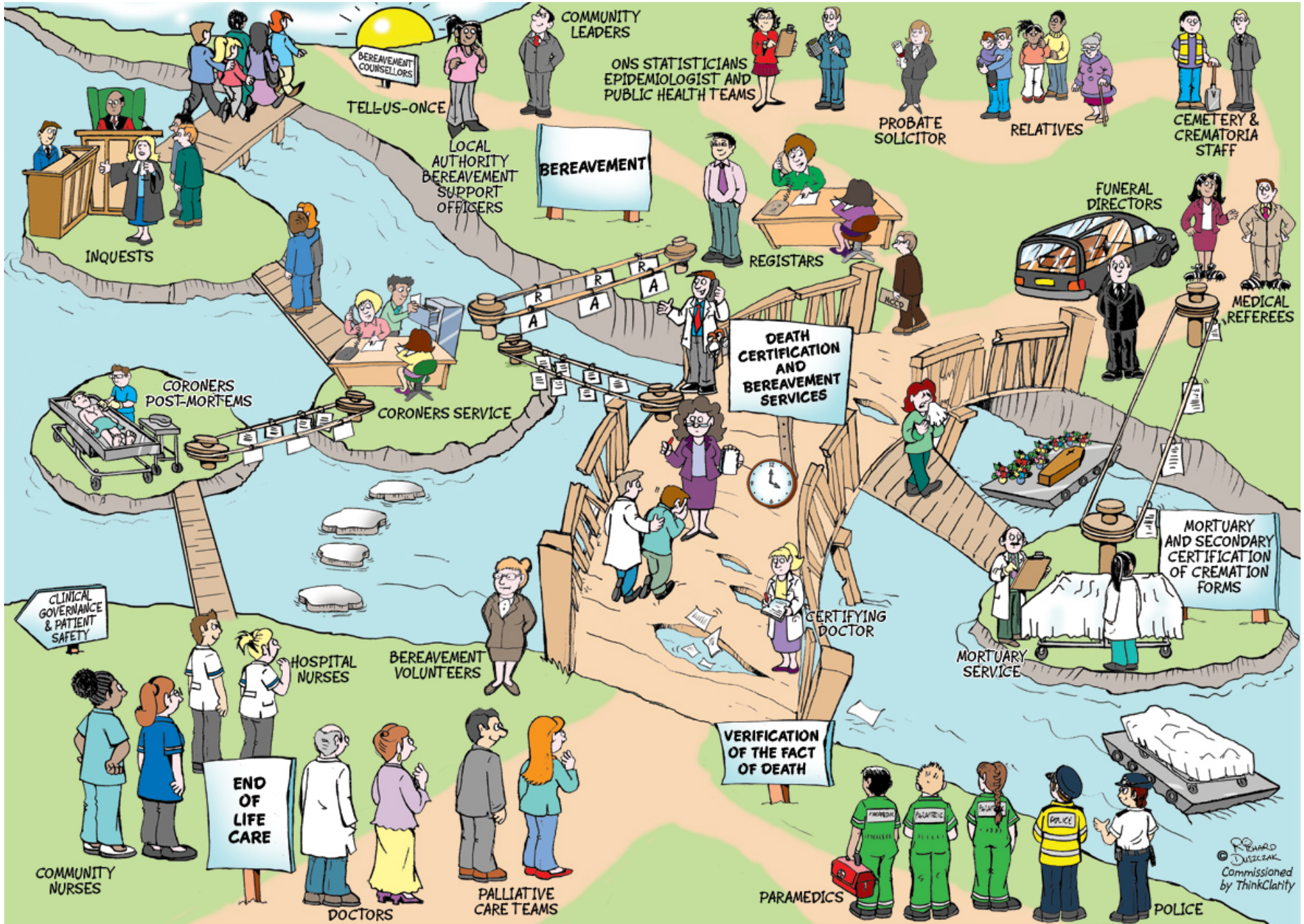
Medical Examiners

Dr Alan Fletcher

November 2018

People, Process & Technology in the Current System



Medical examiner purpose

- What do patients die from?
- Accurate medical certificate of cause of death (MCCD) completion

