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- Does this document meet the requirements under the Equality Act 2010 in relation to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation? **Yes**
- Does this document meet our additional commitment as a Trust to extend our public sector duty to carers, veterans, people from a low socioeconomic background, and people with diverse gender identities? **Yes**

Document for Public Display: No

CONTENTS

1. SUMMARY

1.1 This SOP provides a clear understanding of the Medical Examiner (ME) and Medical Examiner Officer (MEO) roles and process in providing independent scrutiny of all non-coronial deaths. NHS England: Letter re Statutory Medical Examiner Systems

1.2 The introduction of Medical Examiners (ME) is part of the Department of Health and Social Care's (DHSC's) death certification reforms programme for England and Wales.

1.3 The reforms included the introduction of a unified system of scrutiny by independent Medical Examiners of all deaths in England and Wales that are not investigated by a coroner.

1.4 Amendment to the Coroners and Justice Act 2009, has been made through the Health and Care Act 2022, to enable medical examiners in England to be hosted in NHS bodies.

1.5 The introduction of a non-statutory Medical Examiner system began in April 2019.

1.6 In June 2021, NHS England set out what local health systems needed to do to extend the role of medical examiner offices to include all non-coronial deaths. NHS England: Letter re Statutory Medical Examiner Systems

1.7 The centrally funded statutory Medical Examiner system must be implemented from April 2023

2. PURPOSE

2.1 The purpose of this SOP is to set out the processes that enable Medical Examiners service (MES) hosted by UHMBT to deliver the objectives and outcomes of the medical examiner system.

2.2 The introduction of the medical examiner system is designed to:

- 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 a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.

2.3 Each medical examiner office is required to lead work to establish arrangements with local health and care providers in their area, supported by regional medical examiners where needed. to extend the role of these offices to include all non-coronial deaths, wherever they occur by April 2023

3. SCOPE

All staff employed by UHMBT.

This SOP and its principles are intended to cover the deaths of all patients who die whilst an inpatient or whilst attending the Emergency Department.

3.1 Roles and Responsibilities

Role	Responsibilities
Medical Examiners	Medical Examiners are senior Medical Doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties. They must complete training in the legal and clinical elements of death certification processes before commencing in post.
Medical Examiner Officers	Medical Examiner Offices operate along similar lines to Coroner's Offices. They will work closely with other NHS services such as Bereavement Services, Mortuary services and Trust staff, but in doing so retain demonstrable independence. They need to have close working relationships with the Coroner Officer, Registrar service, Funeral directors, Faith groups and other Medical Examiner services regionally.
To establish the credibility and independence of this new system, Medical Examiners and medical examiner officers should demonstrate the highest professional standards at all times. Every effort should be made to deliver timely, efficient and effective services.	

3.1.1 The Medical Examiners role:
To review medical records and interact with qualified attending practitioners and the bereaved to address three key questions:

- What did the person die from? (Ensuring accuracy of the medical certificate of cause of death)
- Does the death need to be reported to a coroner? (Ensuring timely and accurate referral
- Are there any clinical governance concerns? (Ensuring the relevant notification is made where appropriate)

3.1.2 Independence must be maintained at all time. Medical Examiners should not scrutinise cases where their independence may be questioned; for example, the death of a patient they cared for, or where they are professionally or personally related to someone who provided care, or are personally related to the deceased.

3.1.3 Medical Examiners can delegate the following tasks to Medical Examiner Officers:

- Discuss proposed causes of death with the Qualified Attending Practitioner (QAP) and advise about Coroner referral
- Contact the bereaved before the medical certificate of cause of death is issued to establish if they have concerns or questions about the death, and if they do act on them appropriately the medical examiner officer must document all such interactions.

- They cannot delegate scrutiny of medical records

3.1.4 Medical examiners have important links to Learning from Deaths, highlighting cases for review and ensuring they are flagged to the UHMBT mortality lead and/or to the relevant mortality review programme.

3.1.5 Medical examiners should neither be involved in mortality reviews of cases they independently scrutinised, nor undertake mortality review work in medical examiner time. The need to preserve independence makes it inappropriate for a medical examiner to be the overall trust mortality lead.

