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National Medical Examiner's report 2022

17 May 2023

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Foreword

I am proud of the support that medical examiners and officers provide to bereaved people in England and Wales, and the benefits that independent scrutiny is starting to deliver in terms of learning and improving the quality of care.

Inevitably, the impact of the pandemic has continued to present challenges, and it is the dedication of medical examiners and officers that has ensured further extension of medical examiner scrutiny in England and Wales in 2022. This report summarises that progress.

Since the programme commenced in 2019, medical examiners have provided independent scrutiny of more than half a million deaths in England and Wales, and this is accelerating. More than 250,000 of these deaths were in 2022.

As the recent ministerial statement makes clear, all healthcare providers need to work in partnership to enable bereaved people to benefit from independent scrutiny of deaths of their loved ones. This work is gaining momentum, but achieving full rollout is a complex task and, in many areas, more progress is required in coming months to ensure everything is in place. Looking back across the last year, in May 2022, royal assent for the Health and Care Act paved the way for the statutory medical examiner system. No-one can be satisfied when we reflect that this has taken decades. However, let us be encouraged that the finishing line is now firmly in view.

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 2022.

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.

The national medical examiner system

The national medical examiner system is a key component of the Department of Health and Social Care's (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 England at (mainly) acute NHS trusts and at regional hubs in Wales and provide scrutiny of non-coronial deaths in acute care. During 2022 increasing focus was given to extending independent scrutiny to non-coronial deaths in all healthcare settings, and continuation of preparation for the statutory system from April 2024.

> Lots of people thank us and say "we hope you help stop things like this happening again."
>
> Medical examiner office

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 cover all health board areas and there is now a complete workforce which is being shaped to cater for the growing needs of the service. Key relationships with external stakeholders were established in 2022, and offices have made a positive start to scrutiny of deaths in non-acute healthcare settings.

A core part of the medical examiner role is to provide bereaved people with clear information about the cause of death, and to give them a voice by offering an opportunity to ask questions and raise any concerns they may have about the care and treatment the deceased person received. 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.

> "The medical examiner officer was pivotal in providing details of the out of hours pathway for obtaining a MCCD. The medical examiner and on-call doctors were very prompt in ensuring that required paperwork was ready to expedite a faith-based funeral. Getting this paperwork facilitated a prompt funeral the day after my father died, and this was really important to us in our Muslim tradition. These professionals' diligence provided us with a lot of relief during a very difficult time."
>
> A bereaved family member

Implementation and statutory medical examiner system

A key foundation for the forthcoming statutory system was laid by the Health and Care Act 2022, and in July 2022 NHS England wrote to all NHS organisations in England asking them to prepare for the statutory medical examiner system,. A ministerial statement in April 2023 sets out the pathway towards implementing the full statutory medical examiner system, from April 2024.

In a non-statutory period, it was important to provide certainty about the basis for sharing patient records and to implement appropriate information governance and data protection measures. 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 in 2021. Our application was supported, which enabled health and care organisations in England to share records of deceased patients for the purpose of the medical examiner scrutiny in the period before medical examiners become a statutory function. This additional assurance has not been required in Wales in the non-statutory period due to its different healthcare infrastructure and medical examiner service delivery model.

> "The medical examiner system has had a very positive impact for patients, families and professionals. As an acute response team GP, we were able to provide MCCDs for patients who we had seen, but whose GPs had not seen them prior to death. Joining daily processing, clinical guidance and learning has been a breath of fresh air, given system-wide pressures and pandemic fatigue. The clinician and administrative teams are very helpful and considerate and a credit to our leadership, who are facilitating learning themes from deaths in the area."
>
> From a GP

Sharing electronic patient records in England

NHS systems use a range of IT products to share patient records, making it challenging for medical examiner offices and other healthcare providers in England to identify a practical approach to doing this. Among the materials to support medical

examiner offices, the NME's team collated the practical approaches medical examiner offices and healthcare organisations are using to share records of deceased patients for scrutiny.

