The Medical Examiners Service Leeds Teaching Hospitals NHS Trust

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Background

- Why was the Medical Examiner System set up?
- How long has it been running for?
- Roll out in secondary care
- What do we do?
- Who is the team?
- Roll out in primary care
- Specific points around Out of Hours Deaths where urgent burial or organ retrieval is needed

Objectives of today's session

- In this session we will cover the changes to the death certification process that are due to be made.
- This will follow on from our recent session about the Medical Examiners Service. We will recap the process of referral to the Medical Examiners, and will troubleshoot any challenges you may have come across.
- By the end of the session we hope:
- You will be confident with understanding the proposed changes to the death certification process
- You understand the referral process to the Medical Examiner
- You will have had an opportunity to ask any questions you may have

THE NEED

Introduction of Medical Examiners is a key recommendation in several high-profile independent enquiries

Why was the Service set up?

- Greater safeguard for the public
- Greater assurance for the bereaved through independent review
- To ensure timeliness of bereavement processes
- To contribute to learning from deaths
- To reduce unnecessary coronial referrals
- To identify trends
- Improve the quality of death certification
- Improve the quality of mortality data.

How long has it been running?

Review of cases by Medical Examiners has been undertaken in hospitals since 2021

This has been gradually rolled out to include all deaths in hospital

What do we do?

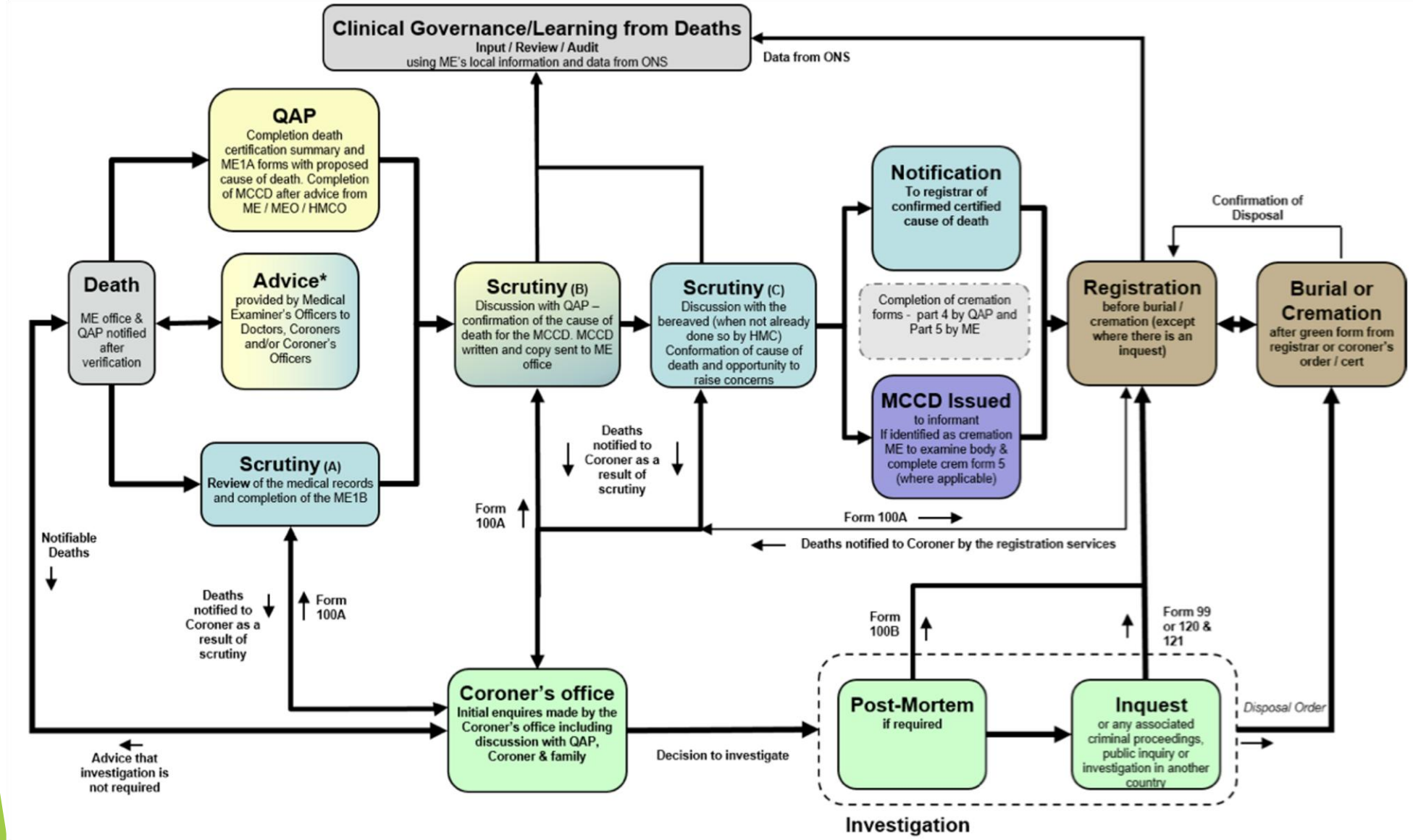
We review non – coronial deaths

We undertake a proportionate review of the patient's notes to ensure that the cause of death is accurate

