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National Medical Examiner's report 2021

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Contents

Foreword

Medical examiner offices have made impressive progress in 2021, building on the solid foundation laid in 2020; despite the inevitable impact and challenges of the coronavirus pandemic.

Throughout 2021, medical examiners continued to receive positive feedback from bereaved people: they said they appreciated being given the opportunity to have a voice in the processes after a death and knowing any concerns were listened to.

We now have two significant areas of focus.

First, medical examiner offices and all healthcare providers need to establish processes so that all non-coronial deaths receive independent scrutiny, not just those that occur in acute hospitals. This is a complex task, and I avoided setting arbitrary deadlines while the NHS responded to the pandemic. I also want to use the non-statutory phase to get implementation right. It is critical that all medical examiner offices fully implement the three elements of scrutiny set out in my good practice guidelines: proportionate review of relevant medical records; reviewing the proposed causes of death and whether the coroner needs to be notified with the doctor completing the medical certificate of cause of death; and asking the bereaved whether they have questions about the cause of death or concerns about the care before death.

Second, Royal Assent for the Health and Care Bill clears the way for the medical examiner system to become a statutory part of death certification processes.

We must be ready to enable all bereaved people to benefit from independent scrutiny of non-coronial deaths, and support the NHS and beyond to learn from our scrutiny and improve the quality of care.

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 2021.

Medical examiners are senior doctors who, in the period before a death is registered (five days), provide independent scrutiny of the causes of death. Quarterly reporting submissions from medical examiner offices in England and reports from Wales evidence that the medical examiner system provides what is needed and is well received by the public and stakeholders.

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, supplied by medical examiner offices in England and Wales.

Inevitably, progress in 2021 continued to be impacted by the coronavirus pandemic and the need for healthcare systems to prioritise frontline care for patients. Nevertheless, the dedication of medical examiners and medical examiner officers ensured that significant milestones were achieved.

“The daughter was really grateful for our input and explanations as she had misunderstood what the doctors had told her. She said the service was fantastic and she felt more at ease knowing the whole story. She wished it had been around when her dad died as she had many questions about that.”
Medical examiner officer

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 programme; 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 remains a member. Dr Fletcher 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 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, and is a key element of the quality and patient safety agenda in Wales, making an important contribution to the long-established mortality review programme.

Medical examiner offices operate in acute trusts in England and at regional hubs in Wales, and initially provided scrutiny of non-coronial deaths in acute care. The next phases of implementation are continuing to extend independent scrutiny to non-coronial deaths in all healthcare settings, and to prepare for the statutory system.

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 where required, to improve services and care for all patients.

Example of medical examiner impact
"Consultants feel supported in being able to discuss complex cases with another senior doctor, this in turn reassures junior doctors on correct causes of death when asked to issue a MCCD."
Senior bereavement officer

Implementation

Despite challenges the NHS faced from continued waves of COVID-19, medical examiners passed significant milestones in England and Wales in 2021.

In Wales, the service is being implemented by NHS Wales Shared Services Partnership (NWSSP), an independent mutual organisation, owned and directed by NHS Wales. Four hub sites covering all health board areas were established.

All acute trusts in England had established medical examiner offices by June 2021, and that month NHS England and NHS Improvement asked all NHS organisations in England to prepare for medical examiners to provide independent scrutiny of all non-coronial deaths wherever they occur.

"One GP is such an advocate for the medical examiner service that he assisted us in approaching other surgeries in his area. Another GP contacted the medical examiner office asking for assistance with cause of death for one of their patients; the GP is based at a surgery that we do not yet work with, but heard such good things about the service they reached out."
Lead medical examiner officer

In a non-statutory system, it was important to consider the implications of sharing patient records with regards to information governance and data protection. To put the legal basis for medical examiner scrutiny of all patient records in England beyond any

doubt, the National Medical Examiner's team made a submission to the Confidentiality Advisory Group. The application was supported, which enabled health and care organisations in England to share confidential patient information for the purpose of the medical examiner programme in the non-statutory phase. This additional assurance was not required in Wales due to its different healthcare infrastructure and medical examiner service delivery model.

