Medical Examiner National Event – London - 25 April 2019

Dr Suzy Lishman, of the Royal College of Pathologists, chaired the medical examiner event in London on 25 April 2019. The event provided updates on the regional structure and the funding model for the medical examiner system as well as including contributions from the Chief Coroner's Office and Board of Deputies of British Jews.

Dr Alan Fletcher, the National Medical Examiner, provided the keynote speech outlining the unique opportunity to deliver a system that will provide for better safeguards for the public, improve the quality of the medical certificate of cause of death and support patient safety across England and Wales. He highlighted that NHS England and NHS Improvement, Department of Health and Social Care (DHSC), NHS Wales Shared Services Partnership and Welsh Government are working collaboratively to deliver the system. In advance of the changes to the law that will fully implement sections relating to medical examiners of the Coroners and Justice Act 2009, Dr Fletcher outlined how the flexibility of a non-statutory process will be used to deliver a system that will provide proportionate scrutiny to all non-coronial deaths. This will be delivered in a phased roll out for all deaths in secondary care by the end of this financial year in March 2020, and for all deaths by the end of March 2021.

Dr Fletcher specifically referred to his commitment to working with coroners, registrars, funeral directors, faith leaders and other partners to ensure the system was fit for purpose and serves the bereaved. He also encouraged those setting up the system locally to work with senior coroners and registrars to appoint those best placed for the role of medical examiner and medical examiner officer.

The local medical examiner system will be supported by a regional structure as well as the national medical examiner. This regional structure will include seven regional lead medical examiners appointed to each of the NHS England and NHS Improvement regional offices along with seven regional lead medical examiner officers. There will be a lead medical examiner and lead medical examiner officer in Wales. The regional structure will ensure leadership and guidance as well as providing the crucial independent professional line of accountability outside of their own organisation where they are employed as a medical examiner or medical examiner officer. Click on the following links to view the adverts for the regional lead medical examiner posts:

- London
- South West
- South East
- North East and Yorkshire
- East of England
- North West
- Midlands

The lead medical examiner post for Wales is also open.

At previous events the medical examiner approach for deaths in hospitals has been discussed, therefore at this event Dr Fletcher focused on the medical examiner approach for deaths which occur outside of hospital in the community. In the non-statutory phase, for deaths in the community, there continues to be a requirement to view the body and to complete relevant cremation forms where the disposal is by means of cremation. The non-statutory model proposed for deaths in the community, was for the qualified attending practitioner to complete cremation form 4 and a second, independent medical practitioner to complete cremation form 5 with the cremation form fees remitted, as it has been historically. But in addition, medical examiners will review records, complete the interaction with the

qualified attending practitioner and with the bereaved, for disposal by means of cremation or burial of non-coroner cases. These activities are the three key elements of medical examiner scrutiny. The medical examiner will not complete cremation form 5 and the fee will not be payable to the medical examiner office. The reimbursement from the DHSC will cover the medical examiner costs in these cases. Dr Fletcher emphasised that this was an interim solution for the non-statutory system, until the changes in the law remove the requirement to view the body for all non-coronial deaths and that NHS England and NHS Improvement and DHSC were talking with the British Medical Association and others on how the new approach would work.

Dr Fletcher referred to the National Medical Examiner bulletin, a regular communication tool including updates as progress is made with the non-statutory and statutory medical examiner systems. The National Medical Examiner also has an email nme@nhs.net and a web page on NHS Improvement's website https://improvement.nhs.uk/resources/establishing-medical-examiner-system-nhs/ . This is in addition to the extensive archive of information from the lead college for medical examiners, the Royal College of Pathologists, which would continue to be a source of information including training material and events. He confirmed that there will be a National Medical Examiner annual report and DHSC had committed to measuring the impact of the medical examiner system on coroners and registrars.