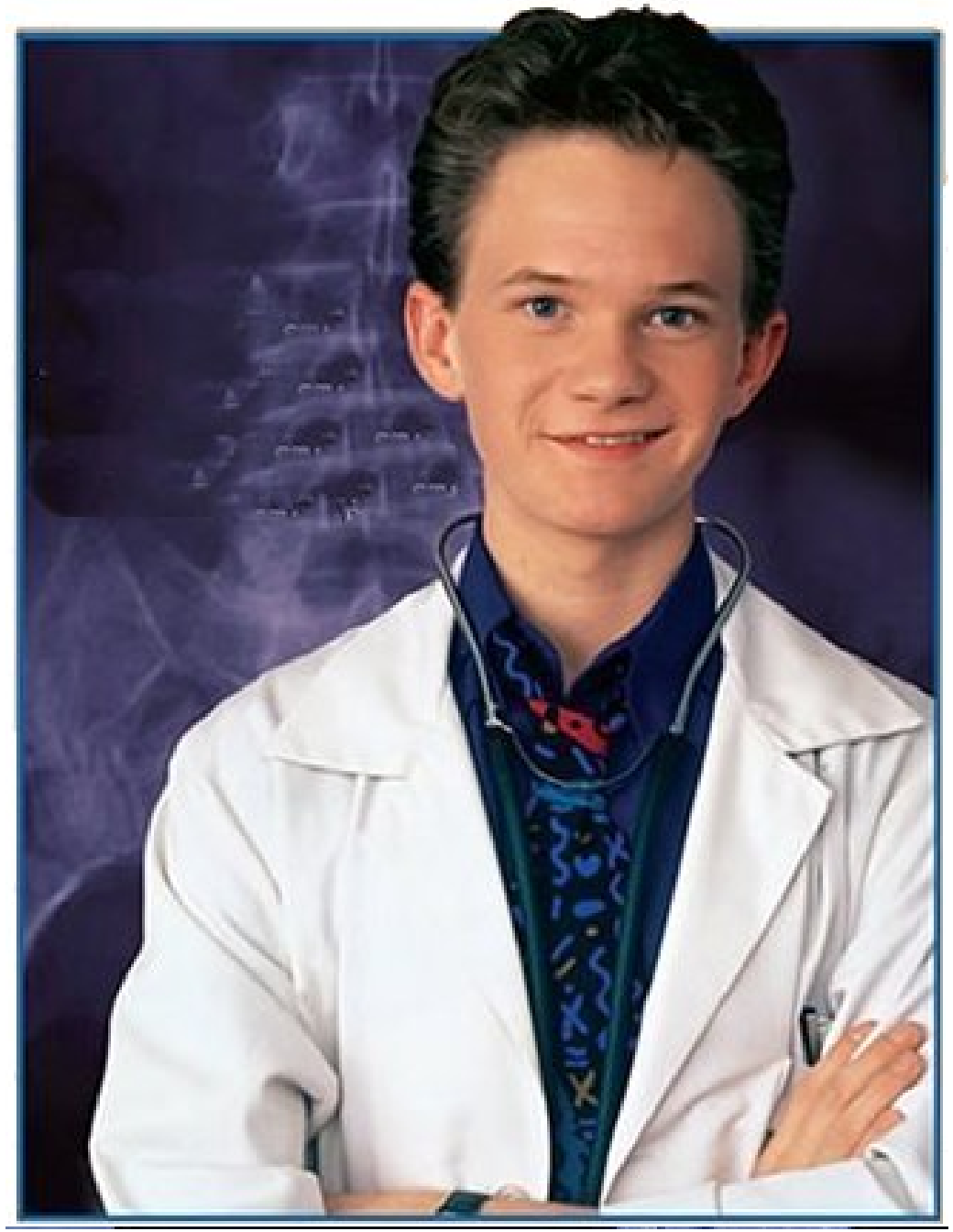
- Does the death need reporting to the coroner?
- Timely and accurate referral to the coroner

- Are there any clinical governance concerns?
- Early detection and notification

Medical Examiner steps

1. Proportionate review of medical records
2. Interaction with the attending doctor
3. Interaction with the bereaved
4. (Confirmation of the medical certificate)

- All within 24 hours of the death being notified (records received)
- 2 and 3 may be delegated to a Medical Examiner Officer



MED A 26 496472

BIRTHS AND DEATHS REGISTRATION ACT 1953

(Form prescribed by the Registration of Births and Deaths Regulations 1987)

MEDICAL CERTIFICATE OF CAUSE OF DEATH

For use only by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the deceased's last illness, and to be delivered by him forthwith to the Registrar of Births and Deaths.

