Written evidence from the National Medical Examiner

The NHS began work implementing the national medical examiner system in England and Wales during 2019/20 on a non-statutory basis. During this time we have published good practice guidelines for medical examiners, in partnership with stakeholders including the Chief Coroner's office, and the majority of acute providers now host a medical examiner office. There is further information about medical examiners in the annexe to this letter.

A core objective of the medical examiner system is to provide the bereaved with a voice and improve their experience of death certification processes. Close work between medical examiners and coroners is key to achieving this. I have encouraged each medical examiner office to build good working relationships with their coroner, and I am very grateful for the excellent relationships that have already been established in many areas.

I encouraged NHS providers to invite coroners to take part in recruitment panels for medical examiners, and we promoted joint training for medical examiners with coroners. Many coroners and their officers have played an important part in making the establishment of medical examiner offices more straightforward in advance of a statutory medical examiner system.

The Notification of Deaths Regulations guidance, first published in 2019, provides a very good example of the benefits that can be realised through a consistent approach, as long as the national approach is fully implemented. Clear guidance makes it far easier for members of the public to understand the notification requirements, and helps coroners and medical examiners to establish effective ways of working at a local level. As time passes, and the medical examiner system matures, medical examiners are likely to move to new roles and areas, and greater consistency will make such mobility more straightforward.

While respecting completely the independence of individual coroners, I would welcome further work to promote consistent approaches by all coroners' offices, so that when statutory arrangements for medical examiners are put in place, we have already established a seamless service for the bereaved.

11 November 2020

Annexe – the medical examiner system

Medical examiners

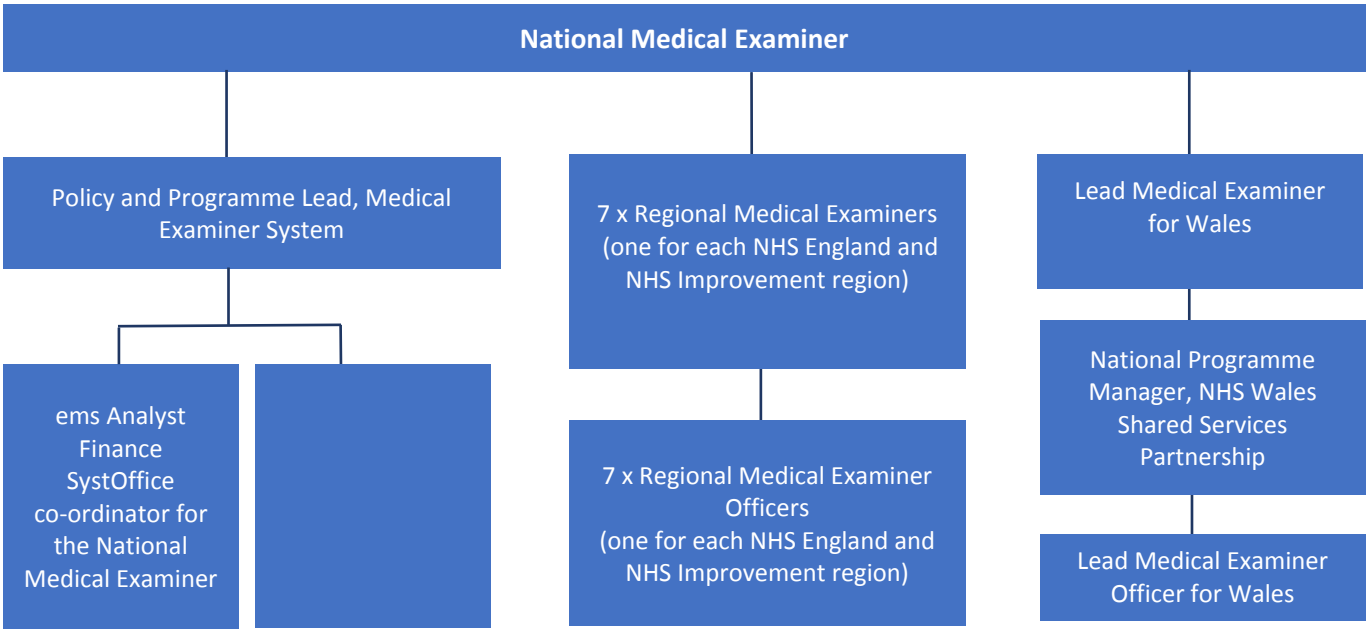
Medical examiners are senior medical doctors contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. Training for medical examiners is coordinated by the Royal College of Pathologists. At 2 September 2020, more than 700 senior doctors have been trained as medical examiners.