3.1.6 When Medical examiners detect and refer concerns to the provider of those healthcare services but are not satisfied that these issues are being resolved or believe that undue influence is being exercised over their independent role, in England they should inform the Regional Medical Examiner after discussion with the Lead Medical Examiner.

3.1.7 The accountability of the Medical Examiners is with the Regional and National Medical Examiner service in conjunction with UHMBT

3.1.8 For Medical Examiners in England medical appraisal and revalidation will be governed by usual GMC Guidance and appraisal will therefore be undertaken by an appraiser approved by their Responsible Officer. The Royal College of Pathologists has published information to support appraisal and revalidation of Medical Examiners

3.1.9 The Lead Medical Examiner provides leadership professionally and operationally to the Medical Examiner service. They are responsible for management of the Medical Examiners within UHMBT The Lead Medical Examiner is responsible for the Lead Medical Examiner officer. The Lead Medical Examiner Officer is accountable to the Regional Lead Medical Examiner officer

3.1.10 Medical Examiner Officers manage cases from initial notification through to completion and communication with the registrar. They are essential for the financial viability of the Medical Examiner system and to enable, support, develop effective and efficient working; the constant in the office, enabling consistency across Medical Examiners who will usually work part-time and come from a range of specialties

3.1.11 Medical Examiner Officer's roles and responsibilities include:

- To support medical examiners in their role in scrutinising the circumstances and causes of death. To be a point of contact and source of advice for relatives of deceased patients, Healthcare professionals and Coroner and Registration services.
- To act as an intermediary between the bereaved and clinicians to establish and if possible, resolve concerns relating to a patient’s death or to direct them to the appropriate governance teams. (i.e., PALS)
- Work with medical examiners to aid them in their responsibility for overseeing the medical examiner process for all deceased patients in the organisation.
- To establish the circumstances of individual patient deaths by performing a preliminary review of medical records to identify clinical and circumstantial information, sourcing additional details where required, for scrutiny by the Medical Examiner.
- To assist the Medical Examiners in highlighting cases for assessment by the UHMBT Mortality review team, Structured Judgement Review team (SJR), Child Death

Overview Panel (CDOP), Clinical Governance teams and the Learning Disability Review Teams (LeDeR).
- To support the Medical Examiners and QAPs in the completion of the Coroner's portal for deaths requiring coronial investigation.
- Maintain an awareness of the diverse needs of users of the Medical Examiner system to ensure equality to any particular group defined by sex, race, religion, ethnicity, sexual orientation, gender reassignment or disability.
- Build and maintain effective relationships with other stakeholders such as Doctors, Bereavement officers, Faith groups, Funeral directors, Coroners, Police, Governance teams and legal services.
- Collate and manage data for completion on the Medical Examiner Quarterly reports

3.1.12 Lead Medical Examiner officer manages Medical Examiner officers. The Lead Medical Examiner Officer is responsible for day-to-day operational management of Medical Examiner service under direction of Lead Medical Examiner.

3.1.13 The lead Medical Examiner officer and Medical Examiner officers are professionally accountable to the Regional Medical Examiner officer in conjunction with UHMBT

4. STANDARD OPERATING PROCEDURE

4.1 Offices

4.1.1 Location
The Medical Examiners service is based within Royal Lancaster Infirmary (First floor, Medical Unit 2) and Furness General Hospital Level 4 admin block Medical Examiner office. Medical Examiners cover all 3 main in-patient sites including Westmorland General Hospital.

4.1.2 Hours of business
The Medical Examiners service hours of operation are Monday to Friday between the hours of 8am - 4.30 pm.

4.1.3 Stages of the procedure all cases

4.1.3.**1**. For every Trust death, Qualified Attending Practitioner (QAP) /Qualified Nurse completes a Care after death document on Lorenzo (CAD). Lorenzo updates Ulysses with the case automatically when the patient is recorded as deceased on Lorenzo and is moved to the Mortuary.

4.1.3.2 In hospital, there may be several doctors who have seen the patient within 28 days of death who can complete a medical certificate of death. It is ultimately the responsibility of the Consultant in charge of the patient's care to ensure that the death is properly certified.

