

Implementing the medical examiner system: National Medical Examiner's good practice guidelines

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Contents

1. Introduction	3
Implementation phases	4
2. Setting up medical examiner offices	5
Resources	5
Incremental implementation	6
3. Medical examiners	7
What do medical examiners do?	7
Who can be a medical examiner?	7
What requirements should be in a medical examiner’s job description?	7
What training will medical examiners require?	8
How should medical examiners escalate concerns?	8
4. Medical examiner officers	10
What do medical examiner officers do?	10
Who can be a medical examiner officer?	11
What requirements should be in a medical examiner officer’s job description?... 11	
What training will medical examiner officers require?..... 11	
5. Principles for medical examiners	12
Three components of scrutiny	12
Independence.....	12
Escalating concerns including patterns and trends	13
Establishing credibility and partnership working	13
Supporting the bereaved	14

Qualified attending practitioner’s role	14
6. Operational requirements and ways of working	16
Availability and prioritisation	16
Accurate and timely documentation of scrutiny	17
Efficient and effective working	17
Medical examiner specialties.....	18
Delegation	18
Timely escalation of concerns or complaints about the local medical examiner system or medical examiners	18
Reporting requirements.....	19
Online tool	19
Local governance and identification of issues for review.....	19
7. Working with coroners and registration services.....	22
Coroners.....	22
Registration services	23
8. Process.....	24
Appendix 1: Support and infrastructure.....	32
Appendix 2: Background and legislation	36
Background	36
Legislation	36

1. Introduction

These good practice guidelines set out how the National Medical Examiner expects medical examiner offices to operate during the current non-statutory phase of the programme.

When medical examiners become a statutory requirement and the statutory medical examiner system is implemented, we will update this guidance, publish standards for medical examiner offices and review funding arrangements.

The introduction of the medical examiner system is designed to:

- provide bereaved families with greater transparency and opportunities to raise concerns
- improve the quality/accuracy of medical certification of cause of death
- ensure referrals to coroners are appropriate
- support local learning/improvement by identifying matters in need of clinical governance and related processes
- provide the public with greater safeguards through improved and consistent scrutiny of all non-coronial deaths, and support healthcare providers to improve care through better learning
- align with related systems such as the [Learning from Deaths Framework and Universal Mortality Reviews](#).

Any delay in the registration or release of a deceased patient's body – for example, due to documentation errors – can be distressing for the bereaved. The medical examiner system will help address such delays by, for example, ensuring Medical Certificates of Cause of Death (MCCDs) are completed consistently and use the correct wording; improving communications within hospitals and primary care; with external agencies such as coroner's offices and registrars; and engaging with and being an accessible expert resource for qualified attending practitioners. Prioritising certain cases is sometimes appropriate and is discussed in more detail in Section 6.

Implementation phases

The introduction of medical examiners is part of the Department of Health and Social Care's (DHSC's) death certification reforms programme for England and Wales (see Appendix 2). This programme's ultimate aim is to create a statutory requirement and basis for the medical examiner system, but this will require changes to the law.

In the meantime, acute trusts in England and Health Boards in Wales, supported by NHS Wales Shared Services Partnership, are setting up medical examiner offices on a non-statutory basis. Acute hospitals and health boards in Wales will already have death certification processes and many provide services for the bereaved. Medical examiner offices should build on existing services and take local practice into account. However, medical examiner offices also need to align with the national model, and will be part of a distinct system with its own funding arrangement.

The timeframe for the non-statutory system is:

- **2019/20**: host organisations are being asked to set up medical examiner offices to independently scrutinise deaths that occur at the acute trust or site. They should also consider how, during 2020/21, they will extend systems to deaths which occur locally but not at the host site or organisation, as this may help determine where the medical examiner office is best located and the resources required.
- **2020/21**: medical examiner offices work with local NHS partners and other stakeholders to widen scrutiny to non-coronial deaths within a specified geographical area.

2. Setting up medical examiner offices

The objective is for medical examiners to independently scrutinise all non-coronial deaths across England and Wales. We expect most medical examiner offices will be located in acute sites in England with, potentially, certain specialist trusts. In Wales, offices will also be based in acute hospitals but managed by NHS Wales Shared Services Partnership (NWSSP).

Resources

In the letter to medical directors in September 2019 giving details of funding arrangements for medical examiner offices in England in the non-statutory phase, NHS England and NHS Improvement emphasised that host organisations must agree their medical examiner office costs with NHS England and NHS Improvement to receive reimbursement ([full annex here](#)). A separate letter was sent to the NHS in Wales setting out their bespoke arrangements, but reflecting the same requirements as in England.

DHSC's impact assessment estimated that for approximately 3,000 patient deaths the medical examiner system will require:

- one whole time equivalent (WTE) medical examiner (from a pool working on a rota basis to cover 10 programmed activities (PAs) per week). We expect each medical examiner will work at least the equivalent of one PA per week and scrutinise enough cases to maintain standards and experience
- three WTE medical examiner officers.

This staffing model may need to be adjusted to reflect local circumstances. In England the specific details for each medical examiner office should be agreed with the office of the National Medical Examiner. For example, host organisations with multiple sites will need to arrange adequate cover at each site. For Wales, NWSSP will work with local health boards to ensure adequate coverage.

Incremental implementation

Implementation will require careful planning and close working with other teams, eg bereavement services, registry offices, coroner's office and mortuary.

The National Medical Examiner strongly advises medical examiner offices to adopt an incremental approach to local implementation, starting with a suitable number of cases rather than all deaths. This will afford medical examiners and medical examiner officers time to undertake training and to put what they learn into practice over a period.

An incremental approach means that for a time two approaches to documenting the causes of death are likely to run in parallel (ie some non-coronial cases will be scrutinised by the medical examiner scrutiny and others will not be). During the implementation period, staff involved in death certification processes will need a mechanism to select the cases to be scrutinised by a medical examiner, eg those on certain wards or clinical specialties. **This implementation period should be short; after three to six months medical examiners should be scrutinising all deaths.**

The following sections give information about the key roles in medical examiner offices – the medical examiners and medical examiner officers.

3. Medical examiners

What do medical examiners do?

Medical examiner offices review medical records and interact with qualified attending practitioners and the bereaved to address three key questions:

- What did the person die from?
(ensuring accuracy of the medical certificate of cause of death)
- Does the death need to be reported to a coroner?
(ensuring timely and accurate referral – there are [national requirements](#))
- Are there any clinical governance concerns?
(ensuring the relevant notification is made where appropriate)

For more information about how this operates, see sections (5) and (6).

Who can be a medical examiner?

Any practising, or recently retired¹, medical practitioner who has been fully registered for at least five years and has a licence to practise with the General Medical Council (GMC) can apply to be a medical examiner.

The National Medical Examiner recommends that medical examiners should be consultant grade doctors or other senior doctors from a range of disciplines or GPs with an equivalent level of experience.

