Medical Examiners from April 2019? The Latest

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Although the government has been saying for some time that a national system of medical examiners to provide independent scrutiny of all deaths will be rolled out from April 2019, there has not been much detail forthcoming about how this will work in practice.

However, we are now starting to see the first steps being taken towards practical implementation of the proposed medical examiner system.

With April 2019 not that far off, this briefing looks at the latest developments.

Recap on what's being proposed

The concept of having a system of medical examiners to provide oversight of all deaths which are not referred to a coroner has been on the cards for many years but - despite pilot medical examiner systems having been successfully running in two areas of the country since 2008 - little concrete progress has been made towards wider roll-out until now.

In our previous briefing on this topic earlier this year, we looked at the government's June 2018 response to the consultation it ran on deaths certification reform which confirmed its commitment to a national medical examiner system being implemented from April 2019.

By way of recap, the government's consultation response proposed the following:

- A non-statutory medical examiner system initially (although there is draft legislation on the stocks for a statutory system, which may be looked at further down the line);
- Medical examiners to be appointed from within the NHS;
- Funding to be via existing cremation fees plus an element of central government funding;
- A National Medical Examiner to provide guidance to medical examiners.

Once the system is fully rolled out, the idea is that all medical certificates of cause of death completed by doctors will be reviewed by a medical examiner, with the aim of improving the quality/accuracy of cause of death certification as well as giving bereaved families more opportunity to raise concerns, ensuring referrals to coroners are made appropriately and promoting learning/good practice by feeding into clinical governance processes.

The potential practical benefits of the medical examiner system have been highlighted via analysis of the ongoing pilots (e.g. See 'Lessons from the Pilots', May 2016), which has shown an improvement in the accuracy of death certification (e.g. one audit showed there had been a change in the cause of death wording following discussion with the medical examiner in 83% of cases), reduction in medical certificates of cause of death being rejected by the registrar to zero, plus medical examiners often being able to 'defuse' potential complaints, with relatives pleased to have a chance to discuss the cause of death with someone not involved in the care (e.g. one audit showed that relatives had raised a question or concern in 17% of cases, which were satisfactorily discussed with the Medical Examiner's Office, with 3% of families having concerns which justified a discussion between the medical examiner and the coroner).

What's the latest?

It seems that April 2019 remains the target date for this, as re-iterated by the Secretary of State for Health and Social Care in a recent statement to Parliament relating to patient safety.

In reality, full roll-out across the system is likely to take some time, although the hope (expressed by the Royal College of

Pathologists, which has been a key driving force behind this) is that 'rapid progress' will be made from April 2019.

What do we know so far?

- *National Medical Examiner* - A National Medical Examiner is to be appointed to NHS Improvement to provide leadership to the system and guidance to medical examiners. This post is currently being advertised.
- *Medical Examiners* - Medical examiners will be employed 'in the NHS system' (which is a somewhat vague term, which we understand to include being employed by NHS acute Trusts). Whilst they will be accountable to their employing organisation's Board, they will also have an independent professional line of accountability to a regional structure outside their employing organisation, which will include a Lead Medical Examiner for each region. A model job description for the role is available via the Royal College of Pathologists website.
- *Medical Examiner Officers* - Medical examiner officers (model job description similarly now available via the above website), who may have a nursing or other clinical background, will provide support to medical examiners, including being a point of contact and source of advice for relatives of deceased patients, healthcare professionals and coroner services.
- *Training* - An e-learning training package for medical examiners is now available via the Health Education England website, plus face-to-face training is in the process of being created.
- *Digital system* - A digital system is being developed to support roll-out, to ensure a joined-up process and consistency of approach to scrutiny by medical examiners. The Department of Health and Social Care has now selected a provider for this.

However, a number of key issues remain unclear from the information published so far, such as:

- What categories of death will the newly recruited medical examiners be covering - e.g. we understand this may be just hospital deaths initially, but this is unclear?
- How many medical examiners/medical examiner officers will each area be expected to recruit?
- Which Trusts will be responsible for employing them (e.g. where there is more than one Trust covering one area)? What about community deaths?
- Will these be full-time roles or combined with other clinical roles?

What next?

We can anticipate more details emerging as to the practicalities of implementing this new system over the coming weeks/months.

Specifically, the Royal College of Pathologists has been running a series of national medical examiner events to discuss implementation of this, with further events planned for January and April 2019.

How we can help

Our large national team of healthcare regulatory lawyers have a wealth of experience in supporting providers and individuals across the health and social care sector in matters relating to patient deaths, including:

- Advice on reporting deaths to the coroner;
- Support with local investigation processes and compliance with the Learning from Deaths Framework;
- Advice on Duty of Candour - thresholds and approach;
- Support throughout the inquest process, including attendance at pre-inquest review hearings and representation at final inquest hearings, with witness support throughout.

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