Registrar to enter No. of Death Entry

Name of deceased .....

Date of death as stated .....

Age as stated to me 72 yrs

Place of death HOSPITAL

Last seen alive by me .....

1 The certified cause of death takes account of information obtained from post-mortem.
2 Information from post-mortem may be available later.
(3) Post-mortem not being held.
4 I have reported this death to the Coroner for further action.
[See overleaf]

Please ring appropriate digit(s) and letter

(a) Seen after death by me.
b Seen after death by another medical practitioner but not by me.
c Not seen after death by a medical practitioner.

CAUSE OF DEATH

The condition thought to be the 'Underlying Cause of Death' should appear in the lowest completed line of Part I.

Bowel cancer

I (a) Disease or condition directly leading to death† LUNG INFECTION

(b) Other disease or condition, if any, leading to I(a) RENAL FAILURE

(c) Other disease or condition, if any, leading to I(b) CARDIAC FAILURE

II Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition causing it. CHRONIC OBSTRUCTIVE AIRWAYS DISEASE

These particulars not to be entered in death register

Approximate interval between onset and death

The death might have been due to or contributed to by the employment followed at some time by the deceased. ☐ Please tick where applicable

†This does not mean the mode of dying, such as heart f... ...cation which caused death.

I hereby certify that I was in medical attendance during the above named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature .....

Qualifications as registered by General Medical Council FRCA

Residence ANAESTHETIC DEPARTMENT NORTHERN GENERAL HOSPITAL Date .....

For deaths in hospital: Please give the name of the consultant responsible for the above-named as a patient.

MED A 26 117308

BIRTHS AND DEATHS REGISTRATION ACT 1953

(Form prescribed by the Registration of Births and Deaths Regulations 1987)

MEDICAL CERTIFICATE OF CAUSE OF DEATH

For use only by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the deceased's last illness, and to be delivered by him forthwith to the Registrar of Births and Deaths.

Registrar to enter No. of Death Entry

Name of deceased .....

Date of death as st ..... Age as stated to me 87

Place of death .....

Last seen alive by me 14 TH day of JANUARY

1 The certified cause of death takes account of information obtained from post-mortem.
2 Information from post-mortem may be available later.
(3) Post-mortem not being held.
4 I have reported this death to the Coroner for further action.

[See overleaf]

Please ring appropriate digit(s) and letter

(a) Seen after death by me.
b Seen after death by another medical practitioner but not by me.
c Not seen after death by a medical practitioner.

CAUSE OF DEATH

The condition thought to be the 'Underlying Cause of Death' should appear in the lowest completed line of Part I.

		These particulars not to be entered in death register
		Approximate interval between onset and death
I (a)	Disease or condition directly leading to death† END STAGE DEMENTIA	
(b)	Other disease or condition, if any, leading to I(a)	
(c)	Other disease or condition, if any, leading to I(b)	
II	Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition causing it. MALNOURISHED	

The death might have been due to or contributed to by the employment followed at some time by the deceased. ☐ Please tick where applicable

†This does not mean the mode of dying, such as heart failure, asphyxia, asthenia, etc: it means the disease, injury, or complication which caused death.

I hereby certify that I was in medical attendance during the above named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature .....

