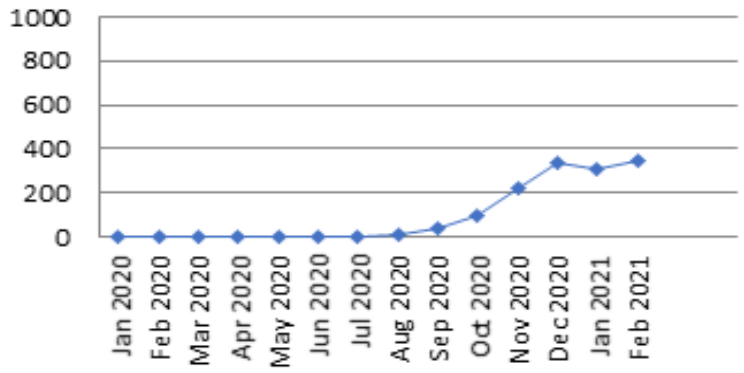


Figure 3: Number of deaths scrutinised by medical examiners in Wales



Trusts in England reported medical examiners scrutinised 44,256 of 61,922 deaths between October and December 2020. We expect this number will increase, given that some trusts only established their medical examiner offices in the second half of 2020, and were still appointing medical examiners and medical examiner officers and embedding processes.

The first formal submissions of medical examiner data from trusts in England to the National Medical Examiner Office were made for the quarter October to December 2020.[3] This provided a more detailed breakdown of the scrutiny of 41,056 deaths in England. Of these, 94.3% were adults and 0.4% were children, with 5.3% not known. Medical examiners reported that 20.5% of the adult deaths and 31.0% of the child deaths were notified to a coroner after medical examiner scrutiny.[4]

Medical examiners further reported 4,696 deaths were referred for case record review or other clinical governance review because they had concerns about care. This represents 10.6% of the 44,256 deaths scrutinised, but is likely to be a slight under-representation as some trusts did not provide a detailed breakdown.

Example of medical examiner impact: Medical examiners identified a number of inappropriate or incomplete 'Do not attempt cardiopulmonary resuscitation' decisions in records, and their intervention resulted in training and awareness raising for staff.

The deaths referred for case record review included 372 deaths of people with a learning disability or severe mental illness.

Medical examiners reported they had notified 453 patient safety incidents as a result of scrutiny.

Trusts reported 1,067 cases where urgent release of the body was achieved within the requested time, against 68 cases where this was not possible. Registrars rejected 222 MCCDs completed after medical examiner scrutiny. Several medical

[3] At the time of writing, some trusts were still providing data and updates, so final numbers may differ slightly.
[4] As some trusts made zero returns in some fields, there is likely to be some under-reporting in all figures provided.

examiners have reported improved working with registrars and reduced numbers of rejected MCCDs.

In 3,162 cases, medical examiners had no interaction with the bereaved. Reasonable explanation was provided for this in 1,216 cases, such as no response from next of kin (whose participation is entirely voluntary). Also, the coronavirus pandemic may have been a contributor during this period. However, as involvement of the bereaved is a core element of medical examiner scrutiny, we expect the proportion of such cases to diminish as medical examiner principles become embedded.

In Wales, following hub site establishment, the number of deaths scrutinised by the service has increased month on month with more care providers being covered, including some primary care and hospice sites in addition to acute and community hospitals. We expect all hospital deaths will be subject to scrutiny by late summer 2021, following the final round of staff recruitment, which will also facilitate the remaining community deaths.

Example of medical examiner impact: A lady with a known heart condition collapsed and a decision was made to admit. However, there was an ambulance delay of several hours. The medical examiner raised this with the coroner and the ambulance service. While all concluded this did not affect the outcome, the medical examiner's intervention identified call handler error, and led to training and a review of call categories.

Feedback received by trusts in England and regional offices in Wales

The National Medical Examiner's office began collating information from medical examiners in October 2020. In quarterly reports, most medical examiner offices provided information about the feedback they had received. The overwhelming majority of feedback was positive:

- next of kin and families appreciated the opportunity to discuss the circumstances of their relative's death with an independent person, and the time taken to do this
- attending clinicians, especially junior doctors, appreciated medical examiners' support and developmental approach when completing MCCDs
- potential complaints were avoided because medical examiners detected concerns quickly and facilitated action before a complaint was made or positions became entrenched
- positive feedback from stakeholders such as coroners and registrars about the accuracy of notifications and MCCDs, and from other hospital services.

