National Medical Examiner update

September 2019

Welcome

We announced the names of our regional medical examiners in England and the lead medical examiner for Wales in our last bulletin. Most have now started in these roles and are making contact with NHS providers and stakeholders. We'll shortly complete our national infrastructure to support providers setting up medical examiner systems with the appointment of regional medical examiner officers in England and the lead medical examiner officer for Wales.

Regional medical examiners and the lead medical examiner for Wales met for the first time this month to discuss our priorities, and we were joined by representatives from the Department of Health and Social Care, Royal College of Pathologists, and the Chief Coroner's Office. I continue to meet the Chief Coroner every month.

I attended the World Patient Safety Day event in London at which several speakers underlined that medical examiners are part of the co-ordinated work to improve patient safety.

Finally, with Professor Steve Powis and Dr Aidan Fowler, I wrote to medical directors on 11 September 2019 to provide more information about what the introduction of medical examiners in England means for their organisation. There is more information about this below. We are currently working on good practice guidelines for medical examiners and plan to provide early sight of these in coming weeks.

Dr Alan Fletcher, National Medical Examiner

What's included in this update

- National and regional infrastructure
- Funding the medical examiner system
- Medical examiners and referrals to coroners
- Working with registrars
- Face-to-face training

National and regional infrastructure

A key priority for us in the early stages of implementing the national medical examiner system is getting the right support in place for providers.

Most of our new regional medical examiners in England and the lead medical examiner for Wales have started work in these new roles, and we have held interviews for regional medical examiner officers (links to the advertisements were included in the previous bulletin).

Funding the national medical examiner system

On 11 September 2019, we issued a letter to give trust and foundation trust medical directors in England (cc chief executives and finance directors) further information on what the introduction of medical examiners in England means for their organisation. The annex to the letter provides details on the regional structure, the digital system and plans for funding the system. Dr Alan Fletcher and Dr Frank Atherton, the Chief Medical Officer for Wales, wrote separately to NHS organisations in Wales.

Medical examiners and referrals to coroners

As you know we strongly encourage medical examiners to work closely with coroners' offices and to develop good working relationships. The Notification of Deaths Regulations 2019, which come into force on 1 October 2019, will make the types of cases that medical practitioners must notify to senior coroners consistent nationally. The Ministry of Justice published guidance on these regulations. This guidance should replace any existing local guidance about the types of cases coroners expect to be referred to them. Of course, in relevant cases all registered medical practitioners including medical examiners, should notify the relevant senior coroner of a person's death as soon as is practicable.

We expect that as the regulations come into force, if coroners have concerns about issues in a hospital (and in due course, within the community) they will raise this with their local medical examiner and agree any action. In some cases it may be appropriate to involve the regional medical examiner, the National Medical Examiner and the Chief Coroner. We encourage medical examiners to engage with coroners where concerns are raised in line with the new regulations and guidance.

Working with registrars

The introduction of medical examiners should bring benefits for registrars, particularly from greater consistency and quality in the medical causes on death certificates. 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.

We have been working with the National Panel of Registration on an updated Cause of Death List for Registrars, for future publication. We will continue to assist the General Register Office in completing their work. As we implement the medical examiner system, the proportion of Medical Certificate of Cause of Deaths (MCCD) that are rejected at registration, and the number of breaches of the five-day registration requirement and reasons for them will be considered.

Face-to-face training

The Royal College of Pathologists will run its first face-to-face training day for medical examiner officers on 5 November 2019, and has added dates for medical examiner training into 2020 to its website.

National Medical Examiner's office

We encourage you to continue to raise queries with us and share your thoughts on the introduction of medical examiners:

- for general enquiries: 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

In Wales

- for enquiries about implementation in Wales: Andrew Evans, Andrew.evans@nhs.wales.uk

Further information

Further information about the programme, including previous editions of this bulletin, can be found on the national medical examiner webpage.

NHS Wales Shared Services Partnership also has a webpage on the medical examiner system in Wales: www.nwssp.wales.nhs.uk/medical-examiner-service