In addition, the National Medical Examiner's team launched an online workspace for medical examiners, providing a range of materials to support their work.

> "Really fantastic service ..has improved the service we can provide to bereaved relatives in ED…"
>
> "greater scrutiny of cause of death helps grieving families…"
>
> "the single most important improvement to how we think about our patients and how the organisation provides governance around death and dying."
> **NHS staff responses to medical examiner office survey**

Medical examiner offices in England continued to provide quarterly reports, with positive feedback from members of the public. Feedback in Wales also reflected the supportive views of bereaved people. Medical examiners in England and Wales continued to report that they were developing good working relationships with coroners and register offices.

Deaths of health and social care workers with COVID-19

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 died after contracting COVID-19. This involved medical examiners considering whether there was reason to suspect the death was a result of the person being exposed to COVID-19 at work, ensuring coroners were notified of relevant deaths, and reporting their conclusions to the National Medical Examiner's office. Where appropriate, employers were asked to consider whether this would give rise to an obligation under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) to report to the Health and Safety Executive. Medical examiners carried out this work with sensitivity and professionalism. This additional programme was concluded in April 2022.

In Wales, separate processes that did not involve medical examiners were in place to support employers in discharging their obligations under the RIDDOR requirements.

Guidance and publications

The National Medical Examiner's good practice guidelines, published in January 2020, remains the core document setting out requirements for medical examiner offices. Further guidance and resources to help organisations establish medical examiner offices and to support medical examiners in their roles were added to the National Medical Examiner's webpage during 2021.

Example of medical examiner impact
"One health board collated findings from mortality reviews of cases referred from the medical examiner service and established a new framework for quality improvement in end-of-life care across the entire acute sector."
Lead medical examiner

National medical examiner updates

Regular update bulletins providing information and news for medical examiners and stakeholders continued in 2021, with distribution growing to about 2,000 individuals in a range of stakeholders.

National Medical Examiner's good practice series

In partnership with subject-matter experts and key stakeholders, the National Medical Examiner produces brief good practice papers, published by the Royal College of Pathologists. These provide focused information for medical examiners on topical matters, and are designed to be easily digested by busy frontline staff, with links to further reading, guidance and support.

The National Medical Examiner produced four in 2021:

- support for people of Black, Asian and minority ethnic heritage
- urgent release of a body
- learning disability and autism
- organ and tissue donation.

The next topics include post-mortem examinations and deaths of children. Further guidance is planned to include mental health and eating disorders; anti-microbial resistance; homelessness; and dementia.

Training

The Royal College of Pathologists leads the delivery of training for medical examiners and medical examiner officers in England and Wales.

At the start of 2021, 870 medical examiners had completed face-to-face medical examiner training. The college continued virtual training in 2021; by the end of the year, 1,427 senior doctors had completed medical examiner training, and 330 staff had completed medical examiner officer training. The college is continuing to provide training programmes through 2022, adding to the available workforce.

In the second half of 2021, the college also worked with the Judicial College to develop joint training for coroners and medical examiners. This started in January 2022, and is being delivered on a regional basis to enable coroners and medical examiners who work together in regions to develop stronger links and understanding of each other's roles.

Example of medical examiner impact
"Three of four trust quality priorities came directly from medical examiner reviews and discussion with relatives. Quality improvement projects led to a new fluid management chart and fluid balance app, and piloting a "Difficult to cannulate" team and flowchart. We have seen a reduction in patient safety incidents as a result."
Chief medical officer, acute trust

Stakeholders

The National Medical Examiner devoted significant time to maintaining relationships with the range of national stakeholders with an interest in death certification processes: from government departments with responsibilities in death certification, such as DHSC; the Home Office (General Register Office); Ministry of Justice; the Welsh government; others with statutory responsibilities, such as the Chief Coroner; and leaders of faith communities. These groups continue to be active in shaping the implementation of medical examiners.