The relatively small number of concerns expressed by stakeholders often related to required adjustments to processes. Related to this, a very small number cited delays, though the large number of excess deaths during 2020 strained the healthcare system, and many are unlikely to be solely due to the medical examiner system itself.

Conversely, some trusts reported medical examiners were reducing the time taken for some processes such as completing MCCDs and accurate coroner referrals. As scrutiny has to be completed within the five days before the death must be registered, it would quickly become clear if MCCD delays were widespread.

Example of medical examiner impact: An elderly man died following surgery, and the family were extremely concerned the patient had been neglected on the ward. The medical examiner and medical examiner officer reviewed the notes, and discussed the case with the patient's consultants. By meeting the family, the medical examiner addressed all their concerns, avoiding a complaints process and an unnecessary postmortem.

Regional medical examiners continue to monitor the timeliness of MCCD completion during the implementation phase.

In Wales, feedback from the bereaved has been very positive, in particular the opportunity to get answers to questions about the MCCD and the care provided. They also appreciated further signposting to address any unresolved matters. This

has been particularly notable during the pandemic where, understandably, care providers found interactions with families more challenging.

Health boards have appreciated the higher quality information provided following scrutiny compared with the existing Stage 1 mortality review process and, in particular, the independence of the process that provides public assurance.

Coroners too have indicated the significant benefit to their processes following independent scrutiny; it results in more informed judicial decision-making.

Example of medical examiner impact: After medical examiners identified that clinical language gave families unrealistic expectations, an intensive care unit changed the way they discussed patients' progress with next of kin, to reduce the risk of causing distress and complaints later.

Next steps

Digital system

The medical examiner system will be supported by a digital product to capture scrutiny. A long-term provider for this system has been secured through NHS Business Services Authority, which will also host the product and provide service support and ongoing development.

During the coronavirus pandemic the electronic transmission of documents to support death certification was universally welcomed, and NHS Business Services Authority will build on this by developing a digitised MCCD. The intention is for both digital products to be available no later than April 2022 or when the medical examiner system becomes statutory.

Statutory system

Publication in February 2021 of the white paper Integration and innovation: working together to improve health and social care for all provides welcome confirmation of government's intention to put medical examiners on a statutory footing in England and Wales.

This underlines that during 2021/22 healthcare providers in England and Wales should seize the opportunity presented by the non-statutory system to prepare to extend medical examiner scrutiny to all non-coronial deaths.

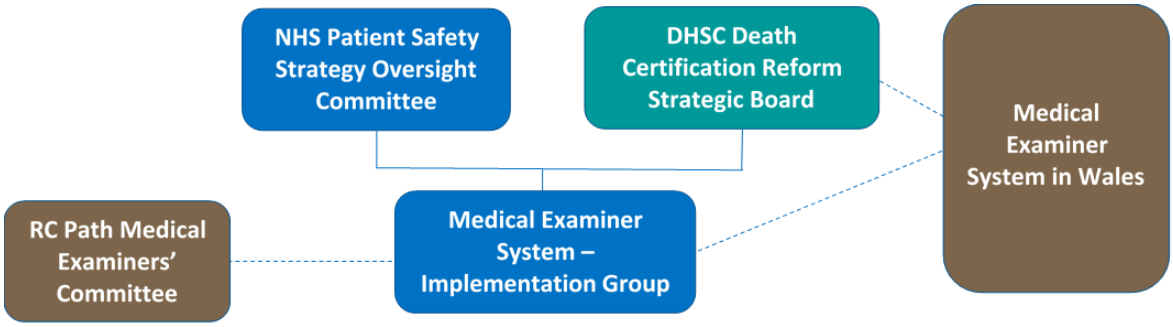
Implementation is still at an early stage; many medical examiner offices opened in the final months of 2020 or were unable to start full operations during the coronavirus response. The medical examiner workforce is growing and is gaining experience, while processes become embedded. There are continued pressures; the vaccination programme is necessarily being prioritised and the National Medical Examiner is mindful of its impact on progress during 2021.

