University Hospitals of Leicester NHS
NHS Trust

UHL's Medical Examiner Policy

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Trust Lead:	Peter Furness, UHL Lead Medical Examiner Rebecca Broughton, Head of Outcomes & Effectiveness
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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

This Policy has been reviewed to be in line with National requirements since the National ME process has been rolled out and also to take into account changes made to the Death Registration and Cremation Form completion requirements post COVID pandemic

Other changes are mainly related to job titles and streamlining of processes within the Medical Examiner office – several appendices have been removed as these will now be Departmental SOPs.

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KEY WORDS

Medical Examiner, Medical Examiner Officers, Death Certification, Proportionate Scrutiny, Structured Judgement Review, MCCD, Bereavement Services, Coroner, Registrar

1 INTRODUCTION AND OVERVIEW

1.1 This document supports the University Hospitals of Leicester's Learning from Deaths from Patients in our Care Policy and sets out the Trust's Policy and Procedures for the Medical Examiner process (ME process).

1.2 The UHL Medical Examiner process has been established to improve the quality of death certification, to provide the bereaved an opportunity to raise any questions or concerns and to ensure all deaths are subject to proportionate scrutiny in line with the National Medical Examiner's Good Practice Guidelines (Jan 2020). This includes ensuring that the referral of deaths to the Coroner is done appropriately, in line with the relevant legislation as interpreted with the assistance of the relevant Senior Coroner.

1.3 The Medical Examiner process is integral to implementation of the Trust's Learning from the Deaths of Patients in our Care Policy.

1.4 Proportionate scrutiny takes place to identify potential learning from deaths that occur in the organisation. Problems in care are identified which may have affected the patient's outcome or experience. If such cases are identified the ME will determine what type of further review is needed, whether to involve the Bereavement Support Nurses or to send feedback to the clinical team

2 POLICY SCOPE

2.1 This policy applies to all deaths of patients in UHL (on an in-patient area, in the operating department or in the Emergency Department).

UHL's Medical Examiner service is being made available for scrutiny and advice relating to deaths in Leicester, Leicestershire and Rutland that occur outside UHL. This service is currently being used by non-UHL doctors and organisations on a voluntary basis, but it is anticipated that such scrutiny will be made a statutory requirement in 2024. This Policy document currently applies only to deaths within UHL. The process relating to deaths in the wider community has some minor differences and is still under development. It is anticipated that a parallel policy document or an update of this document will be finalised before the use of the service in the community becomes a statutory requirement.

2.2 This policy applies to:

a) Medical Examiners and administrative staff involved in the ME process
b) Bereavement Services staff.
c) Corporate Learning from Deaths Team
d) Doctors who have cared for deceased patients and who are eligible to complete the Medical Certificate of the Cause of Death (MCCD).
e) Consultants, Matrons and Ward Sisters
f) Specialty Mortality & Morbidity Leads
g) Bereavement Support Nurses

2.3 This policy should be read in conjunction with:

a) Learning from the Deaths of Patients in our Care Policy B31/2017 (LFD Policy)
b) Last Offices and Care of the Deceased Patient Policy B28/2010 (Last Offices Policy)
c) Policy and Procedures for the Urgent Certification of the Deceased Policy B12/2013 (Urgent Death Certification Policy)
d) Specialty M&M Guidelines B6/2023
e) Bereavement Support Services Guidelines B4/2016

3 DEFINITIONS AND ABBREVIATIONS

3.1 **Medical Examiner (ME**) - The role of the MEs is to support the certifying doctors when deciding the cause of death, to undertake mortality screening (including proportionate scrutiny of the deceased's health care records and speaking to the bereaved relative/carer) and to advise on whether or not a death needs to be reported to the Coroner..

3.2 **Certifying Doctor** - a doctor who is lawfully in a position to certify the death. Whilst MEs can support and advise, the final decision about cause of death remains with the Certifying Doctor.

3.3 **Proportionate Scrutiny** - Involves speaking with the certifying doctor with a view to identifying if there are potential problems in care or lessons to learn; reading through the deceased patients' clinical records (electronic and paper). It also includes speaking to a bereaved relative/carer, usually the 'next of kin' (unless the death has been referred and taken for further investigation by the Coroner).

