

# Pilot of the Department of Health medical examiner

Sheffield was the first pilot site for the Department of Health medical examiner service. The service covers all Sheffield's acute hospitals and a third of its general practices. Since the pilot started in March 2008, the medical examiner has reviewed over 25,000 cases.

Supported by two clinically trained officers (a biomedical scientist and a senior nurse), two medical examiners review all deaths within 24 hours of notification, including those that need to be referred to a coroner. They seek answers to three questions:

1. What did the person die from? (ensuring accuracy of cause of death on the medical certificate)
2. Does this case need to be reported to a coroner? (ensuring timely, accurate referral)
3. Are there any clinical governance concerns? (ensuring the relevant authority is notified).

They do this by following three mandatory steps:

1. proportionate review of medical records
2. interaction with the attending doctor(s)
3. interaction with those who have been bereaved.

Each of these steps is important but the interaction with people who have been bereaved is especially so. For cases not reported to the coroner, contact with bereaved people is made by telephone as soon as possible after the medical certificate is completed. This is done sensitively and is an opportunity to ask them if they have any concerns about the care given and, if they do, consider the need for referral for further investigation.

The medical examiner does not investigate; their role is to detect and pass on – both for individual cases and in a surveillance capacity that includes the opportunity to escalate repeated concerns with the relevant authority.

## Outcomes

The medical examiner office has performed consistent and timely reviews with the views of bereaved people always considered. A recent review of data based on deaths since the pilot started in 2008 found:

- 3,875 cases had been reviewed
- possible adverse harm was detected in 10.5% (n = 405) of all deaths reviewed

- in around half of these cases (n = 217), adverse harm would not have been detected at this early stage but for the medical examiner's involvement
- family concerns were raised in 2.3% of cases (n = 81); these could not have been picked up from the records alone in 26 cases.

## Challenges and solutions

- Overcoming consultants' initial suspicion about someone else independently reviewing their cases.
- Providing a service for urgent release – for example, for faith reasons or transplantation. This was achieved by having an on-call medical examiner and remote secure email.

## Views of a relative

A relative of an 86-year-old woman with advanced cancer who died of pneumonia was concerned about communication on the ward. This concern was referred to the medical examiner office. The relative spoke to a medical examiner and later said: "Thank you for your call earlier, I would like to say that I really appreciated your call. You answered all the questions that I had. You were professional and very sensitive... speaking to you today has reinstated my faith in the system."

## Learning points

- An independent medical examiner can provide a reliable 'filter' for identifying deaths that merit further review.
- This system engages bereaved relatives, and the coroner if needed, at a very early stage.

## Further information

Please contact: **Dr Alan Fletcher**, Lead Medical Examiner, [medical.examiner@live.co.uk](mailto:medical.examiner@live.co.uk)

0300 123 2257 [enquiries@improvement.nhs.uk](mailto:enquiries@improvement.nhs.uk)

[improvement.nhs.uk](http://improvement.nhs.uk)

© NHS Improvement December 2017