Towards the end of 2022, work started on a national solution for areas that had yet to make progress, supported by the NHS e-Referral Service. This system enables GP practices to alert medical examiner offices of newly deceased patients through a well-established web service and share patient records for scrutiny. It also enables GP practices and medical examiner offices to track progress of cases.

Case management system and digital MCCD

DHSC commissioned NHS Business Services Authority (NHSBSA) to develop the medical examiner case management system in England. It is a bespoke system which is being built specifically for the programme. After a period of testing and review, NHSBSA is preparing for milestone reviews to enable further testing and rollout.

In Wales, a case management system is used to record all three components of the scrutiny process and generate reports and information. In addition, NWSSP reports progress and activity to the Medical Examiner Programme Board in Wales.

DHSC has also commissioned NHSBSA to deliver the digital MCCD for England and Wales and is currently working with specialist user groups to shape this product.

> "Heartfelt thank you to medical examiner team for two cases recently where there was some concern following the deaths. You organised the coroner notification without the need for me to chase people, and I have been able to send a referral to the relevant Safeguarding Adults Board. I would not have been aware of either of these cases if you had not raised them with us. Your work is very much appreciated, thank you."
>
> Funeral director

Reporting

The National Medical Examiner's team began collating information from medical examiners in England in October 2020. In addition to quarterly submissions of activity and outcomes in England, NWSSP collates reports from Wales. In both nations,

feedback from bereaved people and stakeholders is also collated. The issues medical examiners identify help inform improvements in care and health systems.

Expanding medical examiner scrutiny

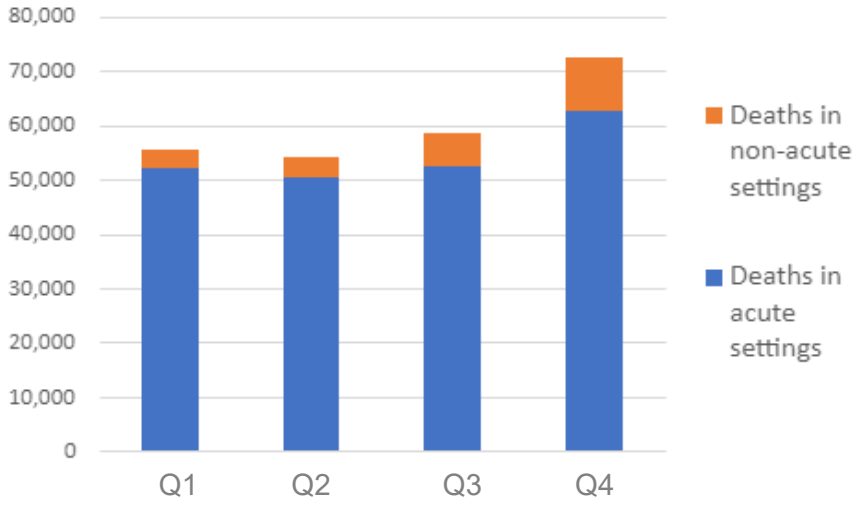
In a typical year in England and Wales, there are about 550,000 deaths and it is estimated about 60,000 deaths are notified directly to a coroner without medical examiner scrutiny. Therefore, a reasonable assumption is that – in a typical year without excess deaths – medical examiners may scrutinise about 490,000 non-coronial deaths each year. About half of these occur in hospital and half in other settings.

In England, there was a marked increase in the number of deaths scrutinised through the year, and encouraging signs that rollout to the community was gathering pace (Figure 1). However, several medical examiner offices highlighted that a minority of GP practices had not engaged with the medical examiner process, and this was limiting rollout to the community.

In 2022, medical examiner offices in England reported independent scrutiny of 240,562 deaths. Of these, 20,050 deaths (8%) were notified to a coroner after medical examiner scrutiny, and 24,095 deaths (10%) were referred for case record review or other clinical governance review. This represents approximately 10% of the deaths scrutinised. Of the deaths referred for case record review, 2,337 were deaths of people with a learning disability or severe mental illness. Medical examiners in England reported they had identified 2,267 patient safety incidents.