Non-medics cannot perform the role of the medical examiner.

What requirements should be in a medical examiner's job description?

A [model job description](#) for medical examiners is available on the Royal College of Pathologists' website.

¹ This means a medical practitioner who has retired from clinical practice within the last five years and is still on the GMC register with a licence to practise.

Medical examiner offices will generally be hosted at acute hospital sites in England and Wales, with medical examiners and officers employed by acute trusts in England and NWSSP in Wales.

Acute hospitals should incorporate the medical examiner role into job plans for doctors employed as medical examiners where relevant, and will be covered in their whole practice appraisal. The medical examiner role is classified as an additional responsibility and either replaces a direct clinical care programmed activity or is an addition to this in an existing job plan, depending on what is feasible for the individual. The role should not be undertaken in supporting programmes activity time.

What training will medical examiners require?

Before their appointment, we expect aspiring medical examiners to complete 26 core e-learning modules, and the remainder of the e-learning programme within one year of appointment. We also expect them to complete the [face-to-face training](#) available from the Royal College of Pathologists within six months of appointment.

Once appointed, medical examiners should undertake continuing professional development (CPD) activities relevant to their role. Examples include completing further e-learning modules, attending regional and national update meetings or further training sessions such as with local coroners. Reflective practice is also encouraged.

How should medical examiners escalate concerns?

For the time being medical examiners will be employed by acute trusts in England and in Wales by NHS Wales Shared Services Partnership. Management and oversight of medical examiners will be established through local line management arrangements with the responsible employer. Where medical examiners detect and pass on concerns regarding the quality of healthcare it is expected that the provider of those services will resolve the concerns. Employers should ensure that employment arrangements facilitate and respect the independent scrutiny of deaths carried out by medical examiners, and should enable medical examiners to share information with regional medical examiners where appropriate, as set out in the two paragraphs below (including, if necessary, information that would normally be confidential).

In England, regional medical examiners (employed by NHS Improvement) will provide expert support and guidance to medical examiners, as will the Lead Medical Examiner in Wales. When medical examiners detect and refer concerns to the provider of those healthcare services but are not satisfied that these issues are being resolved or believe that undue influence is being exercised over their independent role, in England they should inform the regional medical examiner, and in Wales they should inform the Lead Medical Examiner. The regional medical examiner/ Lead Medical Examiner in Wales and the medical director of the organisation employing the medical examiner (or the organisation providing the care, where it is a different body) should work together to agree and implement any solutions that are required. In England the regional medical examiner will liaise with the regional medical director of NHS England and NHS Improvement or their teams as appropriate and will work together with them to enable healthcare providers to take actions forward. In Wales the concerns should be escalated to the health board medical director or the Chief Medical Officer's Office as appropriate. Regional medical examiners and the lead medical examiner for Wales are accountable to the National Medical Examiner, and concerns will be escalated to the National Medical Examiner if required.

It is recommended that a lead medical examiner is appointed in each body employing a medical examiner to provide leadership on operational arrangements.

For medical examiners in both England and Wales, medical appraisal and revalidation will be governed by usual [GMC Guidance](#) and appraisal will therefore be undertaken by an appraiser approved by their responsible officer. The Royal College of Pathologists has published [information to support appraisal and revalidation of medical examiners](#).

4. Medical examiner officers

What do medical examiner officers do?

Medical examiner officers manage cases from initial notification through to completion and communication with the registrar. They are essential for the financial viability of the medical examiner system and effective and efficient working; the constant in the office, enabling consistency across medical examiners who will usually work part-time and come from a range of specialties.

Medical examiner officers will initially require guidance and support to undertake tasks delegated by the medical examiners. Over time, with experience and training, they will in turn be able to advise medical examiners about and support them with causes of death and coroner referrals. They will become well-placed to identify patterns and trends, and to act as a source of expert guidance to all users of the system.

They will obtain and carry out a preliminary review of all relevant medical records (and additional details where required) to develop a case file setting out the circumstances of each death for the medical examiner. This will require them to work with the coroner's office, registrars, bereavement services, complaints managers, legal services and cremation referees. Their work is analogous to that of operating department practitioners assisting anaesthetists, scrub nurses assisting surgeons, nurses assisting physicians and coroner's officers assisting coroners.

Medical examiners can delegate the following tasks to medical examiner officers:

- discuss proposed causes of death with the qualified attending practitioner and advise about coroner referral
- contact the bereaved before the MCCD is issued to establish if they have concerns or questions about the death, and if they do act on them appropriately

The medical examiner officer must document all such interactions.

Delegation is entirely appropriate in many cases, but the medical examiner must see the documentation before signing off the case.

Who can be a medical examiner officer?

A medical examiner officer may or may not have a clinical background. They will:

- probably have experience in a patient or customer-facing role and of working in either current death certification systems, or a clinical or NHS setting
- require an understanding of medical records and disease pathology.
- be able to provide advice on terminology and causes of death, and to explain these and the medical examiner's thoughts and rationale to coroner's officers, doctors and those with no medical understanding.
- have strong interpersonal skills and be comfortable working with people following a bereavement.
- build and maintain effective relationships with other stakeholders such as faith groups, funeral directors and legal services.

What requirements should be in a medical examiner officer's job description?

A [model job description](#) for medical examiner officers is available on the Royal College of Pathologists' website. In Wales, medical examiner officers are accountable to the lead medical examiner officer for Wales. In England, medical examiner officers will have a line manager within the employing organisation. Where the line manager is not the medical examiner, medical examiner officers will have an operational responsibility to the lead medical examiner.

What training will medical examiner officers require?

Medical examiner officers should complete the 26 core [e-learning sessions](#) and [face-to-face training](#) provided by the Royal College of Pathologists. They will benefit from on-the-job training, such as constructive case discussion with medical examiners, as well as a CPD programme and should embrace this investment in their professional development.

5. Principles for medical examiners

As medical examiners are being introduced to provide independent scrutiny of deaths, medical examiner offices must underpin this function with the following principles.

Three components of scrutiny

Scrutiny must comprise medical record review; reviewing the proposed causes of death and whether the coroner needs to be notified with the qualified attending practitioner; and asking the bereaved whether they have questions about the cause or circumstances of death or concerns about the care before death.

Independence

Independence must be maintained at all times. Medical examiners will normally be part time in this role and their relationship with host organisations and regional medical examiners/ Lead Medical Examiner for Wales is described in section 4.

Medical examiners should not scrutinise cases where their independence may be questioned; for example, the death of a patient they or their department cared for, or where they are professionally or personally related to someone who provided care, or are personally related to the deceased.

