NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

NHS
North Bristol
NHS Trust

Medical Examiner Service

Bristol, North Somerset and South Gloucestershire

Charlotte Clews, Lead Medical Examiner Officer

Why was the service created?

Since its introduction in the nineteenth century, the process for certifying death has not changed significantly. When a person died of natural causes the doctor who attended the patient during their last illness would sign a medical certificate of the cause of death. Consequently, there was no requirement for an external examination of the body (unless the body is to be cremated) and there no opportunity for concerns to be raised by relatives.

In January 2000, GP Harold Shipman was convicted of murdering 15 of his patients and had probably killed as many as 200 patients over several years. Harold Shipman had signed the death certificates of the patients he murdered.

Following his conviction, an Independent Inquiry was established and the Inquiry highlighted the fact that it is unsafe to have a single doctor certifying a death of natural causes without independent scrutiny. The inquiry made the recommendation that the introduction of a Medical Examiner would resolve this issue.

In 2014 the Gosport Inquiry was commissioned by the Government to investigate dozens of deaths at Gosport War Memorial Hospital from the 1980/90's. The purpose of this Inquiry was to provide families with a better understanding of what happened to their relatives. The report subsequently revealed in June 2018 that 456 patients died after being given opiates at the hospital.

The findings of the events at Gosport demonstrate that the concerns of staff and patients are a vital source of information to help both avoid harm and improve patient safety and should not be ignored.

Why was the service created?

Inquiries and Reports into Mid Staffordshire and Morecombe Bay, along with the Shipman enquiry, the Gosport enquiry and others led to a call for the introduction of independent Medical Examiners 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.

These recommendations were accepted by the UK Government and laid out in the Coroners and Justice Act 2009, which allowed for the provision of independent Medical Examiners employed by Local Authorities in England. The recent Health and Care Act 2022 has made amendments to allow Medical Examiner services to be hosted by NHS Trusts in England and Health Boards in Wales.

Functions of the service

In response to the requirements contained within the Coroner and Justice Act 2009, the Medical Examiner Office provides the following functions:

- **Strengthen safeguards for the public**, by providing robust and **independent** scrutiny of the medical circumstances and cause of deaths, and ensures that the right deaths are referred to a Coroner
- **Improve the quality of death certification**, by providing expert advice to doctors based on a review of relevant health records
- **Avoid unnecessary distress for the bereaved**, that can result from unanswered questions about the certified cause of death, or from unexpected delays when registering a death
- **Identify patterns and trends of concern** and pass these on to the relevant Trust and National Medical Examiner Office/NHS England and Improvement

How the service works

The Medical Examiner Service will discharge its functions by independently scrutinising all deaths (and ensuring appropriate referral to the Coroner).

This is done by:

- Reviewing medical records
- Discussions with the Qualified Attending Practitioner
- Discussions with the bereaved
- Providing input into Medical Certificates of the Cause of Death and issuing a form ME2 to allow registration of death
- Referring to HM Coroner those deaths that require a Coroner's investigation
- Referring to Trusts deaths that require a further review
- Providing analysis and reports to relevant stakeholders

The three main aspects scrutiny are therefore:

- Proportionate review of the medical records, focusing on the last illness/admission
- Conversation with the Qualified Attending Practitioner who will write the MCCD
- Conversation with the bereaved (Next of Kin) to explain the cause of death, answer questions and hear concerns or issues regarding care

Role of a Medical Examiner

Medical Examiners (MEs) are appropriately trained senior doctors who undertake an independent scrutiny of deaths in order to establish:

- An accurate cause of death, and
- Whether the circumstances surrounding that death give any cause for concern / require further investigation. This may be by the Trust itself or by the Coroner's Service.

MEs are doctors from a range of disciplines who are employed to provide a given number of sessions to the service rather than doctors whose only employment is as an ME. This is because the knowledge and experience they are able to provide is enhanced by their wider remit. MEs typically provide 1-2 sessions per week to the service but this can vary depending on individual circumstances.

Role of a Medical Examiner Officer

Medical Examiner Officers (MEOs) support MEs in scrutinising the circumstances and causes of death by ensuring that the appropriate information is available.

The MEO establishes circumstances of individual deaths by performing a preliminary review of medical records to identify clinical and circumstantial information, and sourcing additional details where required. The may also assist with, under delegated authority from a ME, two aspects of the scrutiny process:

- Discussion with the attending practitioner
- Discussion with the bereaved to establish if they have any concerns or questions about the death of their loved one.

As all MEOs are locally based, they are the local point of contact and source of advice for relatives of the deceased, healthcare professionals, and local Coroner and Registration Services. In this role they also work closely with Bereavement Services to ensure that the process of the scrutiny of death does not cause the bereaved any undue delay or inconvenience.