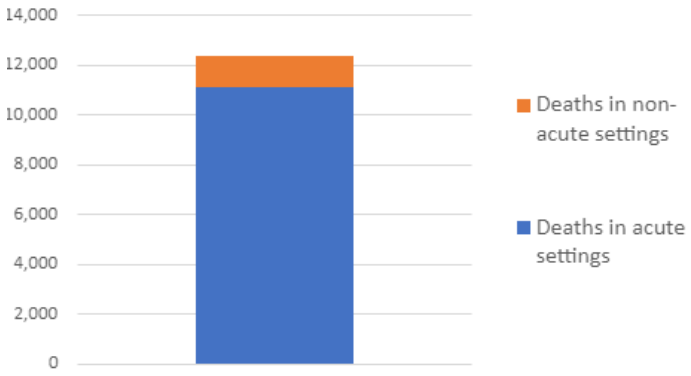
Medical examiner offices in England reported that, urgent release of the body was requested in 5,290 cases, and that in 4,582 of these cases (87%) the body was released within the requested time.

Figure 1: Number of deaths scrutinised by medical examiners in non-acute and acute settings by quarter in England in 2022



Similarly in Wales, with more medical examiners and officers appointed, the number of deaths scrutinised grew in 2022 in both acute and non-acute settings. Smooth operation of the service was facilitated by moving cases between regional hub offices, to better match local demand and capacity across Wales.

Figure 2: Number of deaths scrutinised by medical examiners in Wales in non-acute and acute settings in 2022.



Medical examiners and officers gave bereaved people the chance to ask questions and raise concerns in the overwhelming majority of cases. In England, there was no interaction with the next of kin in only 14,484 cases (6%). Of course, participation by bereaved people is entirely voluntary, and in some limited circumstances, interaction with the bereaved may not take place, for example when there is no response. The

national medical examiner and regional medical examiners continue to monitor this important function.

Medical examiners in England and Wales continued to report they had good working relationships with coroners and register offices.

> "It is hugely positive to have a call to explain cause of death and to ask about the care a loved one received. It will help people to have an opportunity to talk about the experience and the care away from hospital. I hope this is a service that will be rolled out nationwide. I cannot praise and thank the staff highly enough for their care and kindness to us and to my cousin. Even though she was 100, and had lived a full and eventful life, they treated her with dignity and as an individual not just a number. "
>
> Bereaved family member

Deaths of health and social care workers with COVID-19

In England, the process for medical examiners to review deaths of health and adult social care staff who died with COVID-19 was concluded. This discreet process differed from normal medical examiner scrutiny, particularly in that most reviews were retrospective in terms of usual timeframes.

The key question medical examiners considered was whether there was reason to suspect the health or care worker may have acquired COVID-19 through employment. Medical examiners were not asked to determine that COVID-19 was definitely acquired through employment, nor whether the infection was avoidable. Medical examiners ensured that appropriate notifications to coroners had been made, and that employers had an opportunity to consider whether they had a responsibility to report the death to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

Medical examiners were notified of the deaths of 401 colleagues with COVID-19 that NHS organisations had registered with NHS England's Central Patient Notification System, and of the deaths of 105 social care workers that NHS England had been notified of via DHSC.

By the time the process concluded, medical examiners had reviewed 474 deaths, and found reason to suspect the person had been exposed to COVID-19 at work in 357 of these. Regional medical examiners wrote to the employers of those individuals so they could consider whether they had an obligation under RIDDOR to report the death to the Health and Safety Executive. In addition, medical examiners reported that 347 deaths had been notified to the coroner, and the coroner was either investigating or considering investigation.

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

> A senior coroner shared a referral from a medical examiner with a group of lead medical examiners and the regional medical examiner, passing on her thanks that all the salient information was available in the referral, allowing her to issue 100A in a case that would ordinarily see a lot of to and fro with the hospital to gather the information available.

Medical examiner scrutiny

Most of the issues that medical examiners identify will be considered and addressed at local level through existing clinical governance arrangements. While reporting in England at a national level continues to evolve, it also provides information about trends and issues that medical examiners are identifying. Medical examiners will also help to ensure causes of death are recorded more accurately on death certificates, which will support improvements in healthcare research, for example, led by the Office for National Statistics.