In England, medical examiners have important links to Learning from Deaths, highlighting cases for review and ensuring they are flagged to the trust mortality lead and/or to the relevant mortality review programme. In Wales, medical examiners undertake Stage 1 of the Universal Mortality Review process, which will, where appropriate, trigger a referral to the relevant health board's governance system for a Stage 2 mortality review. However, medical examiners should neither be involved in mortality reviews of cases they independently scrutinised, nor undertake mortality review work in medical examiner time. The need to preserve independence makes it inappropriate for a medical examiner to be the overall trust mortality lead.

Depending on their medical specialty, medical examiners may need to adapt their working practices. For example, medical examiners who are also practising pathologists should not conduct a post mortem examination requested by a coroner if they referred the case.

Medical examiner offices will operate along similar lines to coroner's offices. They will work closely with other NHS services such as bereavement services, mortuary services and anatomical pathology technologists, but in doing so must retain demonstrable independence.

Escalating concerns including patterns and trends

Medical examiners will not investigate or review services, but will pass on any concerns they detect, including themes or patterns such as clusters of cases displaying similar characteristics. Concerns about the care in individual cases should be referred as appropriate, eg to the coroner or local clinical governance teams.

Medical examiner offices should share anonymised trends or patterns of concern regarding a locality or an organisation with the regional medical examiner/lead medical examiner for Wales, to facilitate prompt consideration, investigation and action. The regional medical examiner/lead medical examiner for Wales will in turn share such information with the National Medical Examiner, and with the NHS England and NHS Improvement regional medical director/ health board medical director in Wales or Chief Medical Officer as appropriate.

Establishing credibility and partnership working

Medical examiners and medical examiner officers should collaborate with neighbouring medical examiner offices, sharing experiences and expertise to support peer learning. Regional medical examiners and the Lead Medical Examiner for Wales will work with medical examiner offices to facilitate this.

They will also need to develop a good working relationship with the local coroner, registration services and other stakeholders, such as faith groups and funeral directors, as soon as possible. There are several ways to achieve this; for example, setting up local working groups or involving partner organisations in recruiting medical examiners and medical examiner officers.

To establish the credibility and independence of this new system, medical examiners and medical examiner officers should demonstrate the highest professional standards at all times. Every effort should be made to deliver timely, efficient and effective services.

Supporting the bereaved

Medical examiners and medical examiner officers need to be compassionate and sensitive to the bereaved, and aware that their heightened emotions – denial, anger, guilt and despair – may affect how they behave.

They should communicate sensitive information with tact and empathy, appreciating its potential impact. Jargon should be avoided and technical or clinical terms explained in terms that non-clinicians will understand. Explanations should be considered before being given. The bereaved will need to be engaged in an environment that enables them to express their concerns, where they can be confident their worries or feelings are respected and seen as important.

There are likely to be cases where the bereaved raise concerns that require action such as referral to the clinical team responsible for the care for further discussion and/or the trust/health board complaints service. Such referrals should be made in accordance with good practice and local complaints policies.

Medical examiner officers need to establish appropriate ways of working with bereavement services.

Some deceased persons may have no relatives. Medical examiners and medical examiner officers may then be required to engage with an informant representing the next of kin or acting in the absence of next of kin.

Qualified attending practitioner's role

The qualified attending practitioner should develop and record their own preliminary view of the cause of death before discussing the case with the medical examiner or medical examiner officer, and only complete the medical certificate of the cause of death (MCCD) after this discussion.

It is important to note that the qualified attending practitioner remains personally responsible for recording the causes of death on the MCCD "to the best of his [or

her] knowledge and belief". The medical examiners e-learning module reminds Qualified Attending Practitioners:

"By signing the MCCD, you commit yourself to the information contained in it. You have a duty to the late patient and any family, to the authorities, to the standard of conduct demanded by the General Medical Council (GMC) (see Good Medical Practice) but, most importantly, to yourself to ensure that you can stand by every word." (Completion of the Medical Certificate of Cause of Death Part 2: Cause of Death).

This advice means the medical examiner should not tell the qualified attending practitioner what to write, but a pragmatic, constructive discussion will allow the qualified attending practitioner and medical examiner/ medical examiner officer to settle on a cause of death. In the rare case where a difference of opinion between the two is irreconcilable, local escalation to the consultant in charge of the case (if in hospital) and the lead medical examiner is recommended. If this does not resolve the issue, the coroner should be notified and their decision is final.

6. Operational requirements and ways of working

Availability and prioritisation

Medical examiner offices must be open at times that meet the needs of the local population, with cover provided for staff on leave. Some out-of-hours provision is likely to be needed in most areas, though a continuous 'on call' service may not be necessary. For example, it may be reasonable for deaths in the early hours of the morning to be addressed by medical examiners when they start work at 8am.

Host organisations should consider the needs of their local population in determining the appropriate service to provide. Some areas will need to provide an evening service, or an out-of-hours evening, weekend or public holiday service, depending on the religious and other needs of the local population. Some bereaved people are likely to have particular concerns about the potential for medical examiner scrutiny to delay death certification.

It may be helpful for host organisations to consider sharing on-call and out-of-hours services between a number of medical examiner offices. Regional medical examiners in England and the Lead Medical Examiner for Wales can help facilitate discussions between host organisations considering such arrangements.

There should be a system for prioritising cases that require urgent attention, while maintaining the integrity of the medical examiner system. A process for urgent release of the body in certain cases is being considered.

There should also be contingency plans to ensure the availability of a death certification service during emergency situations causing a sudden and unpredictable increase in the death rate.

Accurate and timely documentation of scrutiny

The smooth operation of death certification and registration depends on the accurate and timely completion and submission of the associated documentation. Trusts in England and in Wales, health boards and NHS Wales Shared Services Partnership will need to develop effective processes to notify medical examiners of deaths and provide records.

Medical examiners need to ensure that their scrutiny is recorded accurately and objectively. They should be conscious that records may be seen by other parties and need to be drafted in a manner that avoids causing unnecessary distress. Further information about medical records is given in the [GMC guidance](#).

Any delay caused by scrutiny must be kept to a minimum, while maintaining the integrity of independent scrutiny. We advise medical examiner offices to record delays caused by unavailability of the qualified attending practitioner and/or the bereaved.

We also advise key performance indicators are established to monitor the performance of the system, such as: turnaround times, complaints, rejection of MCCDs at the register office, coroner concerns. These can be discussed at local and regional medical examiner team meetings.

Medical examiners should note that the documented work of the medical examiner office should be subject to appropriate audit processes, in line with national guidelines. Good documentation will also mean medical examiners have the information to satisfy the requirements of medical revalidation in relation to their medical examiner role.

Efficient and effective working

The DHSC's [2018 impact assessment](#) calculated the resources medical examiner systems require for around 3,000 deaths a year.

Where the number of deaths in acute and non-acute settings in an area is insufficient to justify setting up a medical examiner office, host organisations are advised to work with another medical examiner office rather than setting up their own system. We expect the site with the larger number of deaths will host the principal medical examiner office within the host organisation.