4.1.3.3 Bereavement Office receive an automatically generated email when the patient is coded as deceased on Lorenzo. The case is automatically uploaded onto Ulysses and the Bereavement Officers (BO) should check the Mortuary spreadsheet throughout the day for new cases that may have been incorrectly coded.

4.1.3.4 BO to review the care after death document on Lorenzo and check patient details.

4.1.3.5 BO will identify the relevant doctor / team from Lorenzo and send an email to the team and request a completion of a death summary before 10am. The relevant team / doctor will advise the BO who will be attending. BO will advise the doctor (QAP) to attend the Bereavement office between 9am – 3pm.

4.1.3.6. When QAP attends the Bereavement Office the Bereavement Officer will confirm with the QAP that a death summary has been completed for all hospital deaths

- If the death summary is not completed, then BO will ask the QAP to complete it.
- The death summary should be fully completed including proposed cause of death if known.

4.1.3.7 The BO will make the first contact with the Next of Kin (NoK) for every hospital death by telephone to explain the process and to answer any questions. They offer keepsakes (hand prints, hairlocks), advice on tissue donation and inform NoK that the next call will be from the Medical Examiner team

4.1.3.8 The BO will update Ulysses with the following information - Next of kin (NoK), date and time of death, date and time deceased transfer to the mortuary and date and time received in mortuary

4.1.3.9 The BO will pass over via phone / TEAMS to the ME service any relevant information they receive from the family and the document it in Ulysess under contacts

4.1.3.10 MEO needs to check Ulysses and both Mortuary spread sheet for RLI and FGH for new deaths each morning and throughout the day.

4.1.3.11 The MEO will add cases for scrutiny to the Medical Examiner team on teams under current cases for cases 2022. Cases will be put in order of priority. Highlighting urgent cases I.e. child, faith deaths where necessary and potential Coroner cases. Any conflicts of interest can be added to cases on teams when identified.

4.1.3.12 The Medical Examiner Officer looks independently at the case in Lorenzo and creates a summary in Ulysses (Box A6) with the following:

- Admission reasons,
- Past medical history,
- Safeguarding concerns,
- Clinical incidents,
- Any record of concerns documented from staff, family or patient,
- Likely wording for the MCCD
- Identifies Possible Coroner case and document their reasoning

4.1.3.13 The Medical Examiner (ME) works from the list on Teams, The ME will assign the case to themselves and scrutinise cases in order of priority. They will write up their notes on Ulysses on form B in the relevant sections. They will record on teams when scrutiny is complete and written up on Ulysses.

4.1.3.14 All entries on Ulysees needs to be recorded contemporaneously. All additions need to be initialled, dated and timed. Records should not be deleted but where errors in entry have been made it should be documented and reasons for deletion should be documented,

dated, timed and initialled: e.g. identifiable data entered in wrong patients notes

4.1.3.15 The ME should undertake a proportionate review of the notes and complete the notes made during scrutiny in Ulysses section (B2) without first looking at the QAP's proposed Cause of Death in the patient's death summary

4.1.3.16 The ME needs to document their Cause of death (COD) established during scrutiny and insert it in section B4 (provisional tab) in Ulysses. In the cases the Medical Examiner agrees with the proposed cause of death by the QAP on the death summary the ME should document this in Ulysees in section B5

4.1.3.17 Cases the ME has highlighted for Coroners follow section B

4.1.3.18 At the time of ME scrutiny the ME identifies cases for a mortality review/ structured judgement review in line with trust policy (See Trust Learning from deaths policy, section 6) The reason for the referral must be documented in section B3 with a brief outline of why it requires an M/R / SJR. See section C for further information on the process to be followed requesting mailto:mortalityteam@mbht.nhs.uk

4.1.3.19 After completing scrutiny any case identified by QAP/ME/MEO as a Coronial case will follow section B process below

4.1.3.20 The QAP will discuss the cause of death with their senior / Consultant before attending the Bereavement office. The QAP will collect the deceased Bereavement Form A (see section 5 number 1) from the Bereavement office and attend the Medical Examiner office to discuss the case with the MEO / ME.