As the system matures and scrutiny extends to non-coronial deaths in all settings, the benefits of medical examiners should become more widespread, and contribute substantial improvements to patient care and outcomes, as well as providing safeguarding and assurance for members of the public.

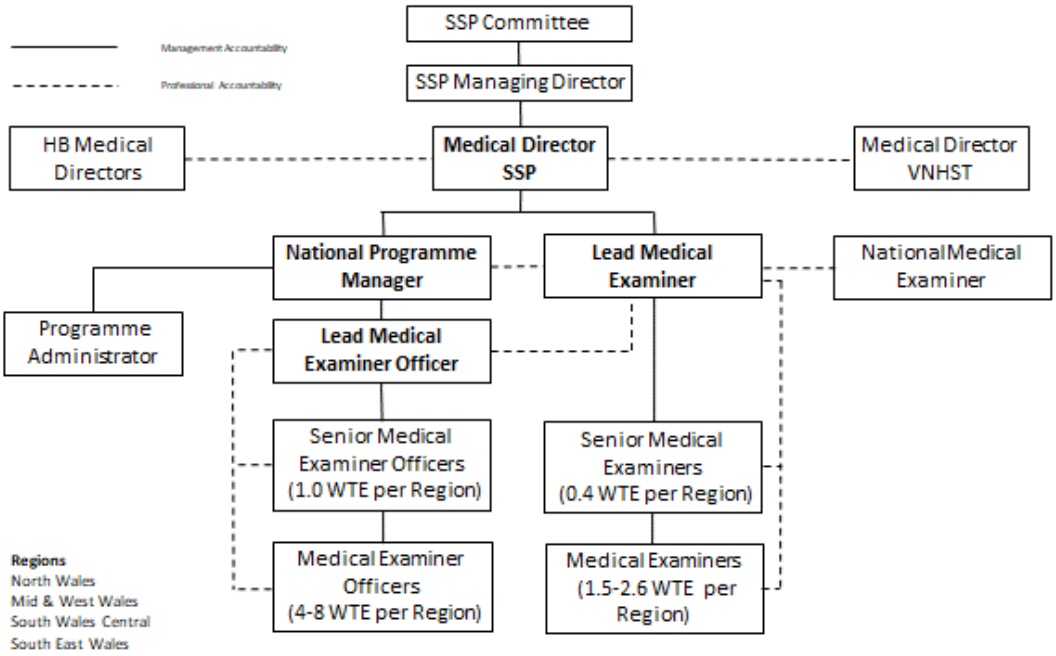
Example of medical examiner impact: A doctor completing an MCCD consulted the medical examiner about cause of a death. The patient, a young male with past medical history including cerebral palsy, learning difficulties and epilepsy, died after rapid deterioration following admission, despite maximum treatment. The medical examiner found the patient's disabilities arose from errors and complications during delivery, which the doctor completing the MCCD had not identified. The medical examiner notified the coroner of the death, also escalating to governance teams for mortality review.

Annex: Governance and structures

Governance structure (England)



Governance structure (Wales)



NME national and regional structures in England and Wales

Dr Alan Fletcher
National Medical Examiner (0.6 FTE)

Nick Day
Policy and Programme Lead, Medical Examiner System

Helen Hill
Office Co-ordinator for National Medical Examiner

Rajiv Prinja
Finance Systems Analyst

Regional Medical Examiners (0.4 FTE):
East of England – Ellen Makings
London – Mette Rodgers
Midlands – Ben Lobo
North East and Yorkshire – Graham Cooper
North West – Huw Twamley
South East – Zoe Hemsley
South West – Golda Shelley-Fraser

Regional Medical Examiner Officers (0.4 FTE):
East of England – Siobhan Costello
London – Laura O'Donoghue
Midlands – Siobhan Costello
North East and Yorkshire – Debbie Peacock
North West – Margaret Butler
South East – Amanda Dooley
South West – Becky Protopsaltis

North Wales Region

Mid/West Wales Region

South Wales Central Region

South Wales East Region

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

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