There are three components of medical examiner scrutiny: a proportionate review of medical records; reviewing the proposed causes of death and whether the coroner needs to be notified;

and asking the bereaved whether they have questions about the cause or circumstances of death or concerns about the care before death.

The National Medical Examiner

After Dr Alan Fletcher was appointed as the National Medical Examiner for England and Wales in March 2019, the National Medical Examiner's office was established, and appointments made to structures in Wales and all English regions.



Implementing the medical examiner system

Implementing the medical examiner system forms part of work to reform death certification processes, led by the Department of Health and Social Care (DHSC). NHS England and NHS Improvement, DHSC, the Welsh Government and NHS Wales Shared Services Partnership are working together to implement a non-statutory system for non-coronial deaths. During 2019/20, acute trusts in England and local health boards in Wales were asked to start setting up medical examiner offices, initially to provide independent scrutiny of non-coronial deaths that occur in their own organisation. NHS England and NHS Improvement published Good Practice Guidelines for medical examiners in England and Wales in January 2020.

The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate notification of deaths to coroners
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification

- improve the quality of mortality data.

Medical examiners' work with coroners

Part of a medical examiner's role is to provide a medical opinion resource for coroners, but not to act as expert witnesses. The National Medical Examiner expects medical examiner offices to work closely and in partnership with coroners' offices, to ensure smooth implementation of the medical examiner system, and to derive maximum benefit from the new ways of working. Effective communication is of great importance, from medical examiner office to coroner office and vice versa. By jointly building effective ways of working, medical examiner offices and coroners' offices can help minimise inconvenience to the bereaved. Practical opportunities for coroners and medical examiners to improve services include: jointly agreeing effective and efficient processes for notifying deaths appropriately to coroners; timely provision of information to assist coroners in reaching decisions; and swift communication of the coroners' decision regarding whether the Medical Certificate of Cause of Death can be issued. Coroner participation in medical examiner appointments is encouraged, as are regular discussion fora. Before the Coronavirus pandemic, regionally based joint training was intended, led by the Judicial College and the Royal College of Pathologists, with National Medical Examiner endorsement.

Medical examiners and the response to COVID-19

The National Medical Examiner and his team assisted government departments drafting Coronavirus Act 2020 clauses (easements during times of excess deaths) and published guidance for medical practitioners. Many NHS providers found medical examiners greatly assisted their coronavirus response, for example by leading certifying work, releasing other doctors to focus on care for patients. In June 2020 NHS England and NHS Improvement asked acute trusts to recommence medical examiner scrutiny and implementation of medical examiners where it had been paused.

In July 2020, medical examiners were asked to provide independent scrutiny of deaths in England of health service and adult social care workers from COVID-19. The National Medical Examiner's team published guidance for medical examiners to ensure there is a consistent approach. Regional medical examiners are coordinating the work of medical examiners and providing support for this ongoing work.

Further resources:

Death certification reforms: https://www.gov.uk/government/publications/changes-to-the-death-certification-process/an-overview-of-the-death-certification-reforms

National Medical Examiner webpage: https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/

National Medical Examiner's Good Practice Guidelines: https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/#national-medical-examiners-good-practice-guidelines

Royal College of Pathologists' medical examiner information: https://www.rcpath.org/discover-pathology/public-affairs/medical-examiners.html

Coronavirus Act – excess death provisions: information and guidance for medical practitioners: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/COVID-19-Act-excess-death-provisions-info-and-guidance-31-03-20.pdf

Investigating the deaths in England of healthcare and social care workers from COVID-19: https://www.england.nhs.uk/coronavirus/publication/investigating-the-deaths-of-healthcare-and-social-care-workers-who-died-after-contracting-coronavirus/