4.1.3.21 All cases need to be reviewed by an ME before the MCCD can be released to the registrar. The ME/MEO will enter and update all discussions/agreements with QAP on Ulysses (B5)

Section A Non-coronial cases

4.1.3.22 Discussions with the MEO should mainly focus on the acceptability of wording on the MCCD. If there is uncertainty about the exact cause of death this should be discussed with the ME

4.1.3.23 If death summary and proposed MCCD by the QAP and ME have a similar opinion, the proposed cause of death is acceptable by the registrar and no concerns raised by the QAP / ME the MEO/ME updates the Bereavement Form A with agreed cause of death

4.1.3.24 If the ME /. MEO and QAP (Qualified attending practitioner) cannot agreed on a cause of death the QAP is advised to discuss the case with a senior colleague and return for a second discussion. If still difficulties agreeing a cause of death the senior will need to contact the ME for a further discussion. It is the responsibility of the QAP (Qualified attending practitioner) to complete the MCCD to the best of their knowledge and belief. If the ME still has concerns about the proposed written MCCD they should discuss with the lead ME and if necessary, concerns can be escalated to the deputy medical director for quality and safety.

4.1.3.25 The QAP (Qualified attending practitioner) returns to doctor's room / bereavement

office and completes the MCCD and complete cremation forms

4.1.3.26 The Bereavement officer will offer any support needed to the QAP (Qualified attending practitioner) completing the MCCD and cremation forms

4.1.3.27 The ME / MEO will contact the NOK and the discussion must be documented in Ulysses section B7. This entry must include date, time, and details of the person to whom you have spoken to.

4.1.3.28 If the family have no concerns or complaints and the cause of death is as expected the MEO will update B7 and select from the drop-down menu – *Cause of death accepted without any concerns raised*

4.1.3.29 If a concern is raised with MEO the MEO will update Ulysses B7, the YES dropdown should be selected, and the concern/complaint should be documented in the comment box and action taken

- PALS / NHS E Complaints Discussion with
- Team / Consultant responsible for care requested to call the family
- ME call with family to understand concerns to see if they can be resolved

4.1.3.30 If the concern is resolved and the family accept the MCCD the MCCD can be released then select from the drop-down menu - Concerns raised and addressed without need for discussion with a Coroner

4.1.3.31 If the Families concerns remain unresolved and/or family are refusing to register the death these will need to be a discussed between the ME and senior QAP before discussing the case with the Coroner (see Ulysses section B)

4.1.3.32 Where the MCCD agreed and accepted the MEO will then update the alert tab on Ulyssess to notify the bereavement office that the MCCD can be released to the Registration office. (Births, Deaths and Marriages)

4.1.3.33 Faith deaths – The Consultant / QAP / Senior nurse / site manager should update the ME office of any patients with a faith background made palliative where the family have indicated an early release of the body is a possibility

4.1.3.34 Any faith patient highlighted to the team the MEO will highlight the case to the ME immediately and a pre-scrutiny can be performed and a QAP and ME discussion should be had.

4.1.3.35 QAP should attend as soon as reasonably possible after death and complete the MCCD.

4.1.3.36 The BO will highlight the case as an urgent to the Registration office following process 4.1.3

4.1.3.37 If the MCCD is rejected by the registrar and returned to the Bereavement office, the Bereavement office will return to the Medical Examiner office by email. The MEO will

- Record rejection in cause of death tab on Ulysses

- Email the ME who scrutinised the case with reason for rejection
- Discuss the case with the duty ME of the day
- Discuss the reasons for the rejection with the QAP
- QAP to review the MCCD and discuss with ME / MEO to re-write or refer the case to the coroner via the portal

4.1.3.38 If the MCCD is rejected by the registrar and sent directly to the Coroner it is dealt with by the Coroner. In these cases, the Coroner's officer updates the ME office of the rejection and Ulysees is updated by the MEO

Section B Coronial Cases

4.1.3.39 Ministry of Justice Guidance
Guidance for registered medical practitioners on the Notification of Deaths Regulations (publishing.service.gov.uk)

For registered medical practitioners on the Notification of Deaths Regulations March 2022 sets out the circumstances in which a death should be notified to the Coroner. In addition, the Lancashire Senior Coroner and Regional Medical Examiner has issued a Standard Operating Procedure for referrals to Coroner (see section 5 form 4)

4.1.3.40 Cases identified as potentially Coronial by MEO/QAP/ME should be jointly discussed. Taking into account local guidelines (see section 5 form 4) and Ministry of Justice Guidance

4.1.3.41 If there is agreement that it should be referred to Coroner then case should be discussed with Coroner's Officer highlighting reason for referral and whether a cause of death can be offered in Ulysees B6

4.1.3.42 Where there is still uncertainty whether Coroner referral is appropriate the ME can contact the coroner to discuss case.