> "Our referral numbers have dropped dramatically. The excellent scrutiny forms and input from medical examiners enable us to work with families better. This is a value-added element at our end but also for the hospital. (In some cases) we have avoided an inquest and saved a lot of clinician time. I have the highest regard and utmost praise for the medical examiner system and the benefits it has brought."
> **HM Senior Coroner**

The Lead Medical Examiner and Lead Medical Examiner Officer in Wales lead on national and local engagement with all relevant stakeholders; for example, through multi-agency implementation boards within health board areas. The all-Wales approach to scrutiny has been tailored to local systems and circumstances, encouraging buy-in to the non-statutory system and alignment with other parts of the healthcare system. In England, lay representatives continue to be active members of on the Implementation and Oversight Group to ensure contributions reflect the interests of patients, the public, families and carers (see Annex).

The National Medical Examiner actively encourages medical examiner offices to engage with the public and lay representatives, and 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.

Increasing the number of non-coronial deaths scrutinised

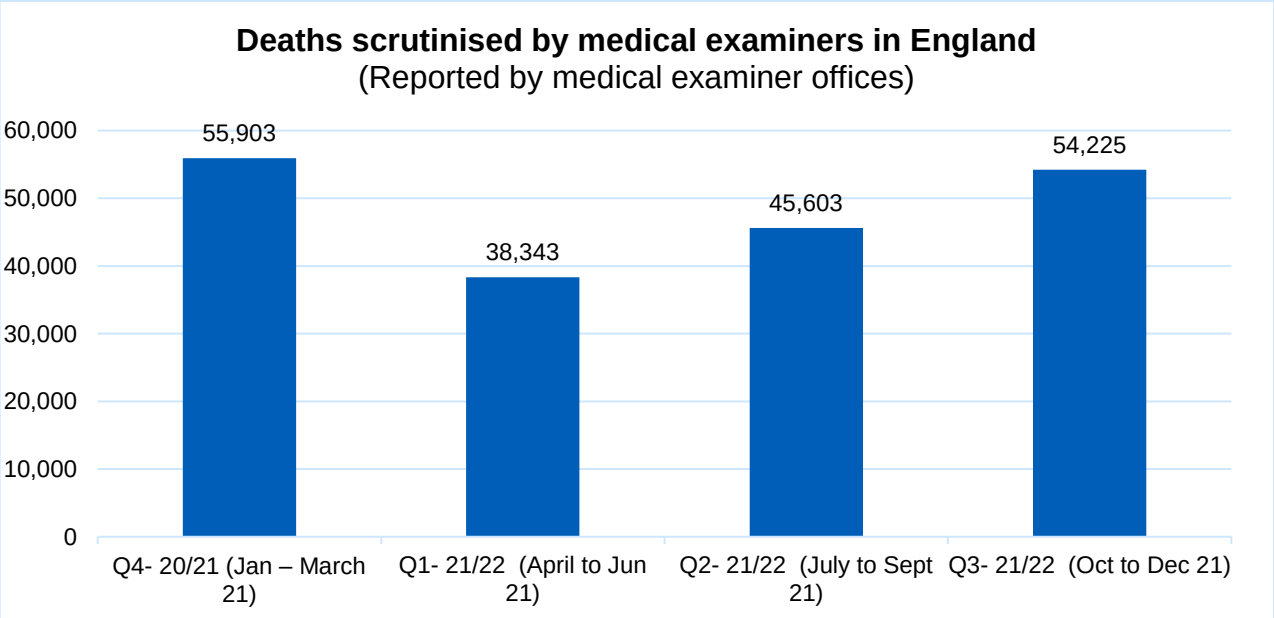
In a typical year in England and Wales, there are approximately 550,000 deaths. A reasonable assumption is that in due course medical examiners may scrutinise up to 490,000 non-coronial deaths each year. About half of these will occur in hospital and half in other settings, meaning at present medical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

Example of medical examiner impact

"Following the death of his wife, a bereaved man was called twice by NHS staff enquiring who verified the death and the location of the body. He had found this very upsetting. The medical examiner officer reported this concern to the CCG, to ensure this did not happen to other bereaved people."

