

Board of Directors (in public)

Item 2.4

Subject: Medical Examiner Service – Annual Report 2024-25
Date of Meeting: 10th June 2025
Prepared by: Damien Cullington, Lead Medical Examiner
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Presented by: Damien Cullington, Lead Medical Examiner
Purpose of report: To Note

BAF Ref	Impact on BAF
BAF 1	Assurance on processes in place for review of deaths

Level of Assurance (please tick) To be used to provide the Board / Committee with a guide on the extent of assurance and evidence of assurance provided within the report.		<input checked="" type="checkbox"/>
Level of Assurance	Description	
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.	<input type="checkbox"/>
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.	<input checked="" type="checkbox"/>
Moderate	There is an adequate system of internal control, however, in some areas weakness in design and/or inconsistent application of controls puts the achievement and some aspects of the system objectives at risk.	<input type="checkbox"/>
Limited	There is a compromised system of internal control as weaknesses in the design and / or inconsistent application of controls puts the achievement of the system objectives at risk.	<input type="checkbox"/>
No	There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives.	<input type="checkbox"/>

1. Executive Summary

- The Medical Examiner (ME) service has been operational in LHCH since August 2020, but the ME reforms only became statutorily in place since September 2024
- MEs are senior medical doctors who are contracted to trusts from NHSE to independently provide scrutiny of health care records outside their usual clinical duties. There are three MEs and one Medical Examiner Officer (MEO) working within the Trust. The MEs perform this role in addition to their normal clinical roles at the Trust. The ME team are independent of but work collaboratively with the bereavement team.
- There has only been slight variance of deaths within the trust for the last 5-6 years – the highest number was in 2021/22.
- The lead ME and MEO are invited to attend the monthly mortality review group at LHCH
- There has been a significant fall in coroner referrals since the inception of the ME service
- Since September 2024, the new statutory process for MCCD completion is now up and running. There are no significant issues of concern to highlight to the board. The ME team together with the bereavement team understand their roles and responsibilities.

2. Background

The Medical Examiner (ME) and Medical Examiner Officer (MEO)

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. This programme aims to create a statutory requirement and basis for the medical examiner system, but this will require changes to the law.

Dame Janet Smith, in the Shipman Inquiry third report 2003, said:

"The fact that the system of death certification of the cause of death depends on a single doctor does not give rise only to the risk of concealment of crime or other wrongdoing by that doctor. There may be occasions when a doctor knows that a death may have been caused or contributed to by some misconduct, lack of care or medical error on the part of a professional colleague."

Liverpool Heart and Chest introduced the Medical Examiner service in September 2020, and all deaths were scrutinised by the Medical Examiner and they would decide if a coronial referral was required based on the circumstances around the death.

All next of kin receive a phone call to discuss the cause of death and relay any concerns they may have regarding care or treatment. If necessary, inform them about the PALS service (email PALS, senior staff re any potential complaints that family may have). There has been positive feedback from bereaved families.

Since 9th September 2024, all deaths in any health setting must be reviewed by an ME. Medical examiner officers (MEO) liaise with the family direct to explain the process, their understanding and to highlight any concerns to the ME. The changes form part of the Department of Health and

Social Care's [Death Certification Reforms](#). (Figure 1)

Changes since becoming a statutory requirement.

- The Death Certification Reforms have introduced a new [medical certificate of cause of death](#) (MCCD).
- Medical practitioners (termed attending practitioners, APs) may complete an MCCD if they attended the deceased in their lifetime. This represents a simplification of previous rules when cases had to be referred to a coroner if the medical practitioner had not seen the patient within the 28 days prior to death or, had not seen in person the patient after death.
- Once the MCCD is completed by the AP, the MCCD must be countersigned by an ME before being electronically sent to the registrar.
- The death certificate will be checked and signed by the ME after the AP has completed the written document.
- The ME signs and sends the certificate off to the registration services only after the family have been informed and explained what the cause of death is on the MCCD certificate and what the various sections 1a, 1b,1c,1d and 2 mean, and ascertain if they understand and agree with the COD.
- Very rarely a family request for a coroner review and this can be made at their request.
- The Medical examiner will also request a coronial referral if it is felt that the death is any way unnatural, or a cause of death cannot be established – 'to the best of their knowledge'.
- There are now two death certificate books issued from DHSC - one for normal deaths occurring in hospital that now require the signature of the attending practitioner (AP) and the ME, and one to be used solely by the ME to issue the death certificate if there is no AP.
- The other important changes on the death certificate are that now it must be documented if the deceased has an internal device such as permanent pacemaker or internal defibrillation as there are no longer cremation documents where this information was previously documented.
- The Medical Examiners also have a weekend/Bank Holiday on call rota to cover any deaths that require urgent body release for faith reasons.
- The bereaved have 5 days to register a death after the ME has signed and sent it the registrar (previously it was 5 days from death)

Coroner referrals/interaction

There is no statutory duty to scrutinise health care records for cases referred to the coroner's office, but scrutiny is seen as good practice for all deaths in the trust and assists the coroner's office with their enquires.