3.4 **Structured Judgement Review (SJR)** - a detailed review of the clinical record, normally undertaken by a senior doctor who works in the same medical specialty as that responsible for the patient's care at the time of death but has not been involved in the care of the patient. It is 'structured' because it follows an approach defined by the Royal College of Physicians

3.5 **Clinical Review** - for the purpose of this policy refers to where the clinician involved in the patient;s care is requested to review a specific aspect of care and to reflect on whether there is any learning or actions required.

3.6 **Next of Kin (NoK)** - Normally a member of the deceased's family or an agreed representative, not necessarily the closest relative,

3.7 **Bereaved relative or carer (the bereaved)** - a bereaved person is one who has a relative or close friend who has recently died. For the purpose of this policy, this will usually be the NoK.

3.8 **Medical Certificate of the Cause of Death (MCCD)** - Statutory certificate required to allow the death to be registered.

3.9 **Death due to Problem in Care** – a death that has been clinically assessed using a recognised method of case record review (Structured Judgement Review), where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death').

4 ROLES AND RESPONSIBILITIES

4.1 Board Level Lead - Medical Director

Overall responsibility for the Trust's Learning from Deaths work programme and supporting policies.

4.2 Non-Executive Director - Chair of Quality and Outcomes Committee is responsible for:

Having oversight of the Trust's Learning from Deaths work programme.

4.3 Mortality Review Committee (MRC) is responsible for:

Overseeing all work-streams and governance processes related to mortality and Learning from Deaths.

4.4 Lead Medical Examiner (Lead ME) is responsible for:

a) in collaboration with the Head of Learning from Deaths (HoLfD) over-seeing the Medical Examiner process.
b) the recruitment and training of Medical Examiners (MEs).
c) being the professional lead for MEs.

d) ensuring the consistency and quality of the work of the MEs.
e) providing MEs with an annual summary of activity for appraisal and revalidation purposes.
f) developing training programmes for all medical staff in relation to interfacing with the Medical Examiners service.
g) liaising with the Coroner and Registrar and to be a point for contact for other external organisations as appropriate.
i) being a source of advice for MEs, ME Officers and Bereavement Office staff on referrals to the Coroner (subject to guidance from the Senior Coroner) and completion of MCCDs.
j) supporting the HoLfD to review the effectiveness of the ME process.
k) collaborating with the HoLfD to develop and improve the ME process.

4.5 Head of Learning from Deaths (HoLfD) is responsible for:

a) being the Operational Lead for the Learning from Deaths framework within UHL.
b) in collaboration with the Lead ME overseeing the ME process and to highlight any issues of concerns with the service delivered by the MEs.
c) supporting effective communication and collaboration between the MEs and M&M Leads.
d) developing and improving the ME process with support from the Lead ME.
d) ensuring adequate MEs are available to fill the rota.
e) overseeing the cost of the ME process and monitoring this in relation to funding received from the National ME Office.
e) ensuring that ME sessions are cross charged appropriately to relevant CMGs.
f) co-ordinating and monitoring the ME Rota.
g) ensuring that appropriate administrative support is in place for the ME Process.
h) monitoring and reporting on the effectiveness of the ME process, with support from the Lead ME.
i) ensuring that office accommodation and equipment is available.
j) overseeing the supervision of the ME Officers and ensuring they receive appropriate training and ongoing development to provide effective support to the MEs.
k) overseeing the work of Bereavement Services office in their roles outlined in this policy.

4.6 Senior Bereavement Services Officer (Senior BSO)

In addition to the responsibilities set out in 4.8 below, the Senior BSO is responsible for: feeding back any problems with the ME process to the HoLfD/Lead ME

4.7 Bereavement Services Officers (BSOs) are responsible for:

a) contacting certifying doctors and to inform them of the need to speak to the ME before completing the MCCD.
b) informing the bereaved that they will be contacted by the ME and to explain purpose of phone call, as applicable.
c) being a point of contact for advice for the MEs in respect of death certification and cremation form completion.
d) providing advice and support in respect of ME related issues with the Coroner's office, crematoria, funeral directors and registrars and where necessary escalating to the HoLfD/Lead ME.
e) feeding back to the ME/ME Officers where errors or issues are found in completion of the MCCD.
f) sending out letters to notify the GP of the cause of death or referral to the Coroner.

