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To: • CEOs and MDs at foundation trusts and NHS trusts

- GP practices
- Integrated care boards

cc. • Primary care networks

NHS England Wellington House 133-155 Waterloo Road London SE1 8UG

11 July 2022

Dear colleagues,

## Statutory medical examiner system

This letter sets out what local health systems need to do to prepare for the statutory medical examiner system. Ministers recently <u>announced</u> their intention to work towards this commencing from April 2023, recognising the need for all relevant government departments to be ready and aligned to enable successful implementation.

In <u>June 2021</u> we wrote to NHS organisations asking you to work with local medical examiner offices, to enable medical examiners to start providing independent scrutiny of non-coronial deaths in all healthcare settings. When the statutory medical examiner system commences, the intended requirement is for medical examiners to provide independent scrutiny of all deaths not taken for investigation by a coroner.

Medical examiner offices have been established in all acute NHS trusts. Many have started implementing processes with other healthcare providers, but this work needs to accelerate. All NHS organisations should have processes to facilitate the work of medical examiners in place by 31 March 2023. To do this will require positive engagement across all healthcare systems to overcome practical and logistical challenges.

## **Acute trusts**

Approximately half of deaths take place outside hospital, meaning the workload of medical examiners offices will double when all non-coronial deaths are scrutinised, compared to just those that occur in hospital. Chief executives and medical directors should ensure medical examiner offices based at their trusts have adequate workforce, and ensure they receive support to process patient records from other healthcare providers. Processes must comply with information governance/ data protection requirements, and recognise the need for medical examiner scrutiny to be independent.

## Mental health trusts, community trusts, specialist trusts, and GP practices

Medical examiners provide independent scrutiny of non-coronial deaths across all healthcare settings, and carry out a proportionate review of relevant medical records. All healthcare providers need to develop and implement arrangements to share the records of deceased patients with their local medical examiner office. Many medical examiner offices have already started working with other NHS organisations within their geographical area, and regional medical examiners can provide support where required.

We have been conscious of the need to ensure information governance and data protection requirements are fulfilled. For the period before the statutory system commences, NHS England submitted an application under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2002 ('section 251 support') to process confidential information without consent. The approved application can be found on the Health Research Authority's website (ref: 21/CAG/0032).

When the statutory medical examiner system commences, we expect the provisions to add medical examiners to the list of persons with a right of access to patient records in the Access to Health Records Act 1990.

## Integrated care boards

Integrated care boards will be important facilitators for implementing the statutory system. This should include facilitating efficient processes to enable medical examiners to provide independent scrutiny of the causes of death. Digital transformation leads should facilitate work between healthcare providers to share electronic patient records wherever possible.

Colleagues across the country have already made significant progress implementing the medical examiner system despite pressures arising from the coronavirus pandemic. The <a href="National Medical Examiner's report for 2021">National Medical Examiner's report for 2021</a> provides more information about progress and benefits.

We are now close to facilitating independent scrutiny of all non-coronial deaths, providing significant opportunities to improve care and learning in future years.

Yours sincerely,

**Dr Alan Fletcher**National Medical Examiner

**Dr Aidan Fowler**NHS National Director of
Patient Safety

Professor Sir Steve Powis National Medical Director