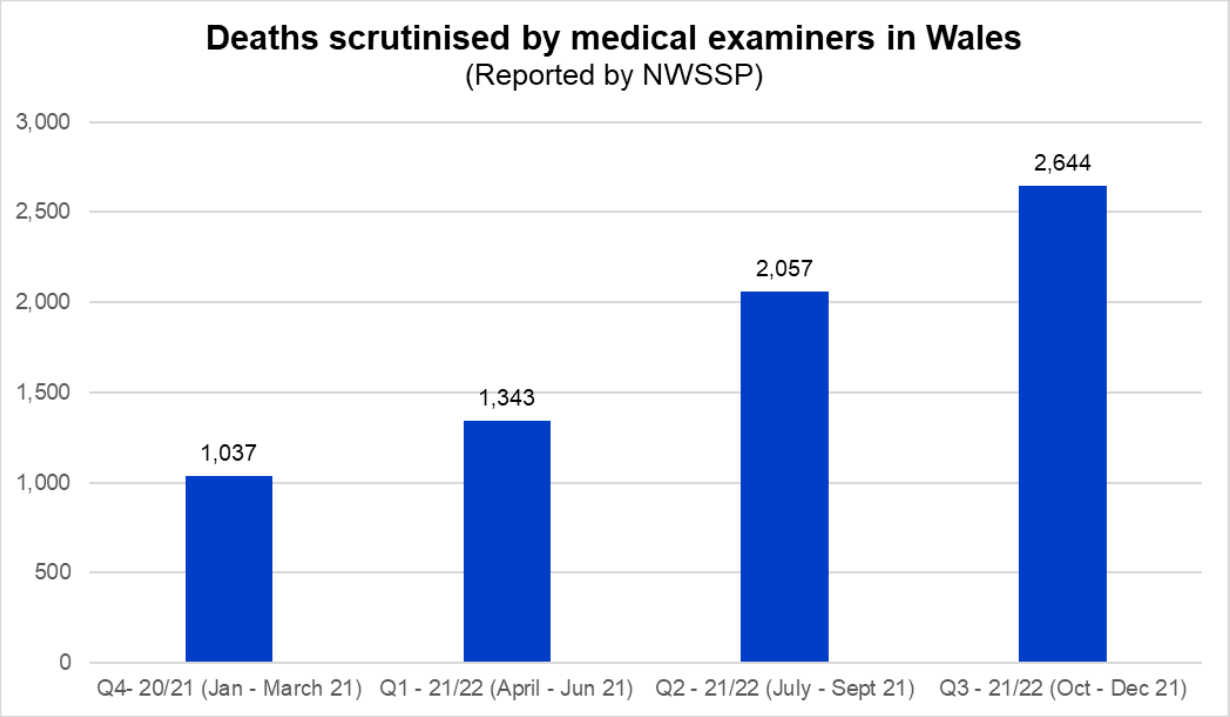
In England, the response to the pandemic constrained the capacity of medical examiner offices to scrutinise deaths in 2021. The number of deaths they scrutinised by quarter also reflects the changing numbers of total deaths through the year; there was a particularly high number during the COVID-19 wave in the first quarter of 2021.

Figure 1: Deaths scrutinised by medical examiners in England in 2021



Similarly in Wales, COVID-19 delayed the implementation of electronic transfer of clinical records from care providers to medical examiners, and also the recruitment of both medical examiners and medical examiner officers. In spite of this, the number of deaths scrutinised continued to grow.