Qualifications as registered by General Medical Council MBCHB

Residence NORTHERN GENERAL HOSPITAL Da

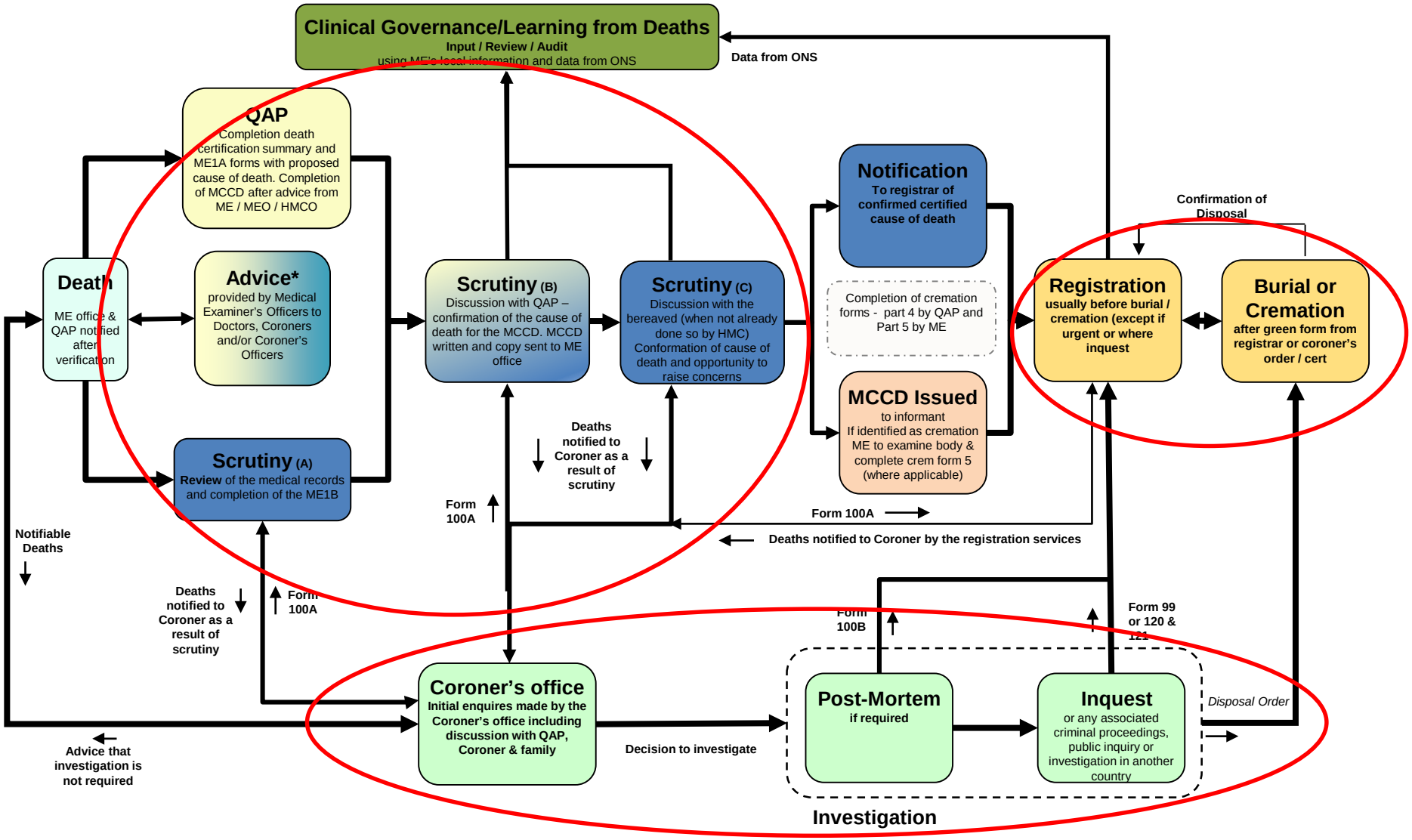
For deaths in hospital: Please give the name of the consultant responsible for the above-named as a patient .....


CORONERS
COURT

Coroner idiosyncrasies

- **Manchester City Coroner**
- All deaths of children and young people under 18, even if due to natural causes. This is for safeguarding purposes.
- Deaths within 24 hours of admission to hospital
- All deaths of people who are in custody or detained under the Mental Health Act, even if due to natural causes, including people living in care homes who are subject to Deprivation of Liberties Safeguarding
- Some unusual illnesses including hepatitis and tuberculosis

Overview of Proposed Process for Death Certification



Key: Process carried out by:

- Local process
- QAP (Qualified Attending Practitioner)
- ME office
- HMC office
- Bereavement services or equivalent (e.g. GP staff)
- Registration services
- Clinical Governance department or equivalent

* It is expected that for the majority of cases, medical examiners will not provide initial advice regarding cause of death before scrutiny of records. Where there is an urgent requirement, medical examiners may need to do so, for example for out of hour cases.

