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The Medical Examiner and patient safety

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The Medical Examiner and patient safety

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The Medical Examiner and patient safety

The Medical Examiner system ensures that acute hospital Trusts are able to say something about every death and, alongside case record review, has the potential to create a world-leading mortality review system.

Introduction

The role of the Medical Examiner has been developing in the United Kingdom (UK) over the last ten years. It has attracted recent interest in response to concerns about avoidable hospital deaths and the need to identify deaths due to problems in care. In this article we describe the role of the Medical Examiner and consider how this role could be used to improve patient safety.

What is a Medical Examiner?

Medical Examiners (of the documents and cause of death) were recommended in 2003 by Dame Janet Smith in the third report of her investigation into the murders committed by Harold Shipman in Hyde, UK[1]. This recommendation was endorsed by Sir Robert Francis in his investigation into deaths at the Mid Staffordshire NHS Foundation Trust[2] and Sir Bill Kirkup in the review of deaths at Morecombe Bay Hospitals.[3]

A Medical Examiner is an independent senior doctor who will be accountable to the National Medical Examiner[4]. The role is to manage three issues, taking the views of the bereaved into consideration:

- Where a medical certificate of cause of death (MCCD) is completed, the content should be as accurate as possible
- Where a case needs to be notified to a coroner, that is undertaken in as timely and accurate manner as possible
- To enable the detection and notification of clinical governance concerns early on

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3 **What does a Medical Examiner do?**
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5 Medical Examiners undertake their duties supported by Medical Examiner Officers at the
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7 beginning of the processes following a death. There are mandatory components of the
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9 work on each case, some of which may be delegated to an appropriately qualified Medical
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11 Examiner Officer. In all cases not investigated by a coroner, there must be a proportionate
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13 review of medical records, interaction with the qualified attending practitioner completing a
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15 MCCD, an interaction with the bereaved to clarify if there are any concerns or questions
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17 regarding the cause or circumstances of death, and a finally a review of the original or copy
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19 of the MCCD. All of these steps must be completed prior to registration of the death and the
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21 target standard is to achieve this within 24 hours of notification of a death. Standards for
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23 the delivery of the Medical Examiner Service have been published by the Medical Examiners
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25 Committee of the Royal College of Pathologists[5].
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28 **What is the impact of Medical Examiner assessment?**
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30 The legislation of the Coroners and Justice Act 2009[6] provides for Medical Examiners but
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32 this has not yet been enacted. Medical Examiners have been established in a number of
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34 pilot sites across the UK to help the Department of Health and Social Care refine their policy
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36 plans and establish the key functions of a medical examiner system. In 2016 the Department
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38 reported data from over 23,000 Medical Examiner reviews of deaths at pilot sites in
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40 Sheffield and Gloucester showing that the referrals to the coroner were more consistent
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42 and appropriate, rejection of the MCCD by the Registrar was eliminated and input from
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44 relatives was assured[7].
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46 A parallel study by the Office for National Statistics to examine the effect of Medical
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48 Examiners on the confirmed cause of death found that the underlying cause of death
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50 changed in 22%[8]. This arose because MCCDs have historically been shown to contain
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52 inaccuracies and incomplete information[9-11], which was corrected by Medical Examiners.
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54 The 2016 review also found that independent scrutiny of medical records, supplemented by
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56 discussions with the bereaved, proved to be a consistent source of high-quality information
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58 about the quality of care, irrespective of the nature of the problem and irrespective of the
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type of organisation involved. This suggests that Medical Examiner review of deaths could have a role in improving patient safety.

What role could Medical Examiners play in improving patient safety?

In December 2016 the Care Quality Commission (CQC) reported that learning from deaths was not being given sufficient priority in some NHS organisations and valuable opportunities for improvements were being missed[12]. It identified the need to engage families and carers and to recognise their insights as a vital source of information. The CQC now requires all acute hospital Trusts to be able to "say something about every death". In March 2017 NHS England launched the Learning from Deaths initiative[13], which required acute hospitals to undertake case record reviews on selected cases based on criteria most likely to yield opportunities for learning, reflection and improvement. No one case record review method was stipulated by NHS England, although structured judgement review[14] was recommended.