Figure 2: Deaths scrutinised by medical examiners in Wales in 2021



Within this overall growth, the number of deaths scrutinised in Wales increased for both those occurring in the community and hospice sites, and in acute and community hospitals. Smooth operation of the service was facilitated by moving cases between hub offices, to better match demand and capacity on a daily basis. This practice will continue as the service develops during 2022.

Medical examiner offices in England reported they provided independent scrutiny of 194,074 deaths in 2021. Of these, 98.4% were adults and 0.8% were children, with 0.8% not reported. Medical examiners reported that 19.3% of the adult deaths and 56.4% of the child deaths were notified to a coroner after medical examiner scrutiny.[1]

Medical examiners further reported 19,807 deaths were referred for case record review or other clinical governance review because they had concerns about care.

[1] As some medical examiner offices made zero returns in certain fields, there is likely to be some under-reporting in all figures provided.

This represents 10.2% of the 194,074 deaths scrutinised but may be a slight under-representation as some medical examiner offices did not provide a detailed breakdown.

Example of medical examiner impact
"We receive a summary of scrutiny of in-hospital deaths of our patients, which have given us a much-needed insight into admission avoidance as well as supporting our conversations with families. Although it does involve some extra work for the practice, the benefits to us have been significant."
GP practice

The deaths referred for case record review included 3,637 deaths of people with a learning disability or severe mental illness. Medical examiners reported they had notified 498 patient safety incidents as a result of scrutiny.

"My family were left with many questions and a lack of clarity preventing them 'joining the dots' as to how each event contributed to my aunt's demise. You cannot underestimate the impact your unhurried discussion had. It helped them understand how each condition was linked. More importantly, it stopped the natural 'what if...' sequence that relatives often feel as part of their grief. They now feel a sense of closure. Naturally, it does not stop the immense sadness that comes with losing a loved one, but makes huge leaps towards 'healthy grieving.'"
Hospital consultant, writing in a personal capacity

Medical examiner offices reported that for 5,142 cases, urgent release of the body was requested. In 4,536 cases (88%) the body was released within the requested time.

Medical examiners contacted the bereaved in the majority (92.3%) of cases, providing them with an opportunity to ask questions and raise concerns. Giving bereaved people a voice is a fundamental principle of the medical examiner system. This helps prevent circumstances arising where families feel forced to pursue concerns about healthcare. In some limited circumstances, interaction with the bereaved may not take place, such as when there is no response from next of kin (whose participation is entirely voluntary.)

Feedback received by medical examiners in England and Wales

The National Medical Examiner's office began collating information from medical examiners in October 2020. Through quarterly reports, medical examiner offices in England provide information about the feedback they receive. Medical examiners in Wales also provide this information and examples of positive interactions with bereaved people and service improvement after medical examiner scrutiny.

Example of medical examiner impact
"A patient came to hospital very sick and quickly deteriorated. The decision was made to stop treatment after less than 24 hours. Whilst this was appropriate, the family had concerns and felt their mother was not given a chance. The son was very distressed, but after speaking to me and being advised an independent medical examiner had reviewed the care and that the correct decision was made, he became calmer and no longer felt that he needed to make a complaint."
Lead medical examiner

The overwhelming majority of feedback was positive, as illustrated by the few examples included in this report.

- Next of kin and bereaved families appreciate the time, independence and expertise of medical examiners and officers.
- Attending doctors often benefit from medical examiners' support in completing MCCDs accurately, particularly complex cases.
- The evidence continues to mount that medical examiners help prevent potential complaints, by detecting concerns quickly and ensuring action can be taken before a complaint is made.
- Positive feedback has come 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 commonly related to bedding-in issues during implementation, or wider issues due to the pandemic and therefore beyond medical examiners' control.

Example of medical examiner impact
"A cluster of deaths associated with an invasive procedure was identified and escalated. Although this is a recognised complication of the procedure, the number of deaths over a short period was considered to be higher than expected, therefore the procedure was suspended while the trust investigated."