In many cases, ME scrutiny helps to avoid unnecessary coronial referrals. MEs and MEOs are trained in the legal and clinical elements of death certification processes. They have statutory responsibilities which are set out in regulations. Medical Examiners:

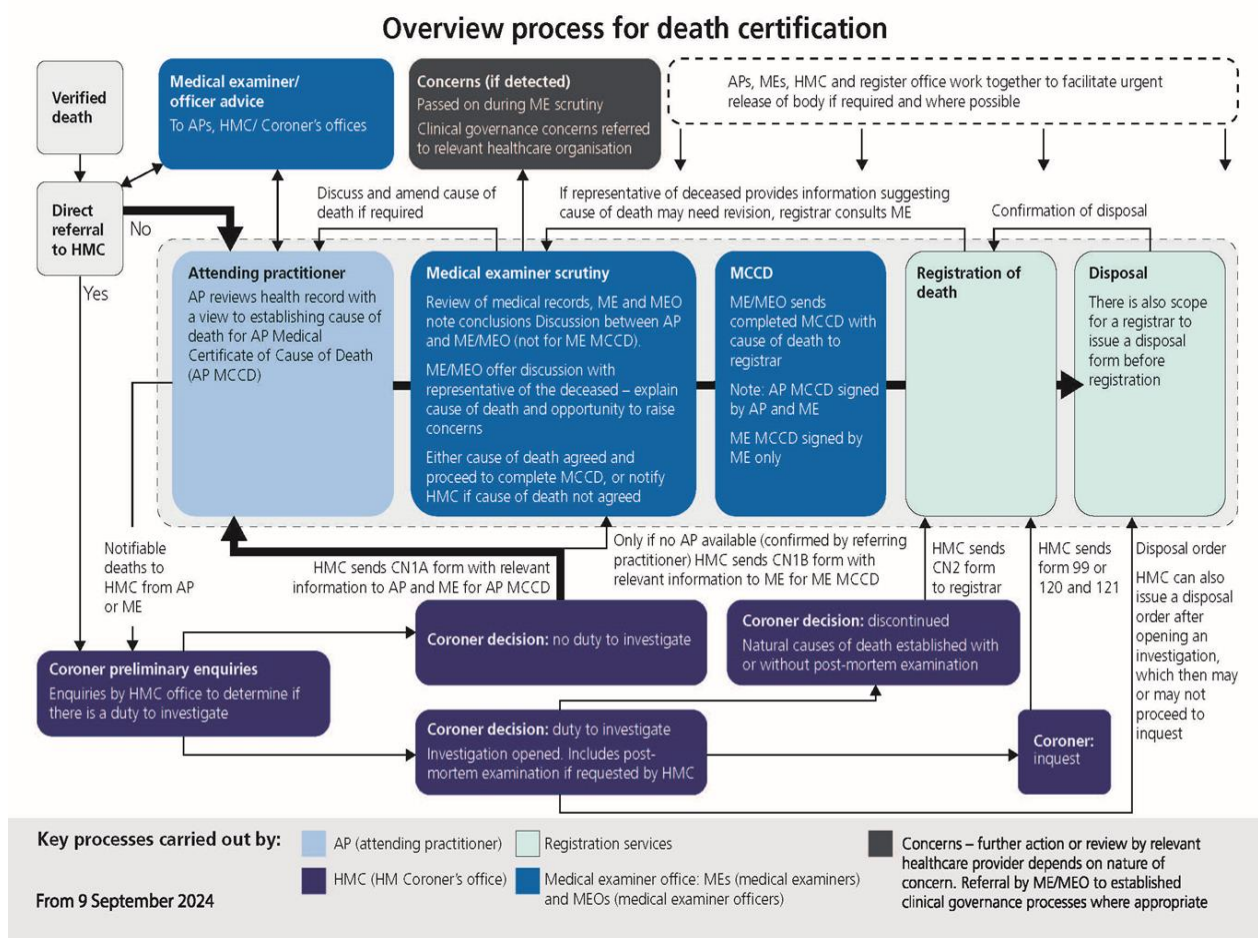
- provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide bereaved people with an opportunity to ask questions and raise any concerns to someone not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data
- raise appropriate concerns within and outside of the trust and recommend further governance review.