4.8 Medical Examiners (ME / MEs)

MEs will be recruited from experienced UHL consultants or General Practitioners (GP) with a minimum of 5 years' NHS experience at a consultant/GP level and are responsible for undertaking required training as in Section 6.1.

MEs will normally be available between 8:30 and 4:30 or 9:30 and 5:30 on their rostered days, in order to be available for discussions with certifying doctors.

MEs are responsible for:

a) liaising with the ME Officer and BSO team at the beginning of the day to identify the number of cases awaiting completion, urgent releases and new cases.
b) supporting the certifying doctors to decide and record an accurate cause of death on the MCCD or the need for referral to the Coroner and to identify any potential problems in care or learning that has been identified by the owning team.
c) Undertaking effective proportionate scrutiny of deaths to include review of the information provided by the ME officers and further reading through of the clinical paper and electronic records
d) speaking to the NoK and/or other bereaved relatives/carers, to answer any questions around cause of death and to ask if there are any questions or concerns about care provided to the deceased
e) where potential problems in care are identified which may have had an impact on outcome supporting the medical team with referring the death to the Coroner and also referring for internal Structured Judgement Review
f) escalating to the relevant clinical team if any identified problems in care are considered to have patient safety implications and for confirming that these are reported as such accordingly in line with the Trust's Incident Reporting Policy
g) where other potential learning identified to refer for further review by the clinical team, seeking input from the Bereavement Support Nurses or sending feedback
h) completing all relevant sections of the ME screening proforma and to summarise feedback received from the bereaved and their observations about the care provided.
i) Escalating to the ME Officer any cases that need urgent referral for SJR
j) Liaising with colleagues if anticipated delays with completing cases in order to prioritise and reallocate if possible
k) delivering a professional and consistent service and to raise any concerns to the HoLfD or Lead ME as applicable
l) meeting the standards in Section 5 of this policy
m) Facilitating the arrangement of non-coronial post-mortem examinations, including the required consent process, when such a post-mortem examination is requested by the deceased's relatives or by the clinical team. This will normally be done in close collaboration with Bereavement Support Service staff.

4.9 Medical Examiners Officers (MEOs) are responsible for:

a) liaising with the BSO team in order to identify new cases for the ME process.
b) accurately preparing the ME Proforma with background and clinical information using the clinical information systems and paper records as applicable and ensuring MEs have all relevant information needed for proportionate scrutiny including a search of the Datix system and deceased patient's next of kin details.
c) supporting the ME with contacting the NoK, if the ME has unsuccessfully tried on 2 occasions.
d) checking completed ME proformas, to clarify any queries directly with the relevant ME or to escalate to HoLfD or Lead ME if there are any issues.

e) correctly extracting information from the ME profroma and completing all relevant fields on the UHL LfD database.
f) Requesting relevant templates from the Corporate LfD team and requesting input from the Bereavement Support Nurses or sending feedback to the clinical team as per the outcome of the ME's proportionate scrutiny.
g) Copying the Bereavement Support Nurse (BSN) into requests for SJRs or Clinical Reviews where family have requested to know the outcome of the review.
h) co-ordinating the requesting and tracking of case notes relating to the ME screening process or where referred for SJR.
i) following all relevant procedures in this policy.