We discuss the cause of death if required – by telephone or email as per the preference of the doctor who is responsible for the patient

We also discuss the cause of death with the deceased's family and answer questions they have about the death certification process

This has been extended to primary care and will become a legally mandated process in September 2024


Clinical Governance/Learning from Deaths
Input / Review / Audit
using ME's local information and data from ONS
Data from ONS
QAP
Completion death certification summary and ME1A forms with proposed cause of death. Completion of MCCD after advice from ME / MEO / HMCO
Death
ME office & QAP notified after verification
Advice*
provided by Medical Examiner's Officers to Doctors, Coroners and/or Coroner's Officers
Scrutiny (A)
Review of the medical records and completion of the ME1B
Scrutiny (B)
Discussion with QAP – confirmation of the cause of death for the MCCD. MCCD written and copy sent to ME office
Scrutiny (C)
Discussion with the bereaved (when not already done so by HMC) Conformation of cause of death and opportunity to raise concerns
Notification
To registrar of confirmed certified cause of death
Completion of cremation forms - part 4 by QAP and Part 5 by ME
MCCD Issued
to informant
If identified as cremation ME to examine body & complete crem form 5 (where applicable)
Confirmation of Disposal
Registration
before burial / cremation (except where there is an inquest)
Burial or Cremation
after green form from registrar or coroner's order / cert
Deaths notified to Coroner as a result of scrutiny
Form 100A
Form 100A
Deaths notified to Coroner by the registration services
Notifiable Deaths
Deaths notified to Coroner as a result of scrutiny
Form 100A
Form 100B
Form 99 or 120 & 121
Coroner's office
Initial enquires made by the Coroner's office including discussion with QAP, Coroner & family
Post-Mortem
if required
Inquest
or any associated criminal proceedings, public inquiry or investigation in another country
Disposal Order
Advice that investigation is not required
Decision to investigate
Investigation

Independence of the Medical Examiner

- One of the most important aspects of Medical Examiners is our independence
- A medical examiner must always be independent of the case and cannot know, or have treated, the deceased patient on which they are carrying out scrutiny of the circumstances of death.

Who is the team?

There are 18 Medical Examiners (MEs). The team includes GPs, consultant surgeons, anaesthetists, physicians and a consultant in Emergency Medicine.

There are 6 Medical Examiners Officers (MEOs)

The team work together on a rotational basis

We understand the need for representation across multiple specialities and to have GPs involved in the process particularly as it is being rolled out to general practice

Roll out in Primary Care

- We have rolled the process out to primary care with a number of practices already sending cases to us
- As usual coronial cases will go straight to the coroner
- Any other cases should be referred to the Medical Examiner's Office for review
- This is an efficient process and where burial is required urgently for faith reasons, will be expedited further
- Complete the template and send it to the ME office
- We anticipate very few cases where the GP would need to discuss the case further with an ME
- Once reviewed and Cause of Death agreed, the MCCD can be issued

What GPs will need to do

- SystmOne Practices – complete the template on S1, which will then trigger a task. The Medical Examiners will be able to gain access to this and reply with a task.
- EMIS Practices – we will ask for a 3 month summary of the medical notes and the proposed Cause of Death to be sent to us on a form for approval.
- In most cases amendments are unlikely to be needed, so then the MCCD can be completed but not sent to the registrar
- If amendments are suggested by the Medical Examiner we will explain the reason for the recommendations
- It usually doesn't take long for us to respond so there shouldn't be a delay in completing the MCCD.

Specific points around Out of Hours Deaths where urgent burial or organ retrieval is needed

FOR DEATHS IN WHICH AN URGENT MCCD IS REQUIRED WE WILL EXPEDITE THE PROCESS FURTHER

CURRENTLY THE MEDICAL EXAMINERS DO NOT WORK OUT OF HOURS BUT SOON WILL

Changes to the Death Certification Process

- Definition of attending medical practitioner – ANY medical practitioner who has attended the deceased in their lifetime and has knowledge of the cause of death
- Attending practitioner starts the process – the ME Office submits to the registrar
- The ME will need to sign the MCCD
- Ethnicity will be recorded on the MCCD
- Pregnancy will be recorded on the MCCD
- New line 1d
- Medical devices/implants will be recorded on the MCCD

Changes.. continued

- Allowance for an ME MCCD – NEW process

- For deaths reported to the coroner the form 100A will no longer be needed if the coroner decides the death is of natural causes, the case will be passed to the ME for scrutiny
- Registrars will no longer refer cases to the coroner regarding the wording on the MCCD
- The definition of informant is to be widened to include a partner or a representative of the deceased
- There will be a new short version of the MCCD without the Cause of Death, so the informant does not have to disclose the CofD where they do not wish to do so
- The Cremation Form will become obselete

Uncertified deaths

- 2000 a year previously
- 8000 in 2022
- 14,000 in 2023
- Aim to reduce these

- ONS mortality statistics inform Public Health Decisions
- Try to record duration of the illness – useful to determine underlying Cause of Death

Why engage now rather than in September?

- The bereaved are at the heart of this process
- We need a seamless transition for them in September

- We would welcome your feedback and have time over the next few months to address any concerns before it becomes statutory

- It gives the service an opportunity to ensure we have the right level of cover in place so that delays are minimised in September, which will be beneficial for all

Contact us

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