4.1.3.43 It is anticipated that usually in practice, it will be the practitioner who is qualified (QAP) to complete the medical certificate cause of death (MCCD) who will be making the notification to the senior coroner.

4.1.3.44 To facilitate referral the ME Service will where necessary complete Deceased Details (icasework.com) and include ME scrutiny and QAP Death Summary

4.1.3.45 Where the death is clearly unnatural it may be more appropriate for a notification to be made to the senior coroner straight away by the Consultant responsible for the patients care.eg where the Police are involved

4.1.3.46. Regulation 4(1) requires the notification to the senior coroner to be made as soon as is reasonably practicable after the medical practitioner has determined that the death should be notified.

4.1.3.47 While the regulations do not prescribe a specific time limit for notifications this notification should be prioritised. If the death arises from an event or occurrence that may be suspicious then the police should be informed immediately.

4.1.3.48 A death may have already been reported to the coroner by a person other than a medical practitioner, such as a friend or family member of the deceased, or the police. Such reports will not usually include the information required at regulation 4(3) and (4), and may not provide the coroner with the full medical picture.

4.1.3.49 Therefore, even if a medical practitioner is aware that someone other than a medical practitioner has reported a death to the coroner, the registered medical practitioner should still make a notification under the Regulations

4.1.3.50 The medical practitioner should usually take reasonable steps to establish the cause of death before notifying the coroner. This may include seeking advice from another medical practitioner, such as a medical examiner or any other responsible consultant.

4.1.3.51 If in opinion of ME case should be referred to Coroner and QAP wants to issue MCCD and does not want to refer to Coroner the QAP should be advised to discuss case with their senior Colleague.

4.1.3.52 If the ME and Consultant responsible for patient care cannot reach agreement and the ME still thinks it is appropriate to refer the case to the Coroner then the ME should discuss the case with another ME or Lead ME, or if necessary, in their absence Regional ME.to agree next steps.

4.1.3.53 A coroner's investigation may not be necessary in all notifiable cases.

100A / A Form

4.1.3.54 If the senior coroner is satisfied that he/she does not need to open an investigation then he/she may issue a 100A form (A Form), or refer the case back to the medical practitioner, who can issue a medical certificate of cause of death.

4.1.3.55 When the coroner authorises a Form A (100A) with a QAP, the MCCD is completed by the QAP with the bereavement office support if needed. The Bereavement officer copy's the 100A MCCD (A form) and sends through to the Coroner's office. The Coroner officer will update the BO when the 100A MCCD is authorised and the BO then sends the MCCD 100A to the Registration office The BO updates Ulysses with the referral details and MCCD content

Post Mortem Process

4.1.3.56 When the Coroner's outcome is a Post Mortem the Coroner Officer updates the Medical Examiner officer and Bereavement officer via email addresses and the Bereavement officer updates Ulysses with the outcome

Inquest No PM

4.1.3.57 When the Coroner's outcome is an Inquest No Post Morten the BO will send the Inquest No PM form (see section 5 number 2 or 3) to the QAP to complete. The QAP will return to the BO once completed and the BO will send to the Coroner's officer

No further action by Coroner

4.1.3.58 The Coroner needs no further involvement in the case the MCCD can be written out with the cause of death agreed between the QAP and ME. Then follow process **4.1.3.23**

Section C Mortality Reviews Learning form Deaths Policy
(See Learning from Deaths Policy, section 6)

4.1.3.59 The LMEO is responsible for emailing the mortality team at mortalityteam@mbht.nhs.uk to inform them of any requests for reviews the ME's have highlighted in their scrutiny, documented in Ulysses, copying from Ulysses B3. These will be sent through at the end of each week. If the ME decides at a later date that a review is required, they must inform the MEO directly. mailto:mortalityteam@mbht.nhs.uk

4.1.3.60 Case selection and identification The Trust has an agreed inclusion criteria for selecting cases for a Mortality Review. This is based on recommendations by the Royal College of Physicians, peer review and Trust priorities, and includes all inpatients aged 18 and over in the following categories:

- ★ *Elective cases (not expected to die)

- ★ *Deaths of patients with a Learning Disability, aligned with external Learning Disabilities Mortality Review (LeDeR) programme.