4.10 Bereavement Support Nurses (BSN) are responsible for:

a) liaising with the HofD and Lead ME in respect of any concerns raised by bereaved relatives about the ME process
b) being a point of reference for consultation about proposed developments in ME process which relate to contacting the bereaved
c) receiving and acting upon requests to make contact with bereaved relatives/carers, either directly from the MEs or via the ME Officer
d) providing support for bereaved relatives/carers, as per the Bereavement Support Guidelines (B10/2016)

4.11 Consultants

The Consultant who was responsible for the last episode of the patient's care is ultimately responsible for:

a) ensuring that an eligible doctor is made available to certify the death
b) providing further information and advice about the case if requested by the ME or certifying doctor
c) undertaking clinical reviews of cases referred by the ME and taking forward any learning or actions as per the UHL LfD of Patients in our Care Policy

4.12 Certifying Doctors are responsible for:

a) ensuring they satisfy the current legal requirements for issuing a certificate of the cause of death (normally that they have a GMC Licence to Practise and have personally provided care and attended the deceased within 28 days before death).
b) being confident they can give a clinically acceptable cause of death.
c) ensuring that they are familiar with relevant events of the deceased's last hospital admission - specifically leading up to the death to allow them to succinctly present the case to the ME. In preparation for the discussion with the ME the case should be discussed with a senior member of the owning team. This will enable the certifying doctor to answer relevant questions relating to the cause of death or whether there is a need to make a referral to the Coroner or if there were any problems or adverse incidents in the provision of care.
d) presenting relevant information to the ME in a factual, accurate and concise manner
e) recording in the patient's clinical notes the agreed cause of death or reason for referral to the Coroner, including details of discussion with the ME,as applicable.
f) referring to the Coroner's Office any deaths meeting statutory requirements for Coronial referral and those deemed by the ME to justify such referral, using the Coroner's Referral Portal.

g) Where applicable, providing contact details in case further information needed by either the Medical Examiner or Coroner's Office
h) advising the Medical Examiner of any potential concerns in care when discussing the cause of death/cremation form completion
i) advising the ME if the death should be referred for SJR for learning purposes

4.13 All Doctors who have cared for the deceased are responsible for:

a) facilitating the timely certification of cause of death and/or referral to the Coroner of those patients who have been in their care.

4.14 Specialty Mortality & Morbidity Leads are responsible for:

a) having oversight of the process of Structured Judgement Review or Clinical Review of cases referred by the ME.
b) feeding back any queries or concerns about the ME process or quality of mortality screening.
c) ensuring appropriate learning and action is taken, as per the M&M Review Policy.

4.15 Matrons and Ward Sisters are responsible for:

a) undertaking clinical reviews of cases referred by the ME and taking forward any learning or actions as per the M&M Review Policy.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

The following standards apply to all deaths of patients, where the death occurs on an in-patient area, in the operating department or in the Emergency Department.

5.1 Preparation of cases for death certification, cremation form completion and ME proportionate scrutiny

a) The Bereavement Service Officers will receive details of all deaths as per the Last Offices policy

b) The ME Officer will liaise with the Bereavement Services Office to confirm the details of deceased patients and will collate all relevant information and prepare the ME proforma to support proportionate scrutiny by the ME

5.2 MCCD / Cremation Form completion

a) The certifying doctor will speak to an ME before completing the MCCD in every case. At the LRI and Glenfield this will in most instances be a face to face conversation in the ME office. For LGH deaths the certifying doctor will normally speak to the ME over the phone.

b) If the certifying doctor believes that referral to the Coroner is appropriate, this would normally be confirmed with the ME first and also to discuss the cause of death to be proposed to the Coroner's office.

c) Referral to the Coroner is permissible without ME involvement if this would cause unnecessary delay and the requirement for referral is obvious. Unexpected child deaths in the Paediatric Emergency Department may have already been referred by the Police.

However HM Senior Coroner has advised she expects all referrals to her office to have had input from the Medical Examiner where the patient's medical history will be relevant to her enquiries.

d) The certifying doctor will complete the 'Pre ME Discussion form' prior to speaking to the ME in order to prepare a summary of key points of the case and to record their proposed cause of death.

e) Following discussion with the ME, the Medical Examiner will record a summary of the discussion on the ME proforma and the certifying doctor will document the agreed cause of death or reason for Coroner referral on the Pre ME Discussion form which will then be filed in the deceased patient's records.

f) The certifying doctor will then either complete the MCCD or make the referral to the Coroner.

g) Where the relatives have identified that the deceased is to be cremated AND where the certifying doctor has been instructed to complete the MCCD, the certifying doctor will normally complete Part 1 of the Cremation Form 4 (Crem Form). If for some reason this is impractical it is permissible for another doctor who saw the patient whilst alive to complete Part 1 of the Crem Form IF that doctor has spoken to the doctor who completed the MCCD.