Some numbers

Currently

- 533,253 deaths registered in England and Wales in 2017
- 229,700 deaths were reported to coroners in 2017 **(43%)**
- 85,600 coronial autopsies **(16%)**
- 31,500 inquests opened **(6%)**

Sheffield

- 39% of cases reported (from 42%)
- Autopsy rate 18% (static)
- Inquests opened 11% (from 8%)

- Of Form A cases,
- 32% reported to satisfy Cremation Form 5 doctors
- 5.6% reported to satisfy Cause of Death List

Cause of Death List

- Undergoing revision in collaboration with the Royal College of Pathologists and approval from GRO and ONS
- Input from the Chief Coroner's office
- Some bizarre entries will be removed
- Some consistency for other natural causes
- Additional common conditions that are now used
- Date?

What should we expect?

- Hospital cases primarily
- Depends on the baseline
- Form A cases should go down (by as much as 30%)
- Autopsies will probably be similar with no effect on trends
- Inquests may go up (by as much as 30%), stay the same or go down, according to pilots/early adopter information
- Rejection rates at registration should be very low

Considerations

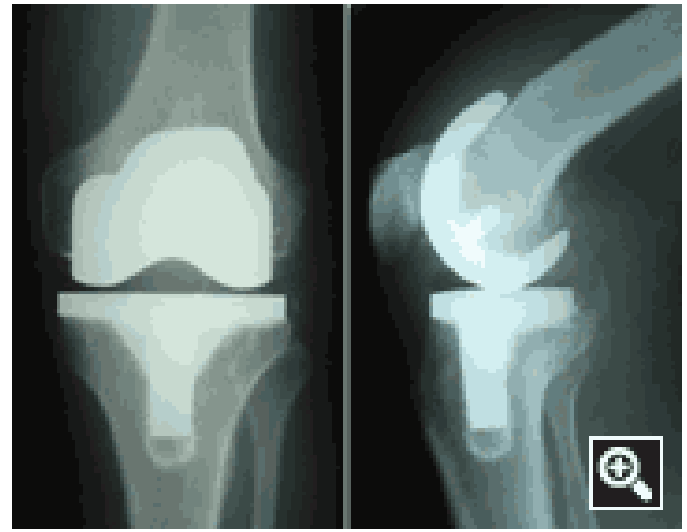
- Transmission of information
  - From the ME office
  - To the ME office
- ME office is a single point of reference
- An informed medical opinion to assist the coroner
- Expect a query or challenge from time to time
- Regular reviews and discussion of service

Results

- **3875** cases
- **405** cases (10.5% of all deaths) possible adverse harm events (AHEs)
- **339** (8.7% of all deaths) 'reason to suspect' AHEs caused or contributed to death
- **66** no 'reason to suspect' AHE’s caused or contributed
- ‘ME effect’ in **217** (5.6%)
- Family concerns in **81** (2.3%) of which **26** not detectable in records