In Wales, NWSSP reports to the Medical Examiner Programme Board. Reports include a summary of medical examiner activity, workforce and recruitment, and links to clinical governance. There is now a complete workforce which is being shaped to cater for the growing needs of the service, and so focus continues to ensure that an ‘at capacity’ quota of medical examiners and medical examiner officers are maintained. to provide scrutiny for all deaths.

Common themes or patterns identified by medical examiners that generally required action at provider, local or system level included:

- Deaths related to sepsis, and in the winter period, high numbers of deaths linked to COVID-19 and influenza.
- Difficulties achieving timely MCCD completion, often as a result of post-pandemic pressures, along with reversion to standard death certification processes after the emergency Coronavirus Act measures ended in March 2022.
- Deficiencies in end-of-life care in the community, resulting in inappropriate admissions.
- Staff vacancies, sickness and absence, including of junior doctors impacting service delivery.
- Deaths featuring delays in care have been highlighted across a number of medical examiner offices.

Further steps are being taken to link intelligence from medical examiners to other national quality and surveillance processes in order to deliver ongoing service improvement and feedback.

Feedback and stakeholder engagement

Feedback received by medical examiners

Feedback from bereaved families and stakeholders in England and Wales is overwhelmingly positive, as shown by examples throughout this report. Bereaved families appreciate the independence and expertise of medical examiner teams and the time they take to discuss concerns with them. Doctors completing MCCDs often benefit from medical examiners' support to ensure causes of death are recorded accurately, particularly where cases are complex. Medical examiners can help prevent complaints, by understanding concerns quickly and taking action before a person feels the need to start a formal process. Stakeholders such as coroners and registrars find the involvement of medical examiners improves the accuracy of notifications and MCCDs. By helping to ensure causes of death are recorded more accurately, medical examiners reduce problems for bereaved people, for example when registrars reject MCCDs. More accurate MCCDs support healthcare research which relies on causes of death recorded in death certificates.

> "The medical examiner service is invaluable and the medical examiner officers are always very helpful."
>
> NHS trust senior consultant

The relatively small number of concerns expressed in feedback often related to issues beyond the remit of medical examiners, such as delays in care and administration during post-pandemic recovery of health services. Many medical examiner offices noted an increase in cases where it was difficult to identify an attending doctor to complete the MCCD.

Stakeholders

The National Medical Examiner and his team devote significant time to working in partnership with a range of national stakeholders and this has continued throughout 2022. DHSC leads the Death Certification Reform programme, but the National Medical Examiner also has valued links with other government departments including the General Register Office (Home Office), and Ministry of Justice. Important engagement is carried out with Welsh Government, the Chief Coroner, and leaders of faith communities. Lay representatives on NHS England's Medical Examiner Implementation and Oversight Group provide invaluable insight and challenge from the perspective of patients and their families.

> "It has been great to be involved in setting up the medical examiner service in this area within general practice and you should be proud of this achievement. My experience of it as a practitioner has been wholly positive and I think we should be used as a beacon for areas facing resistance to this. Most importantly it has been valuable for bereaved families and should be our overriding aim."
>
> General Practitioner

Discussions with stakeholders continue to shape the implementation of the medical examiner system, and inform development of policies and guidance, such as good practice papers. The medical examiner system will continue to evolve, learning from an increasing body of experience, and ensuring the NHS system is prepared for the new statutory process. Evidence of this learning and evolving process can already be noted when reflecting on the difficulties caused at the end of the Coronavirus Act when doctors were unavailable to complete MCCD's, particularly in the community, and the way that the medical examiners stepped in to support the process to enable service continuation.

In Wales, the Lead Medical Examiner and Lead Medical Examiner Officer lead the service and oversee national and local engagement with all relevant stakeholders. The all-Wales approach to scrutiny has been tailored to local systems and circumstances, encouraging buy-in during the non-statutory period, and alignment with the healthcare and death certification systems.

