National Medical Examiner update

June 2019

Welcome

June is proving busy and we are making progress on key tasks to establish the national medical examiner system, in particular establishing the senior team to work with NHS providers across England and Wales. I have started interviewing for the seven regional medical examiners in England and the lead medical examiner in Wales, and I have been really encouraged by the enthusiastic response to our advertisements.

We will shortly advertise for regional medical examiner officers to support the regional medical examiners. Interviews for these posts should take place in September 2019.

Work on the digital system to support the medical examiner office function continues at pace. We have continued to work closely with colleagues at the Department of Health and Social Care (DHSC) on the financial and practical arrangements for establishing the medical examiner system, and plan to write to all providers about these in July. I will continue to engage with wider audiences in the coming weeks to provide more information about the medical examiner system – for example, when speaking at the Patient Safety Congress in Manchester on 2 July 2019.

Dr Alan Fletcher, National Medical Examiner

What's included in this update

- The role of medical examiner officer
- Neonatal and child deaths
- Alignment with Learning from Deaths
- Recruitment to local medical examiner posts

The role of the medical examiner officer

To support you to recruit the right people to these important roles, we thought it would be helpful to outline what the position typically involves.

Medical examiner officers are responsible for managing the medical examiner office, they manage the cases from initial notification through to completion and communication with the registrar. Medical examiner officers obtain all relevant medical records to allow medical examiners to focus on scrutiny. They are a source of advice and are the constant in the office, enabling consistency across medical examiners working part-time and from a range of specialties.

A key role is interaction with the next of kin or informant under delegated authority from the medical examiner. Medical examiner officers explain causes of death, answer questions, and respond to concerns raised by the bereaved, discussing these further with the medical examiner where appropriate. The ability to interact with the bereaved in a professional but empathetic way is a key skill. The emotional impact of regular contact with the bereaved should not be underestimated – medical examiner officers need personal resilience.

Again under delegated authority from the medical examiner, another key role is interaction with the Qualified Attending Practitioner. The medical examiner officer needs to understand medical records, explain the medical examiner's thoughts and rationale, as well as providing advice on terminology and causes of death. Medical examiner officers also need to build and maintain effective relationships with other organisations such as care providers, coroners' offices, funeral directors and faith groups. There are parallels with the way coroner's officers work.

While there is some delegated authority, the medical examiner retains responsibility for scrutiny of each case and for deciding whether referral to the coroner is necessary. A positive and supportive working relationship between the medical examiner and medical examiner officer is crucial for the efficient running of the office, and the medical examiner will facilitate the development of officers' skills and expertise.

An example medical examiner officer job description is available. We would expect this to be locally tailored to ensure the best fit, and we consider Agenda for Change Band 5 or 6 is the correct level for the role. Medical examiner officers will come from a variety of backgrounds; these may include bereavement services, registrars, nurses and other allied health professionals. We recommend there is one whole time equivalent medical examiner officer per 1,000 deaths.

Neonatal and child deaths

You have been asking us questions about neonatal and child deaths. We have worked closely with colleagues at NHS England and NHS Improvement to ensure medical examiners are familiar with and complement the new statutory child death review processes (see the statutory guidance). Medical examiners will be involved in the scrutiny of these deaths, but we wish to avoid unnecessary repeated contact with bereaved parents. In most cases, we recommend the family's key worker communicates with the medical examiner office, checks understanding of the proposed cause of death with parents and carers, and asks if they have any concerns about the treatment their child received. The funding from DHSC will cover the time required by medical examiners and medical examiner officers for such cases.

Alignment with Learning from Deaths

The Learning from Deaths programme in England was established in 2017 following publication of the Care Quality Commission's report *Learning, candour and accountability*. This found that valuable opportunities are being missed across the system to learn from the care provided to those who die and that many families do not experience the NHS as being open and transparent. All NHS acute, community and mental health trusts have Learning from Deaths policies, and this requirement will shortly be extended to ambulance trusts.

The medical examiner system and the Learning from Deaths programme will improve mortality governance and will promote compassionate and open care for bereaved families.

Medical examiners will have an important interaction with the Learning from Deaths programme, they highlight cases to be considered for review and ensure these are flagged to the trust mortality lead and/or to the relevant mortality review programme. However, medical examiners should neither be involved in mortality reviews of cases they have independently scrutinised, nor undertake mortality review work in medical examiner time. It is not appropriate for a medical examiner to be the overall trust

mortality lead, because of the need to keep these two roles separate. However, when not acting in the capacity of a medical examiner, doctors to whom this applies can undertake or contribute to case record reviews and other mortality review processes.

Recruitment to medical examiner offices

It is encouraging to learn that providers are implementing or making plans to set up medical examiner offices. We hope this will increase in coming months. It will be important to build relationships with local stakeholders as part of this process, and we would particularly encourage providers to invite local coroners to participate in the interview and selection process, for example, by joining interview panels. This is an important way to continue assurance of medical examiners' independence. If you have any questions about recruiting medical examiners and medical examiner officers, please email nme@nhs.net.

National Medical Examiner's office

Nick Day joined us as Policy and Programme Lead, Medical Examiner System at the beginning of June.

Providers have been engaging with the team, and we encourage you to continue to raise queries with us and share your thoughts on the introduction of medical examiners:

- for general enquiries: please continue to use nme@nhs.net
- for enquiries about the National Medical Examiner's diary: Helen Hill, helen.hill6@nhs.net
- for enquiries about implementation: Nick Day, nickday@nhs.net

Further information

Further information about the programme can be found on the national medical examiner webpage.