While reporting in England is not yet formalised, and not yet provided through the medical examiner case management system DHSC has commissioned from NHS Business Services Authority (NHSBSA), it is starting to provide information about trends and issues medical examiners are identifying. A new process for regional medical examiners to provide summary updates was implemented in England from July 2021. Reflecting this increase in business-as-usual reporting in England, the Implementation Group terms of reference were updated, and the group re-badged the Implementation and Oversight Group.

In Wales, NWSSP reports progress to the Medical Examiner Programme Board. Reports include a summary of medical examiner activity, workforce and recruitment, and links to clinical governance. As in England, there is a continuing focus on recruiting the workforce so that there is the capacity to provide scrutiny of all non-coronial deaths.

Themes or patterns identified by medical examiners generally required action at provider, local or system-level. Common issues included:

- hydration
- failure to respond to infections in a timely manner
- end-of-life care pathways, particularly in supporting people of minority ethnic heritage and avoiding unnecessary admissions
- patients presenting late and with serious conditions, often due to hesitancy about seeking help during the pandemic
- an increase in hospital-acquired COVID-19 deaths.

One medical examiner office identified a cluster of orthopaedic intra- and post-operative deaths following bone cementing, and reported this to the Coroner. Other issues raised at local levels concerned a wide range of matters, such as an increase in deaths from thrombotic causes such as myocardial infarction and stroke; clot disease, mainly VTE; and medicines management.

It is recognised that more needs to be done to capture wider themes and learning. This is dependent on medical examiners scrutinising all non-coronial deaths, which will be achieved as the system expands and the case management system commissioned by DHSC is established.

Next steps

Case management system and digital MCCD

The NHSBSA started rolling out the medical examiner case management system in England in January 2022, and will continue to develop the system in response to user feedback and experience. In Wales, a case management system is used to record all three components of the scrutiny process, and generates reports and information. In addition, NWSSP reports progress and activity to the Medical Examiner Programme Board in Wales.

NHSBSA has also been commissioned to deliver the digital MCCD for England and Wales, and is seeking opportunities to make this compatible with the case management system. The intention is for both digital products to be available when the medical examiner system becomes statutory.

Example of medical examiner impact
"We picked up a theme around medicines management, in particular errors in prescribing and monitoring of anticoagulation, contributing to death. Through our bi-monthly steering group meetings, attended by an LMC representative and head of patient safety for the CCG, we fed this back and have agreed next steps."
Lead medical examiner