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 health services such as mortuary and bereavement services.

> Another service stated that as a result of their family discussions they have been able to arrange meetings for families with clinical teams, to address their concerns in greater detail. Families found this to be of great value, enabling them to start their grieving process.
>
> Medical examiner office

Resources and guidance

The National Medical Examiner's team launched an online workspace for medical examiners, providing a range of materials to support rollout to other healthcare settings.

The National Medical Examiner's good practice guidelines, published in January 2020, remains the core document setting out requirements for medical examiner offices and this resource continues to grow as we near statutory footings. Further guidance and resources to help organisations establish medical examiner offices and to support scrutiny in the community can be found on the National Medical Examiner's webpage, this has continued to be updated during 2022.

> "Visiting doctors like coming to complete an MCCD - they find it educational, supportive and a safe space to share their experiences."
>
> Medical examiner office

National medical examiner updates

Regular update bulletins providing information and news for medical examiners and stakeholders continued through 2022, with distribution growing to 2,300 individuals representing a range of stakeholders.

National Medical Examiner's good practice series

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

The National Medical Examiner produced five papers in 2022:

- post mortem examinations
- child deaths
- mental health and eating disorders

- out of hours arrangements
- recording antimicrobial resistance on the Medical Certificate Cause of Death.

A paper on homelessness has been published in February 2023, and further guidance is planned on dementia, major incidents and palliative care.

Training

The Royal College of Pathologists leads the delivery of training for medical examiners and medical examiner officers in England and Wales, offering virtual training alongside in-person training sessions.

At the start of 2022, 1,427 medical examiners had completed face-to-face and virtual medical examiner training, and by year end of 2022 this number had risen to 1,800. In addition, 501 staff completed medical examiner officer training.

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 (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.

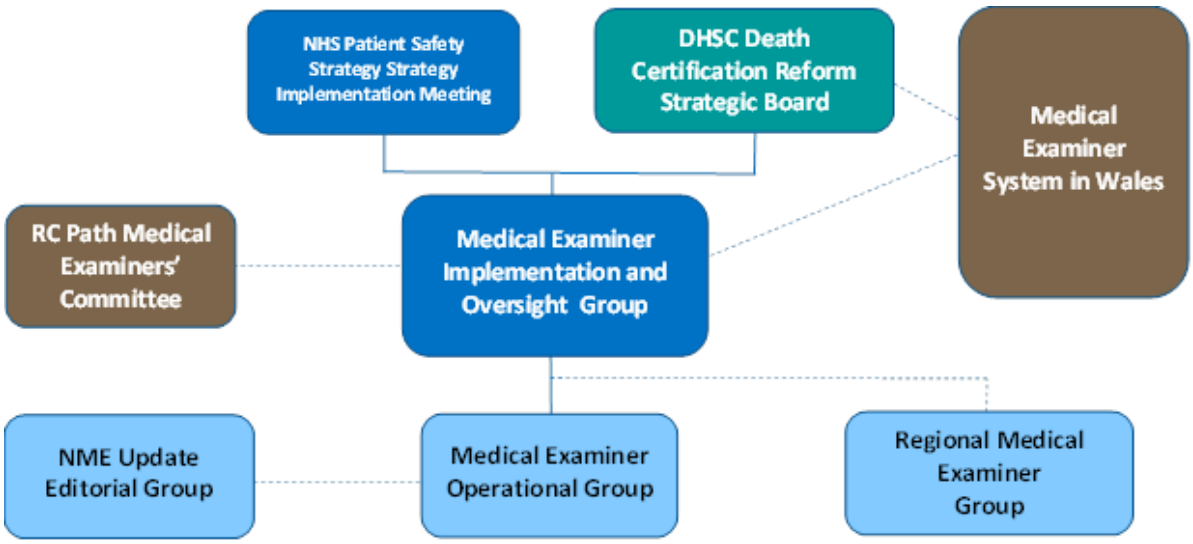
Dr Fletcher is national clinical lead for medical examiner e-learning and is a member of the DHSC's Death Certification Reform Strategic Board. He was chair of the Royal College of Pathologists Medical Examiners Committee from 2015 to 2019 and remains a member. Dr Fletcher maintains his clinical practice as consultant in emergency medicine and general internal medicine at Sheffield Teaching Hospitals NHS Foundation Trust.