Jeremy Mean, Deputy Director of Health Ethics at DHSC and the Programme Director for the introduction of medical examiners, shared a message of support from the health minister responsible for medical examiners, Caroline Dinenage:

> *'I am greatly encouraged to see progress being made on the introduction of medical examiners and I see scrutinising all deaths as an essential safeguard to help the NHS learn vital lessons.*
> *We must get this right because at the heart of the new medical examiner system are bereaved families in need of answers. In every tragic case, we must ensure families are offered the opportunity to discuss what has happened and ask questions.*
> *With the appointment of a National Medical Examiner, we are another step closer to establishing the new system across England and Wales. But before we make it a legal requirement for medical examiners to scrutinise all non-coronial deaths we have an opportunity to shape the system we want to see.'*

Jeremy Mean set out the Government's financial commitment to the medical examiner programme. At a previous event he made a commitment to further develop the funding model for the non-statutory system and secure additional resource to provide a cost neutral solution to the NHS. For non-coronial deaths which occur in hospitals, a medical examiner would be taking on the role of completing cremation form 5; the current fee for completing this form would need to be paid to the NHS trust hosting the system, rather than directly to a medical practitioner. The fee would follow the work undertaken by the salaried medical examiners. There will need to be some discussion with Funeral Directors regarding billing arrangements during the set-up of the local medical examiner offices.

While the precise payment and contracting process for the non-statutory system are being finalised and then communicated directly to NHS trusts, Jeremy Mean outlined how NHS England and NHS Improvement propose the system to work. The expected costs, based on information from the pilot sites, will be agreed with individual NHS trusts as they start up their medical examiner office. This will include the expected income from cremation form 5, and the funding required for the medical examiner system to cover child deaths, burials and cases referred by the medical examiner to the coroner, based on existing data.

A series of quarterly payments, commencing the quarter after an office is established, will then be made throughout the year, based on expected costs of the system. A reconciliation will take place at year end, adjusting the last payment, to ensure the actual costs are reflected. For those organisations which have been proactive and set up well-established medical examiner systems, there may be some adaptations required to meet a national model. Not all NHS trusts will need an individual medical examiner office, depending on the average number of deaths, and will therefore enter into an agreement with a neighbouring organisation. It is important that NHS trusts work with the office of the National Medical Examiner to consider set-up, so that expected costs are understood and agreed by all parties.

A digital tool was under development to support the work of the medical examiners and ultimately provide the relevant confidential records to contribute to the death certification process in the statutory system. The digital tool had passed the first phase of testing and was ready to expand and develop as systems were set up. NHS trusts which had set up or are considering setting up a medical examiner system were invited to email the National Medical Examiner nme@nhs.net to provide an indication of readiness.

For those NHS trusts which had been proactive and set up well-established medical examiner systems, but are not onboarded to the digital tool until later in the year, this would not affect financial reimbursement. Email nme@nhs.net to discuss.

A team made up of medical examiners and medical examiner officers was always the model followed by the pilot sites and detailed in the published impact assessment and continues to be the model for implementation that will be covered by the funding from DHSC.

Derek Winter, Deputy Chief Coroner, addressed the audience and stated that the Chief Coroner was encouraged by the appointment of the National Medical Examiner. Derek Winter announced that it was agreed by the Chief Coroner and the National Medical Examiner that training will be provided for coroners (including area and assistant coroners) regarding the medical examiner system in England and Wales. Derek Winter welcomed the involvement of coroners in the appointment of medical examiners and medical examiner officers and he stated that the Chief Coroner was encouraged by the collaborative working and will continue to review the relationship going forward. Derek Winter outlined the draft notification to coroner's regulations would ensure national coroner guidelines rather than local interpretation. Alan Fletcher added that the General Register Office cause of death list was being reviewed and is planned to be published at a similar time, Autumn 2019.

Dr Suzy Lishman of the Royal College of Pathologists and lead medical examiner for North West Anglia NHS Foundation Trust, provided an update on medical examiner training. She outlined how to find out more about becoming a medical examiner and the library of information available on the Royal College of Pathologists website https://www.rcpath.org/profession/medical-examiners.html .

Dr Lishman highlighted the e-learning which is available on https://www.e-lfh.org.uk/programmes/medical-examiner/ and includes 26 core e-learning modules (revised November 2018). To date over two hundred individuals have completed the e-learning. The recommended completion time is no less than between 8-10 hours. This is the same for those who may have undertaken the previous modules as there is new reading material in line with the proposed non-statutory system. There is also mandatory face-to-face training available, which includes short presentations and small group discussions of case scenarios. For schedule of dates of face-to-face training see https://www.rcpath.org/profession/conferences/events.html . On completion of the e-learning and the face to face training medical examiners are invited to become members of the Royal College of Pathologists. As part of their membership they will be awarded the use of the

new post nominals 'RCPathME'. An annual membership fee, £100 in the first year, will be charged to remain a member and use the post nominals (RCPath College fellows will not be required to pay the £100 annual membership fee). Both the e-learning and face-to-face training are also relevant and recommended for medical examiner officers.