Leads for the service

Lead Medical Examiner (LME) – Dr David Crossley

The LME provides leadership and guidance to ensure that the service is set up and governed effectively, and also provides leadership and support to MEs, including providing them with an independent professional line of accountability.

The LME supports the South West Regional ME (Dr Golda Shelley-Fraser) and National ME (Dr Alan Fletcher), by ensuring that relevant legislation, guidance and standards are understood and implemented effectively in Bristol and Weston, and by keeping them informed of progress and issues arising.

Lead Medical Examiner Officer (LMEO) – Ms Charlotte Clews

The LMEO provides support to the LME in establishing and maintaining a high-quality service.

As the professional lead for MEOs working in Bristol and Weston, the LMEO provides both strategic planning and operational management of the service to enable it to operate effectively and efficiently.

The LMEO is responsible for assuring the quality of MEO work and will be the main source of advice and guidance on the service for key partners, including Coroner's Offices, Registration Service Offices, Bereavement Services and local care teams/organisations.

The service in BNSSG

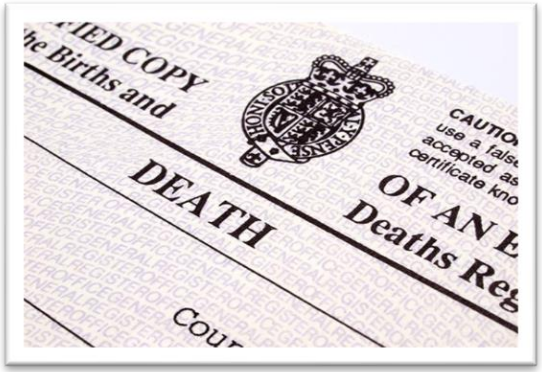
Although the legal responsibility for providing Medical Examiners rests with individual NHS Trusts, it is important to the credibility of the service that ME's are able to provide independent scrutiny of death.

As a result, the service for Bristol and Weston was delivered in partnership between UHBW and NBT.

In order to ensure the highest level of independent scrutiny of the cause of, and circumstances surrounding a death, Medical Examiners are not be involved in the scrutiny of deaths in the area in which they work.

The service in BNSSG

The Medical Examiner Service is hosted by NBT and currently provides an independent scrutiny of 100% of the acute Trusts' adult deaths (NBT & UHBW) – around 4000 per annum.



Currently, the service employs 2 WTE Medical Examiners (20PAs, consisting of 12 individuals) and 5.4 WTE Medical Examiner Officers (6 individuals).

The first recruitment to the service was in May 2020, and by December 2020 all ME's and MEO's were in post. 50% scrutiny was achieved by September 2020, and 95% by March 2021.

We have offices established at Bristol Royal Infirmary, Southmead Brunel, and Weston General Hospital. These offices cover the deaths that occur across both trust's 10 hospital sites.

Recruitment for expansion of the service has begun and further accommodation is being sought to support the roll out to cover non-acute deaths.

Data collected

Quarterly, the ME Service sends the following information to the National ME Office:

- Number of deaths scrutinised
- Burial/cremation information
- Number of cases referred to HM Coroner
- Cases sent to Trust governance departments for Mortality Review, Patient Safety review or similar further action
- Number of MCCDs not complete with 3 calendar days
- Number of MCCDs rejected by Register Office after ME scrutiny
- Number of cases where urgent release of a body is requested
- Number of cases in which communication with the bereaved is not achieved
- Ethnicity data

The National ME Annual Report provides a high-level overview of the data submitted nationwide (2021 report published 18/05/22):

https://www.england.nhs.uk/wp-content/uploads/2021/04/B1580_national-medical-examiner-report-for-2021.pdf

Data collected

Communication with bereaved families is a rich source of data

The BNSSG ME Office reliably speak to over 90% of bereaved families

Specific remit to our conversation with the bereaved, but great potential for qualitative analysis

Many other potential avenues for research - ~18 months of data collected so far

Expansion into the community will allow comparison of acute vs non-acute deaths, e.g. quality of hospital vs at-home deaths, appropriateness of discharge for those who die within 30 days of discharge from hospital

Moving forwards

The service is due to become statutory from April 2023, when all deaths in England and Wales that are not investigated by the Coroner will be scrutinised by a Medical Examiner

We are currently working to include paediatric, neonatal and maternal deaths at the acute Trusts

Planning of the rollout to cover deaths occurring outside of acute hospitals has commenced, with the appointment of a further 3 WTE MEOs and 0.8 WTE MEs (8PAs) in progress.
We are working with Sirona, the local hospices and a small number of pilot GP practices to plan the rollout – but would be very interested to hear from any further GPs or practices interested in working with us in the early stages

Dr David Crossley, Lead Medical Examiner for BNSSG & Ms Charlotte Clews Lead Medical Examiner Office for BNSSG