Department of Health & Social Care

October 2019

Health Service Safety Investigations Bill

Medical Examiners

The Health Service Safety Investigations Bill amends existing legislation to establish a statutory Medical Examiner system within the NHS to scrutinise all deaths which do not involve a coroner.

1) The legislation will amend the Coroners and Justice Act 2009 to introduce a power for NHS Trusts, Foundation Trusts and other NHS Bodies to appoint Medical Examiners.

2) A coroner must conduct an inquest into a death that they suspect was violent or unnatural, where for example, the deceased might have been murdered or taken their own life, if the cause of death is unknown, the person dies in custody or in state detention.

3) The Medical Examiner system will be a key element of the NHS safety system, giving the bereaved a voice, while ensuring that the period after death is as problem-free as possible.

4) Once fully in place, the Medical Examiner system will ensure that every death in England and Wales is scrutinised, either by a coroner or a medical examiner, and that any clinical issues and learning can be quickly identified to improve patient safety.

5) The introduction of Medical Examiners responds to a number of inquiries, including the Shipman Inquiry's conclusions which recommended the creation of a new rigorous, unified system of death certification for both burials and cremations in England.

6) A National Medical Examiner for England and Wales was appointed to NHS England and NHS Improvement in early 2019. The National Medical Examiner will oversee a structure of a regional medical examiner and lead medical examiner officer in each of the seven NHS regions.

What will Medical Examiners do?

7) Medical Examiners will provide a service to the bereaved, increasing transparency and offering them the opportunity to raise concerns. They will provide a new level of scrutiny to help deter criminal activity and poor practice.

8) Medical Examiners will also report clinical governance matters which will support local learning and help determine changes to practice and procedures.

9) The medical examiner system will benefit the public, patient safety and the health service in a number of significant ways:

   a. **It will be fair** – all deaths will be scrutinised in a robust and proportionate way regardless of whether they are followed by burial or cremation;

   b. **It will be independent** – a medical examiner will scrutinise all MCCD's prepared by the attending doctor;

   c. **It will be transparent** – families will have the cause of death explained to them, including clarification of medical terms and be able to ask questions or raise concerns;

   d. **It will be accurate** – medical examiners will be experienced doctors capable of ensuring that the MCCD is completed fully and accurately, providing better quality cause of death information to help inform health policy;

   e. **It will improve safety** – medical examiners will be able to identify trends, unusual patterns and local clinical governance issues and make malpractice easier to detect.

10) The three key elements of the Medical Examiner scrutiny process are to:

   i. Strengthen safeguards for the public by providing additional scrutiny of the medical circumstances and cause of deaths, and ensuring the right deaths are referred to coroners

   ii. Improve the quality of death certification by providing expert advice to doctors based on a review of the relevant health records; and

   iii. Avoid unnecessary distress for the bereaved that can result from unanswered questions about the certified cause of deaths or from unexpected delays when registering a death.

Who will be responsible for Medical Examiners?

11) Under the legislation, NHS Bodies have the power to appoint Medical Examiners. Some organisations may arrange to use the services of a medical examiner in another NHS body as part of the medical examiners system.

12) Medical Examiners will be employed by the NHS and will cooperate fully with HSSIB investigations.

13) Medical Examiners will follow their organisation's existing lines for reporting concerns about deaths.