Effective deployment of medical examiner officers will be required to enable medical examiners to focus on their role and to facilitate cost-effective operation of the medical examiner office (see the earlier section about the role of medical examiner officers).

Medical examiner specialties

It is helpful to have medical examiners from a range of medical specialties to provide a breadth of clinical experience and expertise. We recommend that each medical examiner office appoints a lead medical examiner to provide leadership on operational arrangements.

Delegation

Medical examiners are accountable for ensuring all components of scrutiny are carried out, and that concerns are assessed and escalated where necessary. Of the three components (see Section 5), the medical examiner can delegate two to the medical examiner officer: reviewing the proposed causes of death and whether the coroner needs to be notified with the qualified attending practitioner and discussion with the bereaved. The medical examiner cannot delegate the medical record review.

Delegating tasks to medical examiner officers helps make the medical examiner system flexible and efficient, but as mentioned earlier it is important to recognise that the medical examiner remains accountable for all decisions, and must ensure they have reviewed medical records. For more detail about delegation to medical examiner officers, see section 4.

Timely escalation of concerns or complaints about the local medical examiner system or medical examiners

There should be a mechanism for receiving and responding appropriately to complaints about a medical examiner office, with full documentation of both the complaints and responses. This should use existing host organisation complaint procedures and services, providing these do not compromise the independence of the medical examiner system.

Reporting requirements

Each medical examiner and medical examiner office has a responsibility to record the information that will be required for national reporting (not just financial). The National Medical Examiner's office will publish further information on this in due course.

Online tool

An online tool is being developed to support the work of medical examiners and to inform the death certification process in the future statutory system. A centralised process will bring medical examiner offices on board.

Local governance and identification of issues for review

Medical examiner offices should clarify and agree appropriate governance arrangements. These should include the method of referring cases for review (eg in England to clinical governance, Structured Judgement Review and Learning from Deaths). In Wales, the Medical Examiner Service will make referrals via the DATIX system for a Stage 2 mortality review, with system-level reporting into the clinical governance infrastructure within each health board or trust.

During scrutiny of deaths at their host site, medical examiners may identify concerns relating to previous care at other providers that contributed to the death or caused significant harm. Table 1 sets out to whom we propose medical examiners should refer such issues. Medical examiners should test these with local partner organisations and agree specific local arrangements. If medical examiners judge that concerns are not being addressed adequately, they should follow the escalation guidance in section 3.

Table 1

Location of issue identified during scrutiny ²	Proposed recipient of medical examiner referral ³	
	England	Wales
Primary care	<p>Clinical/quality lead (or equivalent) at clinical commissioning group</p> <p>Where issue relates to deficient clinical care or inappropriate professional conduct also inform regional Professional Standards team at NHS England and NHS Improvement with details of GP</p>	Health Board Medical Director and/or relevant Assistant Medical Director
Local authority (eg social care provision)	Safeguarding Lead	Safeguarding Lead
Independent provider (eg private hospital or hospice)	Medical Director	Medical Director
NHS Community trust/ hospital	Medical Director	Health Board Medical Director and/or relevant Assistant Medical Director

² It is perfectly appropriate for more than one issue to be identified and more than one recipient to be notified.

³ Coroner notification will be required in parallel with these notifications when the Notification of Deaths Regulations apply.

Location of issue identified during scrutiny ²	Proposed recipient of medical examiner referral ³	
	England	Wales
NHS Mental health trust or provider ⁴	Medical director	Health Board Medical Director and/or relevant Assistant Medical Director
NHS Ambulance service	Medical director	Medical Director, Welsh Ambulance Services NHS Trust
NHS Acute hospital ⁵	National mortality case record review co-ordinator and/or medical director and/or local clinical governance co-ordinator	Health Board Medical Director and/or relevant Assistant Medical Director
Child death (includes neonates and up to age 18)	Child Death Review co-ordinator	Health Board Medical Director and/or relevant Assistant Medical Director Child Death Review Programme

⁴ The death of all patients with severe mental illness should be notified to the medical director of the mental health trust, regardless of its cause.

⁵ For interhospital transfers, more than one trust may need to be notified.

7. Working with coroners and registration services

Both coroners and registration services should benefit from the introduction of medical examiners. For example, consistent completion of the MCCD should reduce the number rejected by registration services. Medical examiner offices should work closely and in partnership with coroner's offices and registration services, to ensure their smooth implementation and maximum benefit from the new ways of working.

Coroners

The [Notification of Deaths Regulations 2019](#) that came into force on 1 October 2019 set out the types of cases that medical practitioners must notify to senior coroners and replace any local guidance. Medical practitioners will have a duty to report deaths to a coroner for which they are unable to ascertain the cause, the cause is unnatural or the death occurred in custody or state detention. The Regulations also place a duty on medical practitioners to report deaths to a coroner where no attending practitioner is required to sign a MCCD, an attending practitioner is required to sign a MCCD but they are unavailable, or the identity of the deceased is unknown. The Ministry of Justice published [guidance](#) on these regulations.

All registered medical practitioners, including medical examiners, should notify a senior coroner of all relevant deaths as soon as is practicable. While we expect that the qualified attending practitioner will make the notification, coroners will value the medical examiner's thoughts on a case (understanding the issues, the result of independent scrutiny). This information must be conveyed in writing with the notification.

When form 100A cases return to the medical examiner office after a coronial decision, medical examiners need to be informed of the reasons for the decision and that the coroner's office have discussed these with the next of kin. This two-way communication establishes strong working relationships and ensures cases are carefully considered by both parties.

Registration services

The introduction of medical examiners should help registrars, particularly by achieving greater consistency and quality in MCCDs. Medical examiners are encouraged to work with local registrars to develop mutual understanding and to ensure that local ways of working are efficient and provide the best possible service to the bereaved.

The introduction of the Notifications of Deaths Regulations and guidance (see above) provides an excellent opportunity for medical examiners and registrars to consider how best to work together locally. The National Medical Examiner has been working with the National Panel for Registration and the Royal College of Pathologists to update the Cause of Death List for registrars, which will be published in due course. As the introduction of medical examiners proceeds, the proportion of MCCDs rejected at registration and number of five-day registration breaches and reasons for them will be kept under review.

8. Process

Exemplar forms for the medical examiner system are available on the National Medical Examiner [website](#).

The stages of the medical examiner process following a death are set out below.