5.3 Proportionate Scrutiny

a) Where possible proportionate scrutiny will be done by the same ME who had already discussed the case with the certifying doctor.

b) The ME who completes the proportionate scrutiny must not have had either overall responsibility or substantial direct involvement in the deceased patient's care during their last admission.

c) Proportionate scrutiny of the clinical records should normally include eObs eMeds; Investigations and Clinical information on Nerve Centre. Scrutiny is intended to identify potential problems in the delivery of healthcare that could have affected clinical outcome or had a serious detrimental effect on patient experience.

d) Proportionate scrutiny will also involve:

- **A conversation with the certifying doctor,** to agree the cause of death, to ascertain whether the coroner needs to be informed of the death and to ask whether, in the opinion of the certifying doctor, there were any problems in the appropriate delivery of healthcare to the deceased.

- **Review of any Patient Safety Incidents or Complaints** registered on Datix

- **A conversation with the NoK** – except where the case has been referred to the Coroner and they have accepted for further investigation.

- **Any further investigations or conversations** that the ME regards as necessary for a specific case to determine the need for further review:

5.4 Outcomes of ME Mortality Screening

5.4.1 Referral for Structured Judgement Review

a) If the ME screening of the clinical records or discussion with the certifying doctor or relatives, ***identifies*** potential problems in care which may have have had an impact on the patient's outcome

In addition to referring for SJR, the Coroner will also need to be informed

These cases will be referred to the relevant M&M lead to organise a formal Structured Judgement Review (SJR).

b) Referral for Mortality Review using national templates (where these exist) should also be selected when the ME identifies that the death falls into one of the nationally agreed categories:

These are currently:

- Children and Infants
- Patients with a Learning disability
- Patients with severe mental illness (not dementia)
- Death following an elective procedure
- Deaths which fall within a diagnostic group that is subject to a Mortality Alert

c) Referral for Mortality Review where patients have a Learning Disability
Learning Disability adult Acute Liaison Nurse will requested to review unless the ME identifies issues in care as part of their proportionate scrutiny

d) Referral for SJR where patients have Severe Mental Illness
The UHL Mental Health Lead will be asked to review where the patient's mental health was being actively treated at time of their admission/death.

Note that deaths referred for SJR under (b), (c) and (d) above will also require referral to the coroner if the criteria in (a) are also fulfilled.

5.4.2 Referral for Clinical Review

a) Where learning about clinical care is identified as part of the ME process but this was not considered to have had an impact on outcome for example delays with medication for pain management, the ME request a clinical review of the case notes be undertaken by the relevant clinical team and case discussed at their M&M meeting if learning confirmed .

b) Referral for clinical review may also be made by an ME if the ME thinks it unlikely that referral for SJR is justified, but there are aspects of the case where the ME does not have the specialty-specific knowledge needed to make that decision with confidence.

5.4.3 Feedback

a) Where learning identified around patient experience, communication with the bereaved or end of life care, the ME will provide feedback to the relevant clinical team either via the Consultant or Matron.

b) To assist the ME Officer with timely feedback to the clinical team, the ME will state whether the matter of concern is primarily a medical or nursing issue.

5.4.3 Referral to the Bereavement Support Nurse

a) Where the bereaved have concerns, the ME will ask their permission to refer to the Bereavement Support Nurse (BSN) so they can discuss in more detail and agree next steps

b) The BSSN will be copied into requests for clinical review and SJRs so that this information is known if the bereaved have requested follow up by the BSSN

5.4.4 Referral Outside UHL

Where screening of the clinical record, or discussion with the bereaved, raises concerns relating to care provided prior to admission to UHL, this should be clearly indicated on the ME Screening Proforma so that the Corporate LfD team can feed this back to the relevant organisation as appropriate. See below:

Concern/Feedback relates to:	**To be sent to:**
Primary Care / Nursing Home	GP Concerns Portal on InSite
Leicestershire Partnership Trust (Community Services)	Tracey Ward, Head of Patient Safety, LPT
Leicestershire Partnership Trust (Mental Health Services)	Dr Mohammed Al-Uzri, Associate Medical Director
East Midlands Ambulance Service	EMAS PALS

5.5 Retrospective Referral to the Coroner

a) If at any point during the screening process the ME becomes concerned that the coroner ought to have been informed, the coroner's office should be contacted by telephone.

b) If that telephone conversation supports referral, the MCCD must be cancelled and the certifying doctor instructed to refer the death to the Coroner.

c) If the MCCD has been sent to the Registry Office, the ME must instruct the Bereavement Services office staff to contact the Registrar and, if possible, the NoK, to inform them that the Coroner is reviewing the death.

5.6 Changes to Death Certificate

a) If during the ME process the cause of death initially agreed with the certifying doctor is felt to need amendment, (but Coroner referral not indicated) the ME will immediately inform the ME Officer and Bereavement Services Office to contact the Certifying Doctor

b) If the MCCD has not been sent to the Registrar, the Certifying Doctor will be requested to amend (following further discussion with the ME)

c) The MCCD should not normally be sent to the Registry Office until the medical examiner process is complete, but this rule may be over-ridden in exceptional urgent cases. If the MCCD has already been sent to the Registry Office, the error must be severe before considering recalling the certificate. In such cases the ME must discuss the case with the Registrar's Office.

d) If the death has been Registered, thought should be given as to whether the correction will modify how the Office for National Statistics will code the cause of death (usually on the last item in part 1). Assistance from the Registry Office will be needed to comply with the complex process required to amend a registered cause of death.

5.7 The UHL ME Proforma must be completed to capture the outcome of the Proportionate Scrutiny and Cause of Death Discussions

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 MEs will be required to complete the online training specified by the Lead Medical Examiner before taking up the role. This is a subset of the national Medical Examiner training which can be found at http://www.e-lfh.org.uk/programmes/medical-examiner/

6.2 An initial face-to-face training session will be provided for new MEs, with annual updates. It is the responsibility of the Lead ME to identify the programme and contributors for these events.

6.3 In-house training and development will be provided to the MEOs, organised by the HoLfD

6.4 Advice and support for the Certifying Doctors on completion of the MCCD or requirements for referral to the Coroner will be given by both the BSOs and MEOs

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Tool	Frequency	Reporting arrange-ments
Timeliness of Cause of Death Discussions	HoLfD	M& M database	Monthly	MRC
Percentage of cases referred for SJR	HoLfD	M& M database	Monthly	MRC
Timeliness of MEs speaking to the Bereaved	HoLfD	M& M database	Monthly	MRC
Monitor cost of the ME process against income received from the National ME Office	HoLfD	Finance accounts	Quarterly	ME Management Team
Issues raised by the Coroner/Registrar / M&M Leads	Lead ME	Concerns Log	Quarterly	ME Management Team

Element to be monitored	Lead	Tool	Frequency	Reporting arrange-ments
Numbers of cases where learning/problems in care subsequently identified which were not referred for further review by the ME	HoLfD	M&M Leads & Patient Safety Team Feedback	Annually	MRC

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

9.1 **Learning, candour and accountability** - A review of the way NHS trusts review and investigate the deaths of patients in England, Care Quality Commission, December 2016 - https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

9.2 **National Guidance on Learning from Deaths** - A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care, National Quality Board, March 2017 - https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

9.3 **Implementing the Learning from Deaths framework**: key requirements for trust boards, NHS Improvement, July 2017 - https://improvement.nhs.uk/uploads/documents/170921__Implementing_LfD_-_information_for_boards_JH_amend_3.pdf