"One GP said that they felt reassured that there was independent scrutiny of the MCCD and there was less chance the MCCD would be rejected by the registration service."

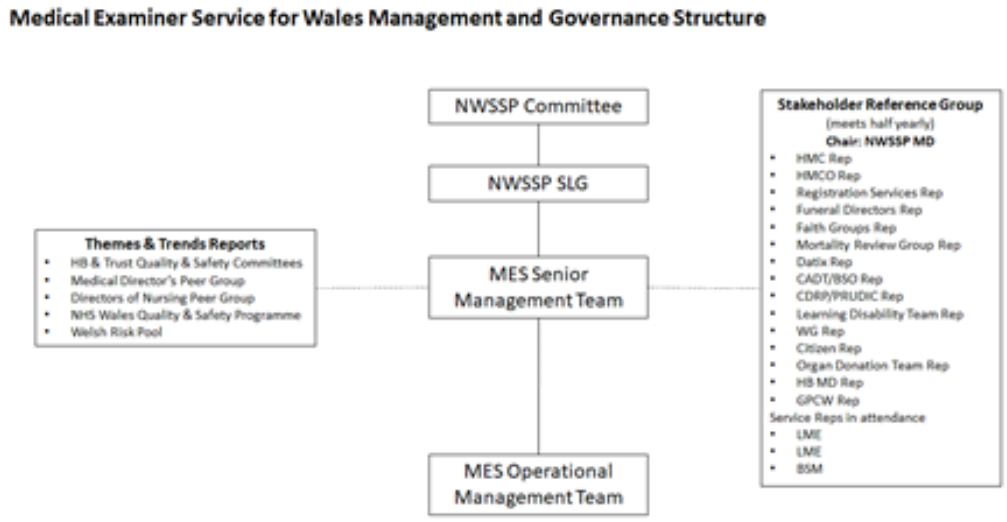
Medical examiner office

Annex: Governance and structures

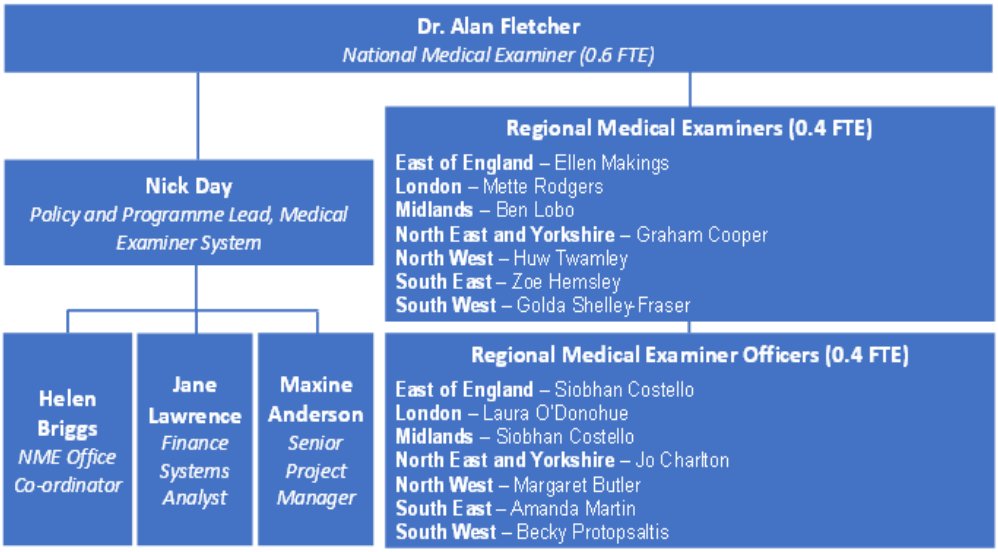
Structure in England and Wales



Governance structure (Wales)



Governance structure (England)



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