The ME service has a good working relationship with HM Senior Coroner and the Area Coroner. We have previously had meetings with the coroner to understand cases they are particularly interested for us to refer but have also come to a working understanding of cases that can be scrutinised in house and do not require automatic referral e.g. salvage operations and coronary intervention.

The ME service works well with HM Coroners in Liverpool and more recently has communications with Cheshire. There have been a few referrals in from Cheshire where there has been a death in the community, the deceased had been recently discharged from LHCH , therefore the coroner has issued a CN1a (document that is asking for a attending practitioner and the ME to write out the death certificate) and a Cn1b which is the coroner asking for a ME to issue the death certificate.

For further enquires, the coroner's office have email details and contact numbers for all members of staff of the ME service at LHCH.

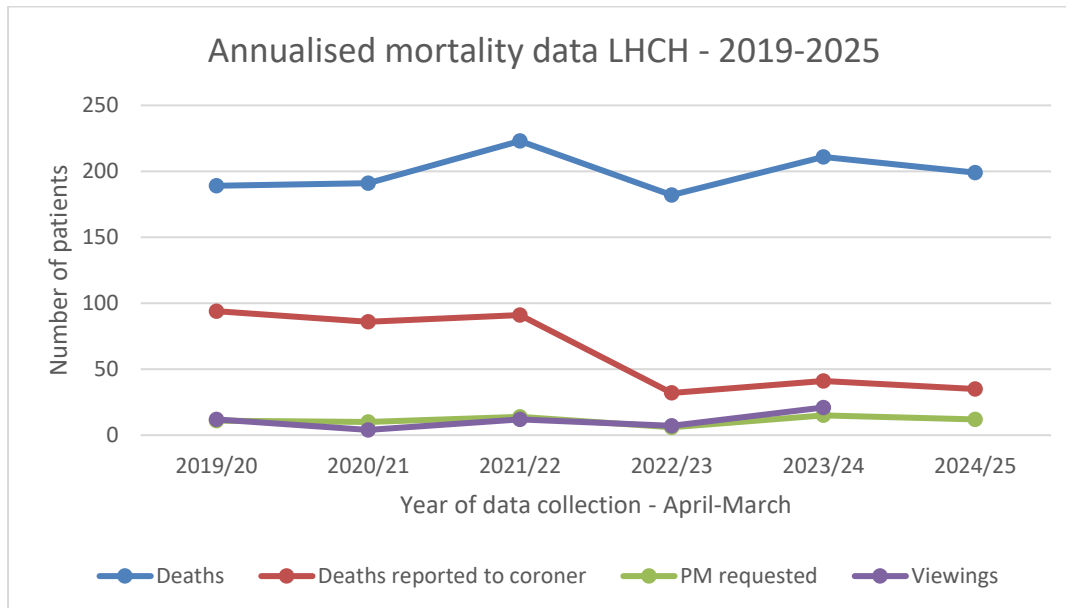
Figure 1 – Flow chart of the process from verification of death to ME review/Coronial review



Network and sharing learning

- The ME/ MEO attends monthly updates via teams meeting with the northwest ME service, this is vital for keeping updated with what is happening in other areas.
- Meetings with the lead MEO for the northwest - feedback is very positive for the service provided here.
- There is a yearly medical examiner conference for England and Wales.
- There are regular webinars from the RCPATH for MEs and MEOs

Annualized LHCH Death Data – Years 2019-2025



- As can be seen in the above chart, the number of deaths per year ranges between 199-223 and there is little variance herein. The average number of deaths per annum is 199.
- Since the full inception of the ME service at LHCH, as one can see from above, the number of coronial referrals has fallen significantly. This is in line with central data submitted to NHSE. This is an expected trend - 174,900 deaths were reported to coroners in 2024, the lowest level since the start of the annual time series in 1995 — down 10% (from 195,000) compared to 2023. The work at LHCH is specialised and over half of deaths are following an acute MI or surgery – the %age drop in our coronial referrals is proportionately more by comparison reflective of the higher associated mortality of the presenting condition and procedures.
- Anecdotally there remains some confusion amongst medical and surgical staff around the necessity for when a coroner's referral is mandated - we encourage discussion between the AP or the named consultant/medical staff who cared for the patients and the ME and MEO before making any submission to HMC since it may not be required – e.g. if the cause of death was a known complication of a procedure and there was no evidence to suggest the procedure was performed in any way below what would be considered a reasonable standard.
- The senior coroner expects there to be ME scrutiny of all cases referred and requests this to be included in the referral documents to assist them with their enquires.

Data since September 2024 when new legislation began.