- ★ *Deaths of patients who are detained under the Mental Health Act6 . Additionally, for those who die whilst detained under the Mental Health Act6, the safeguarding team will make a mandatory notification to the CQC, which activates robust review by NHS England. The safeguarding team also submits a clinical incident and will notify the Head of Patient Safety in order for the appropriate investigation process to commence.

- ★ *Deaths of patients where there is a concern raised by the bereaved or by staff involved
  *Deaths of patients where there is concern arising from the Medical Examiner scrutiny
  *Deaths which are the subject of a serious incident report

- ★ *All deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the Trust through whatever means. For example, via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the Care Quality Commission (CQC) or another regulator.

- ★ *Deaths where learning will inform the Trust's existing or planned improvement work, for example if work is planned on improving sepsis care or surgical care, relevant deaths should be reviewed, as determined by the Trust

- ★ *Deaths where there is an issue of Regulation 28 Report on action to prevent future deaths

4.1.3.61 - LMEO is responsible for working with Mortality Review team to develop processes by which feedback from mortality reviews and Structured Judgement reviews are fed back to ME Service to enable learning.

4.1.3.62 - Lead MEO and LME will attend at least one MR meetings per month and feedback to the ME team in their ME monthly meeting any feedback

Section D Clinical Incidents
(see Reporting and Management of Incidents including Serious Incidents, section 6)

4.1.4 The ME service recognises and complies with the Trust policy on reporting incidents

4.1.4.1 The Trust policy on reporting clinical incidents is to give staff the confidence to report safety issues, in the knowledge that the organisation will treat them fairly. UHMBT culture allows the organisation to learn from an incident and hold people to account where necessary.

4.1.4.2 The ME service is committed to reflection, learning and improvement of process within the service where appropriate.

Circumstances out of the ME Team's Control
We aim to staff both ME officer at Lancaster and Barrow daily but due to circumstances out of the teams control the attending doctors may need to telephone the opposite site to discuss the case with the Medical Examiner team.

The aim and expectation of the ME service is that scrutiny of cases, discussion with QAP's and writing of MCCD's by QAP's will be within 3 days of death. (NHS standard is Target is 80%) In exceptional circumstances this may not be met. (Weekend, Bank Holidays staff sickness) They should however be completed as soon as staffing allows. This timeline does require death summaries to be completed promptly within 12 hours of patient's death wherever possible

Concerns and Complaints
If any concerns or complaints are raised regarding the Medical Examiner service, they should be directed in the first instance to mailto:Ammeta.Joshi@mbht.nhs.uk

4.2 Conditions of Service for the Medical Examiner's Office

4.2.1 Leave Requests

Medical Examiner
The annual leave year will run from the 01 April until 31 March. Annual leave is paid time off work based on the number of years' service an individual has. Staff will receive the entitlement to paid annual leave and public holidays.
The individual MEs will:

- Be responsible for submitting annual leave requests to the Lead MEO copying in the Lead ME in a timely manner to ensure that approval for leave can be granted six weeks prior to the leave dates requested
- Highlight to the Lead MEO any potential cover issues they are aware of.
- If only one ME is on leave in a week the LMEO can authorise.
- If requests of more than one ME are on leave within a week the LMEO will send to the LME to authorise
- Any swapped ME sessions the LMEO must be notified by email

Annual leave should be taken equally across **all** job plan commitments. The ME session should be treated equally with other commitments in the job plan and consideration should be made to the impact on the ME service when requesting study leave or professional

leave.