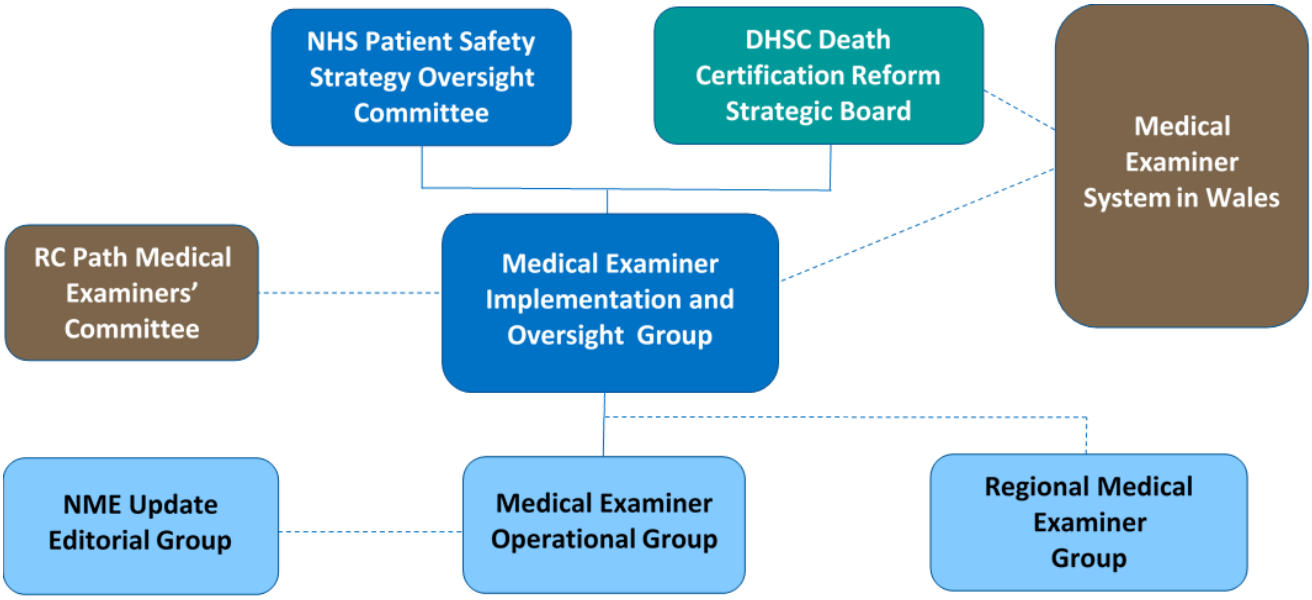
Statutory system

The Health and Care Bill completed its progress through Parliament and received Royal Assent without amendment to the clause for medical examiners.

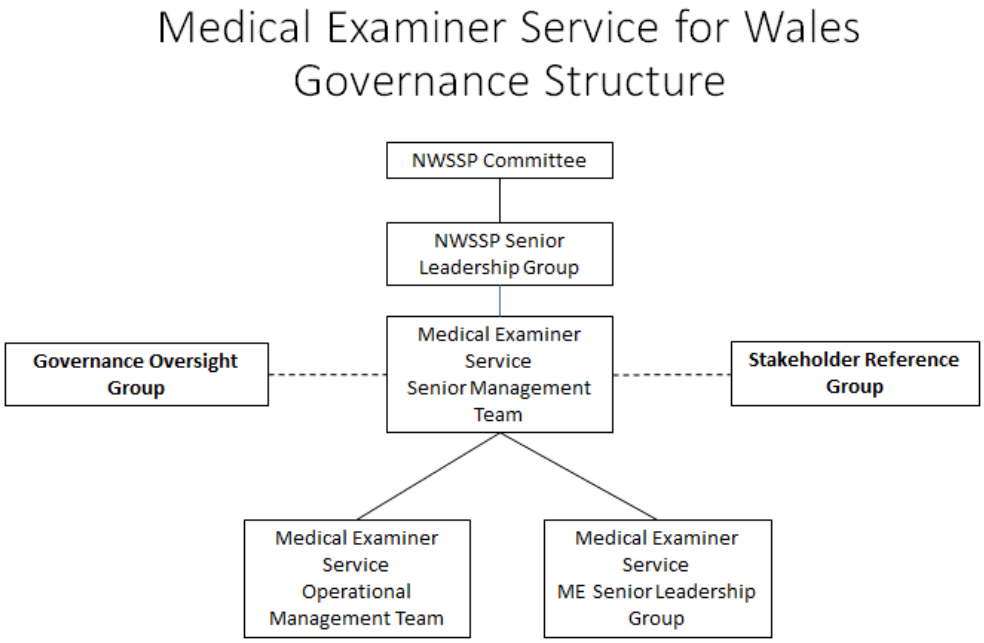
The National Medical Examiner is confident that benefits of the medical examiner system, which are already being realised, will become more and more evident. Besides providing early warning of issues in healthcare, and a route for early resolution of concerns raised by bereaved families, medical examiners will continue to provide opportunities for learning and improvement of the care for patients in future years.

Annex: Governance and structures

Governance structure (England)



Governance structure (Wales)



NME national and regional structures in England and Wales

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