<p>Death</p> <p>Medical examiner office and qualified attending practitioner notified after verification of death</p>	<p>Following the death:</p> <ul style="list-style-type: none">• verification of death, last offices and transfer of the body to a mortuary or funeral directors as per local protocol• notification of death to medical examiner office and qualified attending practitioner by phone, fax or email. Referral may come directly from the qualified attending practitioner or indirectly via the bereavement services officer or mortuary• medical examiner officer obtains paper or electronic records and any other information the medical examiner may require for scrutiny• admin tasks completed: input of patient identifiable data on forms or digital system and generation of a summary of admission/last illness
<p>Advice</p> <p>Provided by medical examiner officers to doctors</p>	<p>Advice from medical examiner officer:</p> <ul style="list-style-type: none">• the qualified attending practitioner may discuss the case with the medical examiner officer or seek clarification about wording and coroner referral

	<ul style="list-style-type: none"> • the medical examiner officer may report obvious coronial cases to the coroner’s office using local procedures if responsibility is delegated by a medical examiner • the medical examiner officer should document all discussions and outcomes • in certain circumstances, the medical examiner may discuss the case with the qualified attending practitioner before reviewing the records as long as this does not compromise independent scrutiny, eg where urgent release of the body is reasonably requested, child deaths and organ donation cases
<p>Qualified attending practitioner</p> <p>Completes death certification summary and ME1A forms (or equivalent) with proposed cause of death.</p>	<p>Proposed cause of death:</p> <ul style="list-style-type: none"> • the qualified attending practitioner should give the medical examiner officer a proposed cause of death before discussion with the medical examiner or officer. They can do this verbally but in all cases it should be documented and recorded on the ME1A form or equivalent • the medical examiner officer may give the qualified attending practitioner advice as to whether they should wait for the medical examiner to review the case before completing the MCCD or referral to the coroner • the medical examiner or medical examiner officer should ask the qualified attending practitioner if they have any concerns or are aware of anyone else having concerns about the care or circumstances leading to death
<p>Scrutiny (A)</p>	<p>Medical examiner’s review of the records:</p> <ul style="list-style-type: none"> • reviews circumstances of the admission or the last illness

<p>Review of the medical records and completion of form ME1B (or equivalent)</p>	<ul style="list-style-type: none"> • documents any concerns with care or events, identifies if the case should be referred to the coroner or clinical governance, and documents a proposed cause of death • considers the qualified attending practitioner’s proposed cause of death if available • discusses case with medical examiner officer if medical examiner officer is to be delegated tasks such as interaction with the qualified attending practitioner and the bereaved
<p>Scrutiny (B)</p> <p>Discussion with qualified attending practitioner – confirmation of the cause of death for the MCCD. MCCD written and copy sent to medical examiner office</p>	<p>Interaction with the qualified attending practitioner:</p> <ul style="list-style-type: none"> • the medical examiner (or medical examiner officer, if responsibility has been delegated to them by the medical examiner) discusses the case with the qualified attending practitioner. This interaction can be in writing. A record of the interaction should be documented • Note: if the medical examiner agrees with the qualified attending practitioner’s proposed cause of death and has no concerns, they do not need to have a second discussion with the qualified attending practitioner • Note: the medical examiner/medical examiner officer do not tell the qualified attending practitioner what to write on the MCCD • where the coroner does not need to be notified of the death or they have been notified and their office has confirmed it will issue a form 100A, the qualified attending practitioner is asked to write the MCCD as agreed and to send a copy to the medical examiner office. When the body is to be cremated, the qualified attending practitioner should complete cremation form 4 and send it to the medical examiner office • for a death notified to the coroner, medical examiner notes should be sent to their office – the coroner must have these to make their decision

	<ul style="list-style-type: none"> the original MCCD should be retained by the doctor or the bereavement office until it is authorised to be released to the informant
<p>Coroner's office</p> <p>Initial enquiries made by the coroner's office including discussion with qualified attending practitioner, coroner and family</p>	<p>Interaction with the coroner's office:</p> <ul style="list-style-type: none"> the qualified attending practitioner may notify the coroner's office of a case in writing before or after medical examiner review, but is advised to discuss the case with the medical examiner officer before doing so and the medical examiner officer should document any discussions or advice given. The medical examiner officer may notify the coroner if the qualified attending practitioner desires and agrees wording the coroner's office and medical examiner officer will interact to ensure the medical examiner and coroner have all available information pertaining to the case. The medical examiner officer should send the medical examiner notes to the coroner's office and the coroner's office should send the death report, sudden death forms and form 100A to the medical examiner office if the coroner investigates a case, the medical examiner office's involvement stops
<p>Scrutiny (C)</p> <p>Discussion with the bereaved (when bereaved have not already discussed with a coroner). Confirmation of cause of death and opportunity to raise concerns</p>	<p>Discussion with the bereaved:</p> <ul style="list-style-type: none"> the medical examiner (or medical examiner officer, if responsibility has been delegated to them by the medical examiner) should contact the nominated next of kin in cases that do not involve the coroner. Interaction may be by telephone or face to face if desired/practical. For form 100A cases, the coroner's office should contact the next of kin. identify themselves and where they are calling from, offer condolences and ask if convenient to talk

	<ul style="list-style-type: none"> • the proposed cause of death, medical examiner scrutiny and events before death should be discussed • the bereaved should be given the opportunity to ask questions and seek clarification • the bereaved should be asked if they have any concerns about the care or cause of death
Issuing the MCCD	<ul style="list-style-type: none"> • the medical examiner officer should contact the doctor or bereavement office holding the MCCD and authorise its release using a unique reference code or signature • the reference code can be added to the top left corner of the MCCD by the qualified attending practitioner, bereavement or admin staff, or where the the medical examiner is on site they may countersign the MCCD to acknowledge the cause of death has been approved • the bereavement service or GP practice staff will arrange a time for the MCCD to be collected and have a meeting with the bereaved as per local process
Notification to registrar of confirmed certified cause of death	<p>Notification to registrar:</p> <ul style="list-style-type: none"> • the registrar needs to know if a medical examiner has been involved in the case and which medical examiner office they belong to. This will ensure registrar enquiries are directed to the correct office. • Using a reference code as described in the previous section is one method of doing this, another is use of ME2 form or equivalent (medical examiner officer completes, any medical examiner signs)
Registration	Registration of death:

<p>Usually before burial/cremation (except if urgent or where inquest is to be conducted)</p>	<ul style="list-style-type: none"> • the informant should attend an appointment with the registrar within 5 days of the death • the MCCD, ME2 (if completed) and form 100A (if applicable) should be available for the registrar • the registrar still has a statutory duty to report to the coroner, but is encouraged to contact the medical examiner office in the first instance • the registrar issues the approval for disposal and the family can proceed with the funeral
<p>Completion of cremation forms</p>	<p>In cases where the medical examiner completes cremation form 5, the following process occurs:</p> <ul style="list-style-type: none"> • medical examiner officer ensures the medical examiner record, cremation form 4 (completed), cremation form 5 (blank), coroner form A, death report and medical records are available to the medical examiner who will complete cremation form 5 • medical examiner completes cremation form 5 and ensures the cremation form 4 was completed to a satisfactory standard. Medical examiner officer may initially complete the admin sections in electronic form 5 if desired/agreed • medical examiner views the body and discusses the case with the qualified attending practitioner and others where required • a different medical examiner from the one who undertook initial scrutiny may complete cremation form 5. This form is less urgent and a second call to the bereaved is unnecessary when a call to a nurse or medical examiner officer will suffice. The form 5 call to the form 4 doctor can be very brief • completed cremation forms are made available to the funeral director via local arrangements

In cases where the medical examiner can not complete the cremation form 5 due to locational difficulties, another qualified doctor should complete the form as per current process.