Lead Medical Examiner
The lead ME will request leave via the Chief Medical Officer copying in the Lead Medical Examiner officer to update the rota and leave card

Medical Examiner officer
The MEOs will submit annual leave requests to the Lead MEO in a timely manner to ensure that approval for leave is able to be granted ideally six weeks prior to the leave dates requested. Requests under 6 weeks' notice may not be approved and will need to be discussed with the LMEO to ensure service cover. Only one MEO/LMEO authorised to be on leave at any one time

Lead Medical Examiner Officer
The Lead Medical Examiner Officer will request leave via Lead Medical Examiner. Only one MEO / LMEO authorised to be on leave at any one time.
The LMEO will record and keep records, leave cards of all ME and MEO's leave
The LMEO will keep a up to date rota ensuring cover and bring any cover issues to the attention on the Lead ME

4.2.2 Reporting Sickness
When a colleague is reporting absence for work due to sickness, for each new period of absence they are required to:

4.2.2.1 Report absence to Lead Medical Examiner Officer and Lead Medical Examiner if on duty via telephone at the earliest opportunity

4.2.2.2 Notification of a period of absence should be by telephone only, however, there may be situations due to the working pattern where it is agreed that the initial notification of absence is via an alternative method to a phone call to ensure that notification is provided at the earliest opportunity. Where this occurs, it is expected that this is then followed up via a phone call by the individual or the line manager during the first day of the absence.

4.2.2.3 Advise of the reason for absence and when they are likely to return to work. Produce a Fit Note (if absence lasts more than 7 consecutive calendar days). They must contact their manager or nominated deputy at least 3 days prior to the expiry of a Fit Note, to confirm a return to work or advise on progress.

4.2.2.4 Agree how and when regular contact should be made during the absence between the individual and manager

4.2.3 ME Session Expectations
It is expected that during an ME session that the focus should be entirely on the ME workload and is considered as direct clinical care (DCC) for which the ME is required on site. It is not appropriate to undertake other competing clinical work or administration tasks such as answering emails or arranging meetings during the ME session. If working remotely then the ME needs to be immediately available for communication with the MEO, QAP or other stakeholders during the entirety of the session. Working remotely is a privilege not an absolute right when working as an ME. Repeated breaches of the expectations of the sessions will require the ME to work on site in the ME office. Indeed, it is preferable that the ME works onsite for maximum efficiency and communication with key stakeholders.

4.3 Team Meetings

The Medical Examiner and Medical Examiner officers will have a monthly team meeting to include set agenda items and record the outcomes. Agenda items will include -

- Apologises for absence
- Minutes from previous meetings
- Matters arising / action log
- Declaration of interest / conflicts of interest
- MCCD's rejected by the Registrar
- MCCD's rejected by the Coroner'
- Feedback from Mortality review meetings
- Quality Improvement / Audit

5. ATTACHMENTS		
Number	**Title**	**Separate attachment**
1	Bereavement Form A	N
2	Inquest Form FGH	N
3	Inquest Form RLI	N
4	Monitoring	N
5	Values and Behaviours Framework	N
6	Equality & Diversity Impact Assessment Tool	N

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
The latest version of the documents listed below can all be found via the Trust Procedural Document Library intranet homepage.	
Unique Identifier	**Title and web links from the document library**
Corp/Pol/186	Learning from Deaths
Corp/Proc/022	Reporting and Management of Incidents including Serious Incidents

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS	
Every effort been made to review/consider the latest evidence to support this document?	Yes
If 'Yes', full references are shown below:	
No.	**References**
1	Ministry of Justice (2022) 'Guidance for registered medical practitioners on the Notification of Deaths Regulations' [Online]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1062499/registered-medical-practitioners-notification-deaths-regulations-25-march-2022.pdf (accessed 20/12/2022)
2	Department of Health and Social Care (2018) 'Introduction of medical examiners and reforms to death certification in England and Wales: Government response to consultation' [Online]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/715224/death-certification-reforms-government-response.pdf (accessed 20/12/2022)
3	Royal College of Pathologists (2022) 'Medical examiners' [Online]. Available from:

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS	
Every effort been made to review/consider the latest evidence to support this document?	Yes
If 'Yes', full references are shown below:	

No.	References
	https://www.rcpath.org/profession/medical-examiners.html (accessed 20/12/2022)
4	Royal College of Pathologists (2022) 'Medical examiner officers' [Online]. Available from: https://www.rcpath.org/profession/medical-examiners/medical-examiner-officers.html (accessed 20/12/2022)
5	Legislation.gov.uk (2009) 'Coroners and Justice Act 2009' [Online]. Available from: https://www.legislation.gov.uk/ukpga/2009/25/contents (accessed 20/12/2022)