Total deaths =99

Primary PCI =33 (14 OOHCA and 11 died in cath lab)

TAVI=3

Cardiology deaths = 10;ACHD=4

Respiratory =1

Cardiac surgery deaths =22; Aortic dissection = 6

Thoracic deaths=10

Coroner referrals =11

Service Positives

- The MEs, MEO and bereavement team work very well collaboratively. There is mutual respect for individual roles and there is good mutual support within the team. We work well together. There is a good spread of experience in the team – of the MEs, Damien is a cardiologist; Helen a palliative care physician and Amy is a cardiac intensivist. Dot is a very experienced former thoracic nurse practitioner. Each are able to bring their own experience and skills to support one another. Any problems which have been encountered have collectively addressed.
- The MEs and MEO have a sharedrive online rota. This is shared with switchboard for weekend on call arrangements. The team can organise themselves independently and cross cover effortlessly. The MEO can check easily which ME is on AL/SL and what cover arrangements are in place.
- The introduction of the new statutory system proceeded without any major issue. All MEs can access LHCH patient data remotely and can complete/countersign the MCCD remotely. The MCCD is then emailed by the ME to the registrar. There are very few returns made by the registrar back to the ME – usually these are for minor errors on the MCCD that are easily corrected.
- There is a ME/MEO sharedrive for documents and presentations plus audit data.
- Our audit data provided to NHSE shows generally that we are performing well and above average. We have not breached the audit standard (5 days) to send the MCCD to the registrar following scrutiny.
- The process of verification; DCS; scrutiny; completion of MCCD; countersigning by the ME and sending onward to the registrar is almost always completed within 7 days of death at LHCH (data can be accessed)
- When relevant clinical issues are highlighted following scrutiny for escalation and a need for further governance review (MRG, LeDeR, duty of candour or any other systematic review), the MEs or the MEO are listened to and concerns are actioned which is a positive reflection of the culture within LHCH.
- There is good evidence of working collaboratively with other ME services to encourage improvements/further investigation. A recent example was from the lead ME at Warrington who contacted the ME service at LHCH to highlight that a recent LHCH discharge who had a DNACPR in place in hospital was not discharged with a community DNACPR (and should have been). Sadly, the patient had a cardiac arrest at home 2

days after discharge but died after the attempted resuscitation – it was highly unlikely the patient would survive given their advanced heart failure diagnosis. This was highlighted to the HF lead at LHCH who then agreed to discuss with staff the importance of community DNACPR on discharge for other similar patients.

Service Risks

- There is only one MEO which is a single point of failure. Plans are already in place to recruit to 15 hrs of an additional MEO. This will remove the additional burden on the MEs needing to cover for the MEO during her periods of absence. Some cases can be complex and require a lot of time invested which the MEs sometimes do not have alongside other competing roles.
- Due to the overlapping job plans of MEs it has proven difficult to hold regular internal governance meetings. This needs attention.
- Submission of audit data to NHSE is cumbersome but for the last 2 quarters has been eased by semi-automating this from manual entry of data into a shared excel sheet on teams. This may become easier in future once the electronic MCCD is rolled out (no date is set for this).
- We have noted a small number of community deaths which have been passed back to LHCH staff to complete the MCCD. Whilst within the guidance, this is sometimes due to the refusal of medical staff within primary care to put forward a cause of death – to the ‘best of their knowledge’. This is primarily a training issue as it often misconstrued that to put forward a cause of death requires ‘beyond reasonable doubt’ and to be sure which is not the standard of proof required. We continue to monitor trends. At present, this is not unduly taxing, and we are happy to assist the coroner’s office. We predict that as the statutory ME system is more embedded in primary care, this may become a non-issue.

Other relevant matters:

- Sometimes there are delays in the completion of the death certification summary (DCS). Technically this should be done prior to the ME scrutiny rather than the AP copying the proposed COD from the ME. Due to time constraints this is not always possible since the ME needs to scrutinise the notes within an allocated time of the day. It is sometimes challenging to identify the AP to complete the DCS.
- There are regular opportunities for education of new doctors so they are familiar with the process - all new doctors entering the trust have a presentation and opportunity to discuss on their induction day. Where relevant and required, on a 1-to-1 basis we fill gaps in medicolegal knowledge around areas of misunderstanding – staff are usually receptive of this and it helps to streamline future discussions as the process is more clearly understood.

Conclusions:

The Medical Examiner service is well established at LHCH and is able to fulfil its statutory duties, working closely with HM Coroner’s offices, LHCH bereavement services and clinical teams within the Trust.

Recommendations:

The Board of Directors is asked to note the contents of this report.