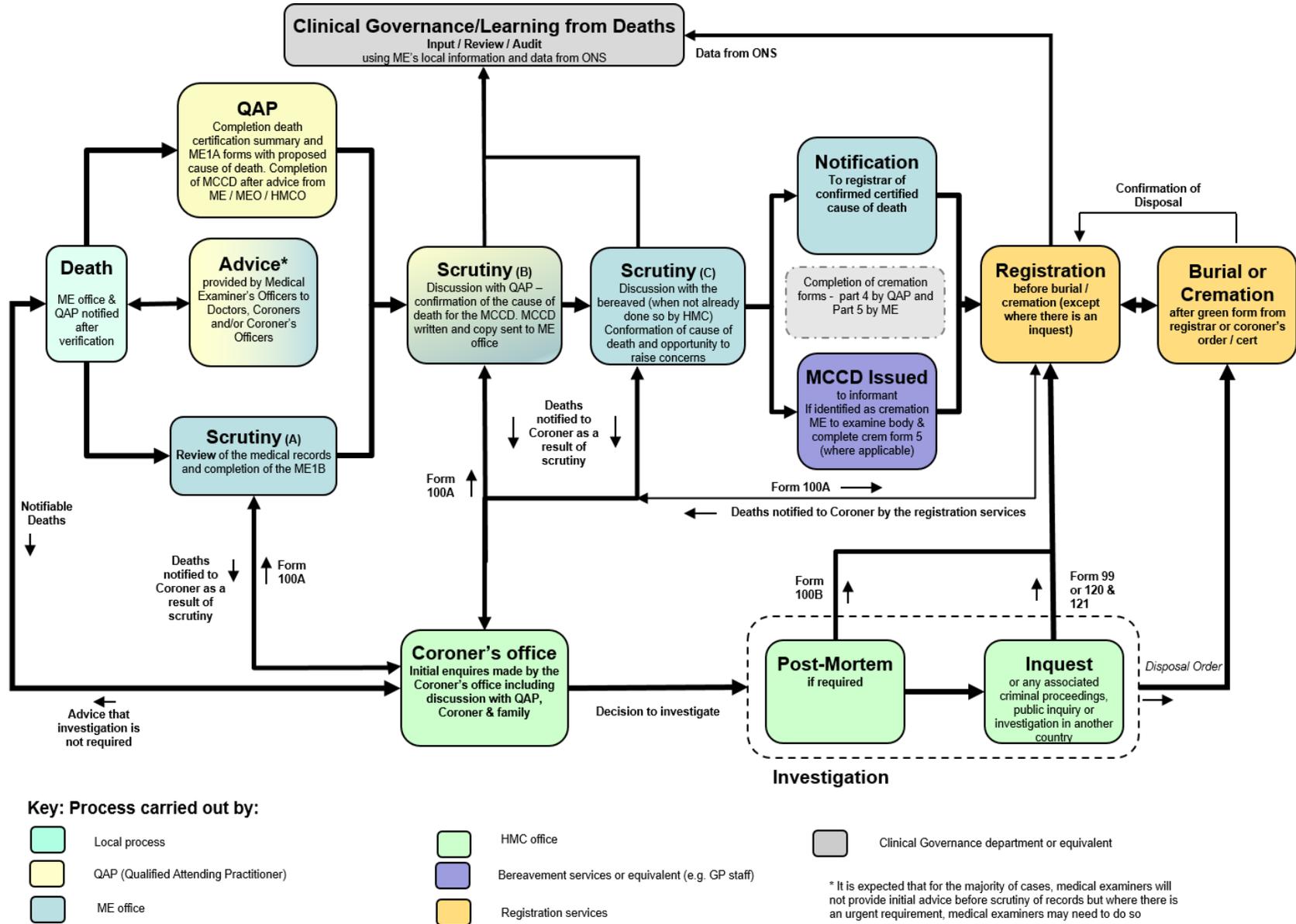
Clinical governance/ learning from deaths

Detection of clinical governance issues and deaths that will be subject to review:

- the medical examiner officer should identify cases marked by the medical examiner for Structured Judgement Review/ Mortality Stage 2 review and clinical governance/ Serious Untoward Incidents
- this should include cases simultaneously notified to the coroner
- a summary standard format should be sent to a nominated individual for further action. The information should include the cause of death and the medical examiner's scrutiny/reason for referral

The process for medical examiner systems following a death is summarised in Figure 2 below.