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
QAP	Qualified attending practitioner
MCCD	Medical certificate cause of death
ME	Medical Examiner
MEO	Medical Examiner Officer
LME	Lead Medical Examiner
LMEO	Lead Medical Examiner Officer
BO	Bereavement Office(r)
DHSC	Department of Health and Social Care
CDOP	Child Death Overview Panel
LeDeR	Learning Disability Review Teams
CAD	Care after Death
NoK	Next of Kin
COD	Cause of Death
CQC	Care Quality Commission
DCC	Direct Clinical Care

9. CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

Name/Meeting	Job Title	Date Consulted
Angela Manning	Medical Examiner	1st June 2020
Andrea Abbas	Medical Examiner	23rd May 2022
Mike Burden	Medical Examiner	1st June 2020
Wael Abdelrhman	Medical Examiner	1st June 2020
Priya Iyer	Lead Medical Examiner	1st April 2020
Ruth Benn	Lead Medical Examiner Officer	21st November 2022
Rebecca Barrow	Medical Examiner Officer	1st September 2022
Ejiro Bel-Osagie	Medical Examiner Officer	1st June 2021

10. DISTRIBUTION & COMMUNICATION PLAN	
Dissemination lead:	Ruth Benn
Previous document already being used?	No
If yes, in what format and where?	
Proposed action to retrieve out-of-date copies of the document:	

10. DISTRIBUTION & COMMUNICATION PLAN	
To be disseminated to:	Medical Examiners, Medical Examiner Officers, Bereavement Team
Document Library	
Proposed actions to communicate the document contents to staff:	Email to Team Include in the UHMB Weekly News. New documents uploaded to the Document Library.

11. TRAINING

Is training required to be given due to the introduction of this procedural document? **No**

If 'Yes', training is shown below:

Action by	Action required	To be completed (date)

12. AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Section/Page Changed**	**Description of Change**	**Review Date**
1	12/04/2023		New document	01/11/2025

Appendix 1: Bereavement Form A

<table>
<tr><td colspan="3">Bereavement Office Patient Information Sheet
For Bereavement Office Use only – if found please return to Bereavement Office</td></tr>
<tr><td colspan="3">Bereavement office informed of death by (please indicate):

Mortuary/Ward/Doctor/ other Date: …… Time: ……</td></tr>
<tr><td>Patients full name:

Age:

DOB:

Address:

☐

<u>Nursing Home</u>:</td><td>Hospital No:

Ward:

NHS No:

Ulysses No.

Date admitted:

Date and time of Death:

----------@----------
<u>Date and Time of Verification:</u>

_____@_____
Verified by: Nurse / Doctor (GMC No)

Time of arrival @ Mortuary:
_____

Time family contacted Bereavement office:

_____</td><td>Consultant:

GP:

Surgery:

Tel no:</td></tr>
<tr><td>☐ ☐ <u>Contacts</u> <u>Primary Contact</u>
<u>Letters:</u>

☐ Relationship:
<u>NOK:</u>

Name:

Address:

Tel No:
Email:</td><td></td><td>☐
Care after death:
☐
Death Summary:
☐
GDPR:
☐
CPNS/Spreadsheet:</td></tr>
<tr><td>☐ ☐ <u>Contacts</u> <u>Primary Contact</u>
<u>Letters</u>:

☐ Relationship:
<u>NOK:</u>

Name:

Address:

Tel No:
Email:</td><td></td><td>Patients Property:
Valuables:
Non-Valuables:

Bereavement Book:
Handprints:
Hairlocks:
Knitted Hearts:

Condolence Card sent:</td></tr>
<tr><td colspan="3">Last Occupation:</td></tr>
</table>

☐ ☐

Funeral Director Nominated by NOK: Council Funeral: Burial: Funeral Director Notified: _____

☐ Confirmed by F/D: Cremation: Crem Forms scanned and sent: _____

☐

MCCD Completed by: Date:

Death Certification Number:

Death certificate A Form Coroners Hospital PM Date advised to collect…….

Date & time approved…… