The Royal College of Pathologists
Pathology: the science behind the cure

Report on Implementing Medical Examiners event

Summary

The Royal College of Pathologists hosted an event on 20 September 2018 to support the implementation of medical examiners. The event was held at the Royal College of Physicians, it was open to all, and there were a total of 227 delegates in attendance from the NHS, coroners, registrars, faith groups, funeral directors, bereavement services and others interested in the introduction of medical examiners. Further events will be held in January and April 2019 prior to national implementation from April 2019.

Overview

The Royal College of Pathologists is the lead college for medical examiners, and the event was jointly chaired by the president, Professor Jo Martin and former president, Dr Suzy Lishman. Aidan Fowler, the National Director of Patient Safety for NHS England and NHS Improvement, highlighted the commitment to appoint the National Medical Examiner in the short term. Aidan also referenced the proposed employment structure where medical examiners and medical examiner officers will be based in the NHS, with a separate professional line of accountability from the employing organisation. Jeremy Mean, the Programme Director for the introduction of medical examiners at the Department of Health and Social Care (DHSC), outlined funding available to support set up and recruitment of the system. Both referred to a wider communication to be disseminated at the end of October 2018 with further details of what was discussed on the day.

Speakers

Speakers included Dr Alan Fletcher, the Lead Medical Examiner at the DHSC pilot in Sheffield, along with Daisy Shale, the lead Sheffield Medical Examiner Officer and Dr Golda Shelly-Fraser, the Lead Medical Examiner at the DHSC pilot in Gloucester, who presented alongside her colleague Kathryn Griffin, the lead medical examiner officer in Gloucester.

Early adopters of the medical examiner system were also invited to speak including Dr Diane Monkhouse, a medical examiner in South Tees, Julia Phillips, Nurse Lead for Mortality Review at Buckinghamshire Healthcare NHS Trust, Dr Mark Howard, former Medical Examiner in Brighton, Professor Peter Furness, Medical Examiner in Leicester and Dr Jason Shannon, National Clinical Lead for Mortality Review in Wales. Alan Wilson, Senior Coroner in Blackpool, and Eric Powell from the Home Office/General Register Office, provided the perspective from parts of the wider system of death registration, which will be impacted by the medical examiner system.

Focus on the bereaved

How the medical examiner system can support and inform the bereaved was a focus of the day. The role of the medical examiner and medical examiner officer in engaging with the

bereaved and building on the expertise of local bereavement services was identified as crucial. Within this context delegates were urged to consider how they currently record and share information in a secure system prior to a digital solution being provided as part of national implementation.

The DHSC medical examiner pilots have demonstrated that the medical examiner system can be efficient and effective without causing undue delays. Committed and appropriately skilled staff help ensure a compassionate and professional service even during pressurised periods. Feedback from families is very positive. The views of the bereaved are essential to the process and ensuring that they are treated with sensitivity and transparency is widely observed.

Independence and working with key stakeholders

Independence in terms of cause of death was emphasised by the key speakers. Medical examiners are able to balance their influence on the final wording on the medical certificate of cause of death by discussing each case with the qualified attending practitioner but not instructing what they write. Agreement is reached via respectful and informed discussion, which may need to include more senior clinicians in some cases.

It was reiterated that the Coroner has the final decision on whether to accept a referral by the medical examiner and that they are bound by their own statutory obligations. Credibility of the medical examiner is key in building successful relationships and ensuring joint understanding of the complexities surrounding specific cases.

There was broad recognition that valuable learning can be gained during the non-statutory running of the ME system. This is particularly important as it offers reassurance for the bereaved and faith communities. Local systems must be operating comprehensively to accommodate faith issues. It was noted that this will require multi-disciplinary, collaborative working across organisational boundaries which will include coroner and registration services. The concerns of faith groups about the impact that the medical examiner system were acknowledged.

Funding

The need for adequate funding of the medical examiner system in both non-statutory and statutory phases were noted. DHSC confirmed medical examiner and medical examiner officers would be salaried posts. The system will be funded through the existing fee for completing certain cremation forms, in combination with central government funding for medical examiner work not covered by those fees.

Alignment with Learning from Deaths

There was agreement by the pilot sites and early adopters that the medical examiner can act as an initial filter to screen patient deaths for formal structured judgement reviews, noting that conducting structured judgement reviews does not form part of the medical examiners' job description, although they may undertake them separately in their capacity as a medical practitioner. Both the medical examiner and Learning from Deaths processes have been shown to be effective mechanisms for feeding back examples of quality clinical care and excellent team practice.

Further information
Details regarding future events will be shared here when available.