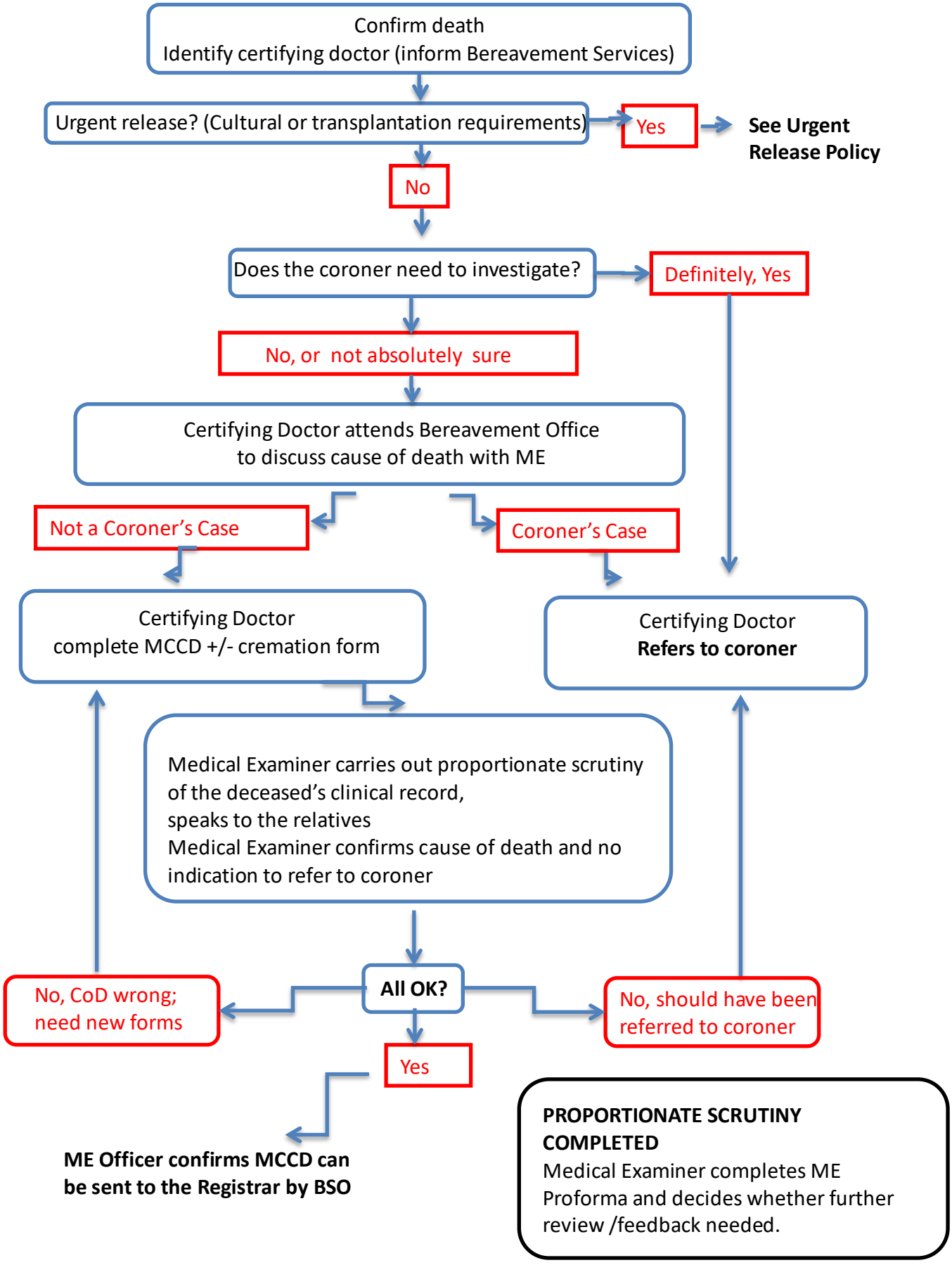
9.4 Standards for the Delivery of the Medical Examiner Service. Developed by the Medical Examiners Committee of the Royal College of Pathologists. https://www.rcpath.org/asset/BA3248D6-EC8B-4179-A635E3CEABE1FDA6/

9.5 Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales From the Office for National Statistics' Death Certification Advisory Group, Revised July 2010 https://www.gro.gov.uk/Images/medcert_July_2010.pdf

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This Policy will be uploaded into the Policies and Guidelines Library on INsite and will be available on the Trust's website.

The Policy will be reviewed in December 2026 by the HoLfD and Lead ME with support from Mortality Review Committee members.