Medical Examiners could help to address these requirements. The role, as developed in the pilot sites, involves proportionate review of all cases not referred to the Coroner, interaction with bereaved relatives and early notification of clinical governance concerns. This process could be used to ensure that every death is examined and that families and carers are engaged, while allowing structured judgement review to focus on cases with clinical governance concerns.

Could Medical Examiner review be used to estimate preventable death rates?

Structured review of hospital deaths can be used to make a judgement about whether death was potentially preventable. Studies using structured judgement review estimated that up to 5.2% of deaths were probably avoidable[15-17]. However, judgements regarding levels of preventability vary between observers[15] so each case would require agreement between independent reviewers for a reliable judgement to be made. Medical Examiner review is intended to identify cause for concern requiring further investigation. It is not

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intended to determine preventability. Subsequent structured review could be used to inform a judgement process about preventability in selected cases but uncertainty around this sometimes very difficult judgement has led many to conclude that review is better used to identify themes in causes for concern.

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Does Medical Examiner assessment appropriately identify threats to patient safety?

Unpublished data from the Sheffield Medical Examiner pilot site (Fletcher, personal communication) showed that out of 2668 consecutive deaths that attending doctors had not intended to refer to the coroner or identified a clinical governance concern, the Medical Examiner identified 153 for coroner referral and 66 for clinical governance notification. This suggests that Medical Examiner screening prior to structured judgement review could substantially reduce the number of reviews required. However, valuable lessons from structured judgement review could be missed if Medical Examiner assessment is too limited or the threshold for clinical governance notification too high. To date we have no data to determine how appropriately Medical Examiner assessment identifies threats to patient safety, although serves the requirement to know something about every death.

The National Institute for Health Research Policy Research Programme has funded a study[18] involving Medical Examiner Pilot sites that will compare the findings of Medical Examiner assessment and structured judgement review as used in the National Mortality Case Record Review Programme[19]. These two processes are different and intended to be complementary, so inconsistencies are expected and neither should be considered the gold standard. However, the study will provide valuable insights into how these two processes work alongside each other and determine how Medical Examiner screening influences the workload and yield of information from structured judgement review.

Should Medical Examiner assessment be used to screen cases for structured judgement review?

Hospital trusts facing the need to implement the requirements of learning from deaths may be tempted to use Medical Examiner screening to select cases for structured judgement review. Trusts need to recognise the current lack of data to support this approach and, until findings from the research in progress are available, should at least augment structured judgement review based on Medical Examiner screening with additional reviews selected using an alternative process.

Medical Examiner assessment and structured judgement review have different origins, purposes and methods, so we should expect different results. However, the opportunity to align these two important policy measures to give a robust independent system that is protected by statute has the potential to make the mortality review system in England and Wales the best in the world.

Key Messages

Medical Examiners provide independent scrutiny of medical records, supplemented by discussions with the bereaved, for all hospital deaths

This assessment can improve recording of the cause of death, address the need to say something about every death and identify threats to patient safety

Medical Examiner assessment is not intended to make a judgement about preventability of death but to highlight causes for concern

Research is in progress to determine how Medical Examiner assessment can work alongside case record review to provide a robust mortality review system

Contributors and sources

AF is chair of the Medical Examiners committee of the Royal College of Pathologists and used this role and his position as a Medical Examiner to write the first draft of the paper and provide key content. JC is project manager for the Safety for Patients through Quality Review study (Evaluation of medical examiners' review to identify potentially avoidable deaths due to problems in care) and was project manager for research developing structured judgement review. She used her involvement on these projects to contribute to

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drafting the paper. SG is Chief Investigator for the Safety for Patients through Quality Review study. He used his involvement in this project and expertise as a National Institute for Health Research Senior Investigator to contribute to drafting the paper. All authors approved the final draft. SG is guarantor for the paper.

Conflicts of interest

AF is chair of the Medical Examiners committee of the Royal College of Pathologists and Medical Examiner at Sheffield Teaching Hospitals NHS Foundation Trust. All three authors are investigators on the Safety for Patients through Quality Review study. SG is chair of the NIHR Health Technology Assessment Clinical Evaluation & Trials Board.

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