Daisy Shale, lead medical examiner officer for the Sheffield pilot site, provided an overview of how the medical examiner and medical examiner officer work together to provide an efficient and effective service to the bereaved. The medical examiner and medical examiner officers' care and duty to the bereaved is to ensure that they are guided through the difficult time whilst being open and honest about events and providing the opportunity to ask questions and seek answers and clarification. One of the strengths of a medical examiner and medical examiner officer forming a multi-disciplinary team, is that it prevents a single opinion or view and provides natural checks and balances within the team.

Medical examiner officers can assist, under delegated authority, with two aspects of the scrutiny process: discussion with the attending doctor and discussion with the bereaved. The medical examiner may delegate some or all of these tasks to the medical examiner officer. To conduct these tasks the medical examiner officer must have a clear understanding of the context of the case, they must be able to read and understand the medical records, be able to explain the medical examiner and qualified attending practitioners' rationale and thoughts surrounding the cause of death and decisions made in relation to the patient's illnesses to both medical staff and the bereaved.

Conversations and decisions or outcomes are recorded and identifiable to the individual conducting the task. The medical examiner will review all work carried out by the medical examiner officer, and any concerns raised by the bereaved must be discussed with the medical examiner before agreeing on the next action. Medical examiner officers can manage workload; it is unlikely in many offices that medical examiners will have capacity to wait for doctors, coroner's officers and families to be available to discuss cases. It makes financial sense to have a constant presence in the medical examiner office by several medical examiner officers than a single medical examiner.

The medical examiner officer should form good working relationships with the coroner's office, bereavement office, mortuary, registration services and others to ensure that the system works seamlessly for the bereaved. They can also highlight urgent cases to a medical examiner; ensure a medical examiner's independence from the case; arrange a second medical examiner review and manage the office rota to ensure there is medical examiner availability when and where needed.

Daniel Elton of the Board of Deputies of British Jews provided a faith perspective in relation to the introduction of medical examiners. Daniel Elton requested that a prioritisation system is incorporated into the process and that scrutiny is available seven days a week in daylight hours. He asked that continued discussions take place with faith groups as the system develops. Daniel Elton provided a background to the approach to death by the Jewish faith. There is a spectrum of views and religious observance but many families will prefer a traditional approach to dealing with death and bereavement. Orthodox Jews do not allow cremation. He referred to an interesting philosophical debate as to who "owns" a body after death, the right of the state to take legal ownership from a family has never been legally established so it is incumbent on state officers (medical examiner, coroner) to be respectful of the wishes of the family.

In Jewish tradition, the body of a person should not be interfered with (e.g. post mortem examination) although there is a provision that law can overrule this. Non-invasive autopsy is always the preferred option and the family should give permission for this. Organ donation is permitted within Judaism. After death, there is a tradition of a *shomer*, or guardian, keeping

company with the body of the deceased, which is the role of a member of a synagogue or a Jewish society (*chevra kadisha)* and not the family. These representatives will perform the ritual preparation of the body. In London, the body is taken from hospital directly to the mortuary attached to the Jewish cemetery. In other locations, arrangements may be in place with a local mortuary.

A funeral service is conducted as soon as possible - within 24 hours being the norm, although longer is becoming more common as families travel. The family are in a state of limbo until after the funeral has taken place as their formal mourning period then begins. A week of mourning, '*shiva'* is held at the family home where friends and family visit to pay respects. This is a planned and set procedure and helps the family reintegrate into community life. Some families have an extended period of mourning. The family is reliant on their religious leader/liaison who reassures them that the religious and cultural formalities are in order. Daniel Elton emphasised that if delays are anticipated, this person is key to reassuring the family. It is therefore essential that the office of the local medical examiner has contact with this local representative and builds relationships.

Dr Alan Fletcher encouraged communication via the email nme@nhs.net for those with an established medical examiner system or currently setting up a system. For those still in the planning phase, he suggested engaging with the regional medical examiner structure once in place. The National Medical Examiner recognised the opportunities and challenges ahead and committed to provide the leadership to establish the medical examiner system.

Dr Suzy Lishman
Chair, Medical Examiner Committee
The Royal College of Pathologists
May 2019