Confirm death
Identify certifying doctor (inform Bereavement Services)
Urgent release? (Cultural or transplantation requirements)
Yes
See Urgent Release Policy
No
Does the coroner need to investigate?
Definitely, Yes
No, or not absolutely sure
Certifying Doctor attends Bereavement Office to discuss cause of death with ME
Not a Coroner's Case
Coroner's Case
Certifying Doctor complete MCCD +/- cremation form
Certifying Doctor Refers to coroner
Medical Examiner carries out proportionate scrutiny of the deceased's clinical record, speaks to the relatives
Medical Examiner confirms cause of death and no indication to refer to coroner
All OK?
No, CoD wrong; need new forms
No, should have been referred to coroner
Yes
ME Officer confirms MCCD can be sent to the Registrar by BSO
PROPORTIONATE SCRUTINY COMPLETED
Medical Examiner completes ME Proforma and decides whether further review /feedback needed.

1.1 Doctors should be aware that the legal requirements on a doctor to refer a death to the coroner are not the same as the legal requirements placed on a coroner to investigate a death, because the coroner is given authority to exercise judgement in whether or not to investigate. Therefore doctors should refer whenever there are reasonable grounds to believe that the coroner ***might*** wish to investigate.

The circumstances when a doctor must report a death to the coroner are set out in the Notification of Death Regulations 2019:

(a) the registered medical practitioner suspects that that the person's death was due to—
(i) poisoning, including by an otherwise benign substance;
(ii) exposure to or contact with a toxic substance;
(iii)the use of a medicinal product, controlled drug or psychoactive substance;
(iv) violence;
(v) trauma or injury;
(vi) self-harm;
(vii) neglect, including self-neglect;
(viii) the person undergoing a treatment or procedure of a medical or similar nature; or
(ix)an injury or disease attributable to any employment held by the person during the person's lifetime;

(b) the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph (a);

(c) the registered medical practitioner—
(i)is an attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person; but
(ii)despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown;

(d) the registered medical practitioner suspects that the person died while in custody or otherwise in state detention;

(e) the registered medical practitioner reasonably believes that there is no attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person;

(f) the registered medical practitioner reasonably believes that—
(i) an attending medical practitioner is required to sign a certificate of cause of death in relation to the deceased person; but
(ii) the attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death;

(g) the registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so.

1.2 If there are reasonable grounds to suspect that a death may be attributable even in part to any of the above factors, the coroner should be informed.

1.3 Where judgement is required in the interpretation of these requirements (notably in respect of 'related to any treatment or procedure of a medical or similar nature'), MEs must bear in mind any guidance issued by Leicester's Senior Coroner. Medical examiners may also request informal advice in specific cases by telephone from the Coroner's Office.

1.1 In addition to cases where the coroner should be notified as in Appendix 2, the Registrar has national guidance on terms which, if they appear on an MCCD, should result in the coroner being informed of the death. Such terms therefore block immediate registration and cause distress for the relatives. Some of these terms seem illogical to those with a medical training, so MEs need to know what they are. A copy of the national guidance document is available in the Medical Examiners' Office.

1.2 Examples include:

- Obstruction, perforation, ulcer or haemorrhage, unless qualified to explain that the cause is natural. Hence 'Subarachnoid haemorrhage' is not acceptable, but 'Spontaneous subarachnoid haemorrhage' is OK.
- 'Perforated duodenal ulcer' is not acceptable, but 'Perforated peptic ulcer of the duodenum' is OK.
- 'Uncertain' is never acceptable, but in some circumstances 'Unknown' is OK.

1.3 Attempt to avoid these terms, or add an appropriate explanation as part of the cause of death.

1.4 If there is any doubt whatsoever as to whether a natural cause of death will cause concern to the Registrar, the ME must email nominated-officer@leicester.gov.uk giving only the name of the deceased, the cause of death and a brief explanation of why there is no cause for concern.

1.5 Please note that this method of communication by email is not sufficiently secure for the transmission of confidential patient information. However, the name of the deceased, the fact of death and the cause of death are items of information that are, or will soon be, in the public domain.