Figure 2: Overview of proposed process for death certification

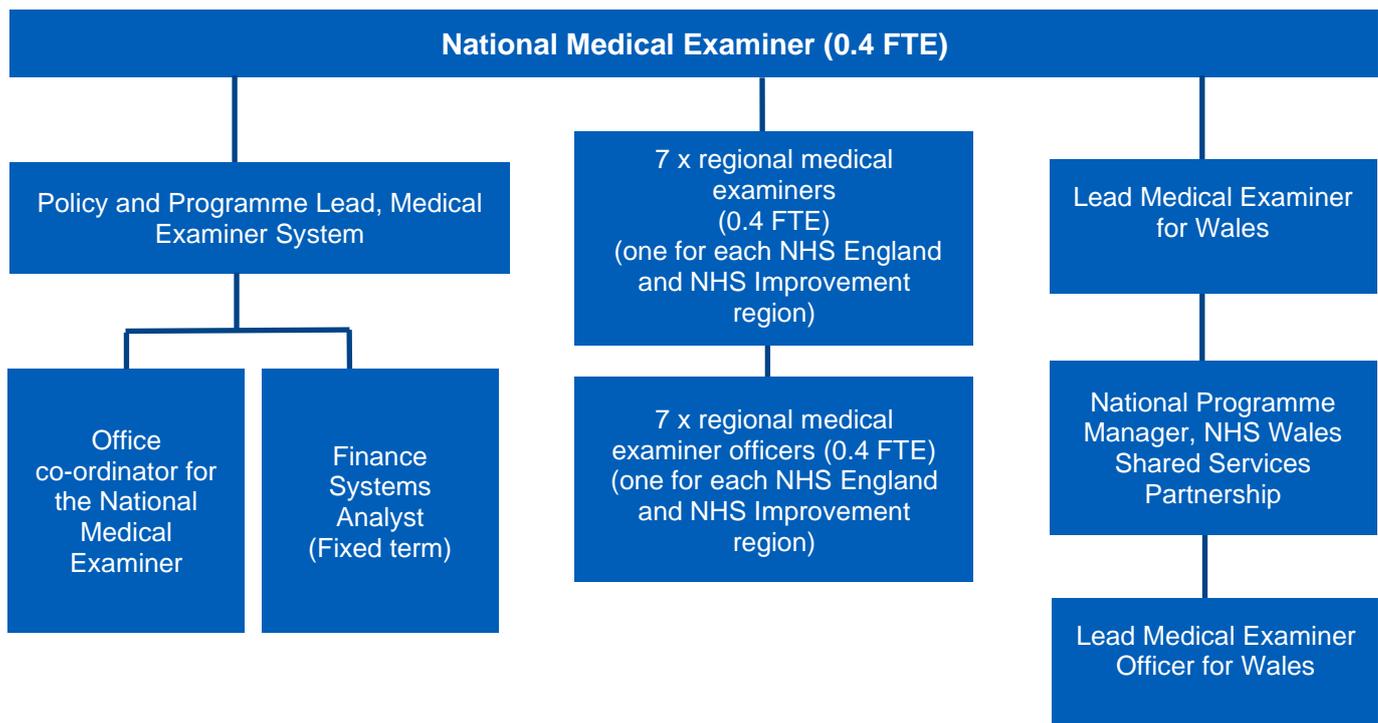


Appendix 1: Support and infrastructure

Further information is available at the following web pages:

- [National Medical Examiner webpage](#)
- [The Royal College of Pathologists](#)
- [Medical examiner training](#)
- [Setting up a medical examiner system](#)
- [Medical examiners committee](#)

The National Medical Examiner has a national office in NHS England and NHS Improvement, and each of the seven NHS regions in England has a regional medical examiner, supported by a regional medical examiner officer. Regional medical examiners are accountable to the National Medical Examiner. The Lead Medical Examiner for Wales is also accountable to the National Medical Examiner.



Regional medical examiners and the lead medical examiner for Wales will work with host organisations to agree how medical examiner officers are hosted. The NHS in Wales is shown in Figure 3 and regions in England are shown in Figure 4 below.

Figure 3: NHS in Wales

WALES

LOCAL HEALTH BOARDS

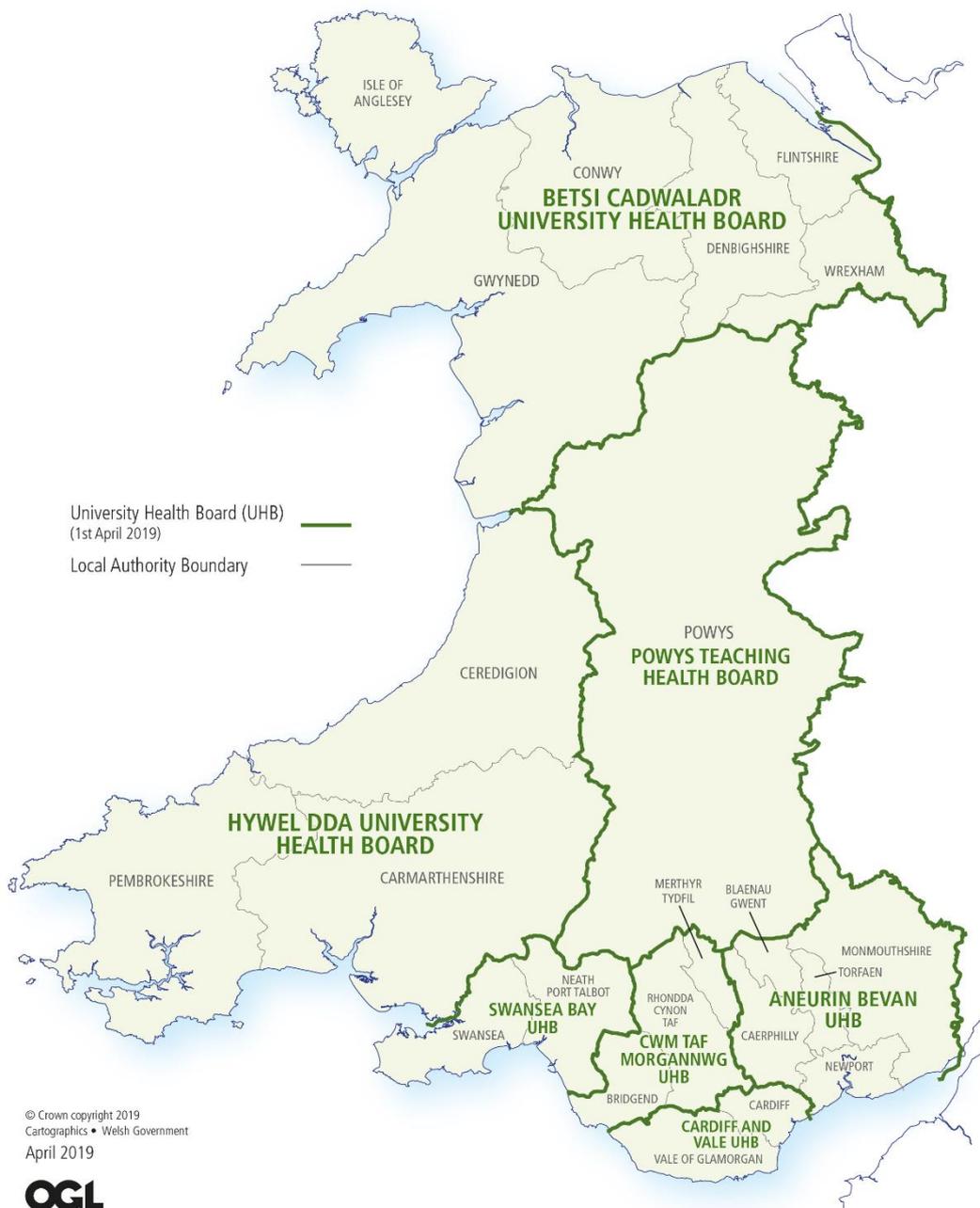
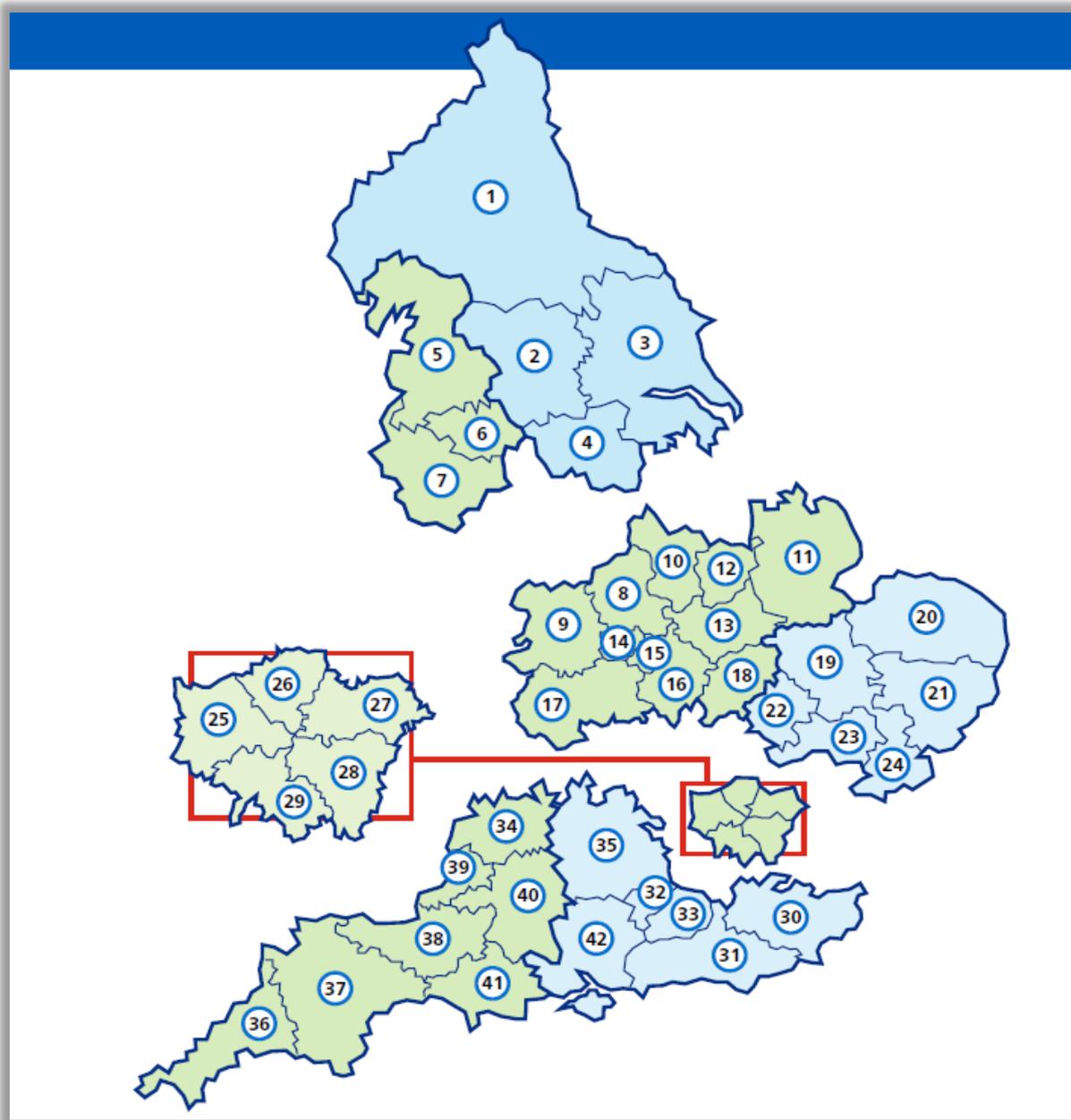