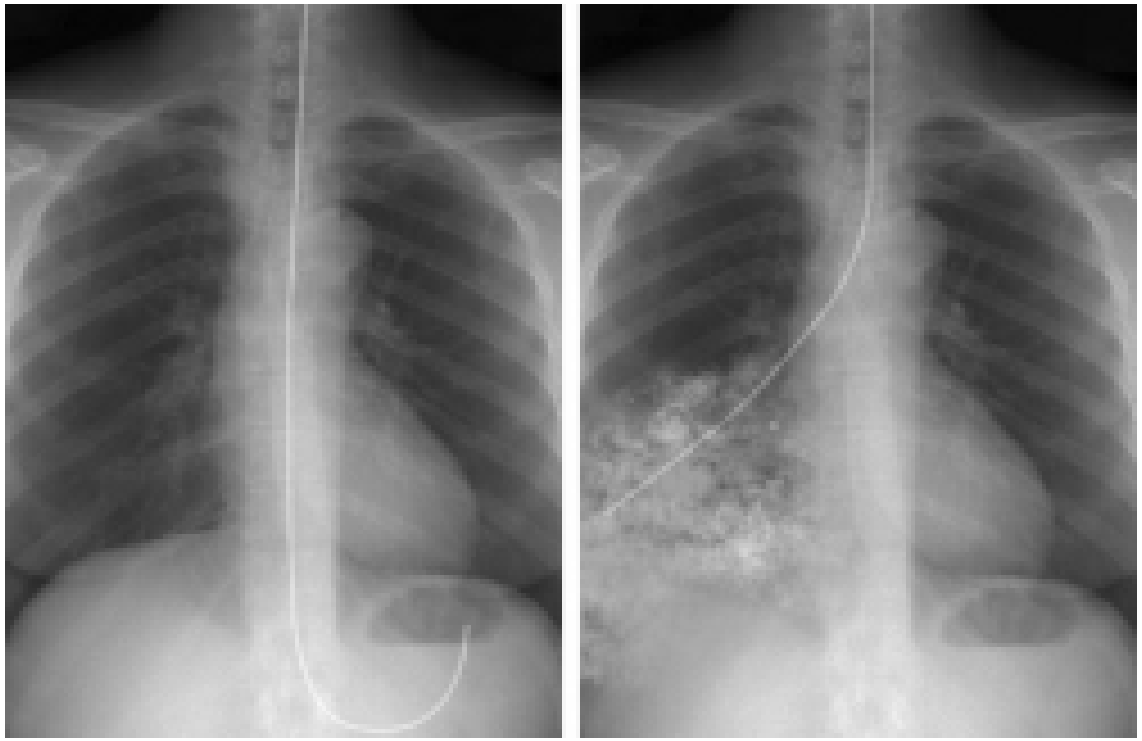
Case 1

- 60 year old woman undergoes uneventful total knee replacement. For reasons not clear, misses 3 doses of prophylactic heparin injections day 2-4. Sudden onset of fast heart rate and shortness of breath. CT scan shows pulmonary embolus on day 5. On transfer to ITU sudden further catastrophic deterioration.



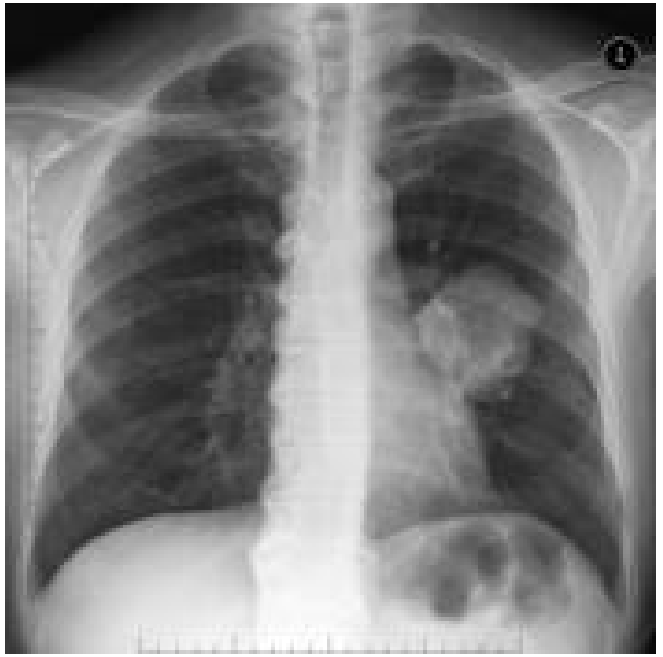
Case 2

- 22 year old man victim of road traffic collision 3 years ago. Devastating head injury. Admitted after seizures and given nasogastric feeding. After deterioration, it is noticed that the nasogastric tube was in the wrong place. He never recovered.



Case 3

- 53 year old diagnosed with advanced lung cancer rapidly deteriorates and dies 2 weeks after X-ray. It turns out he had an x ray at the GP 18 months before that showed '*a small 1 cm nodule in the left lung: follow up x ray in 6 weeks advised or referral to chest specialist*'. It never happened.



In Summary

- The ME system achieves a whole-system independent review of deaths not investigated by the coroner
- It puts the bereaved at the centre of its purpose
- Close working with the coroner's office is essential and a real opportunity
- Expect a change to workload that will take time to settle

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