Figure 4: NHS regions in England



North East and Yorkshire

1. Cumbria and the North East
2. West Yorkshire and Harrogate
3. Humber, Coast and Vale
4. South Yorkshire and Bassetlaw

North West

5. Lancashire and South Cumbria
6. Greater Manchester
7. Cheshire and Merseyside

Midlands

8. Staffordshire and Stoke on Trent
9. Shropshire and Telford and Wrekin
10. Derbyshire
11. Lincolnshire
12. Nottinghamshire
13. Leicester, Leicestershire and Rutland
14. The Black Country
15. Birmingham and Solihull
16. Coventry and Warwickshire
17. Herefordshire and Worcestershire
18. Northamptonshire

East of England

19. Cambridgeshire and Peterborough
20. Norfolk and Waveney

21. Suffolk and North East Essex
22. Bedfordshire, Luton and Milton Keynes
23. Hertfordshire and West Essex
24. Mid and South Essex

London

25. North West London
26. Central London
27. East London
28. South East London
29. South West London

South East

30. Kent and Medway
31. Sussex and East Surrey
32. Frimley Health and Care
33. Surrey Heartlands
35. Buckinghamshire, Oxfordshire and Berkshire West
42. Hampshire and Isle of Wight

South West

34. Gloucestershire
36. Cornwall and the Isles of Scilly
37. Devon
38. Somerset
39. Bristol, North Somerset and South Gloucestershire

Appendix 2: Background and legislation

Background

The introduction of medical examiners will improve the death certification process by increasing the accuracy of the MCCD for deaths that are not investigated by a coroner. The National Medical Examiner system forms part of the [NHS Patient Safety Strategy](#) in England and is an important component of improving patient safety. Medical examiners provide independent scrutiny of causes of death and the care before death, and facilitate feedback from the bereaved.

The Government's proposals for medical examiners, and for a new rigorous, unified system of death certification for both burials and cremations in England and Wales, is part of the response to several independent enquiries.⁶ In June 2016, the Government consulted on a package of reforms to the death certification process, including the introduction of medical examiners. The [Government's response](#) to this was published in June 2018 and set out its intention to introduce a system of medical examiners in the NHS. The Welsh Government issued a response to its consultation on areas of the medical examiner service devolved to Wales in June 2018.

The medical examiner system will be enshrined in statute, but this will take some time. NHS England and NHS Improvement, DHSC, the Welsh Government and NHS Wales Shared Services Partnership are working together to implement the non-statutory system for non-coronial deaths with the intention that during 2020/21 it will cover all non-coronial deaths, not just those that happen in hospitals.

Legislation

The introduction of medical examiners forms part of DHSC's [death certification reforms](#).

⁶ The Shipman Inquiry; the Francis Inquiry into Mid Staffordshire; the Morecambe Bay Inquiry in 2015; and the Gosport Inquiry 2018.

The Coroners and Justice Act 2009 provides a legal framework for reforms in both England and Wales. It also allows Ministers in Wales to develop and consult upon their own regulations in respect of key aspects of the new system, including the terms for the appointment of medical examiners and their functions and the charging of fees.

The associated regulations on which the Government consulted were the:

- Death Certification Regulations (England and Wales)
- Death Certification (Medical Examiners) (England) Regulations
- Death Certification (Medical Examiners) (Fees) (England) Regulations
- National Medical Examiner (Additional Functions) (England and Wales) Regulations
- Notification of Deaths Regulations (England and Wales).

In advance of the changes to the law that will fully implement sections relating to medical examiners of the Coroners and Justice Act 2009, the flexibility of a non-statutory process will be used to deliver a system that provides proportionate scrutiny of all non-coronial deaths.

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This publication can be made available in a number of other formats on request.

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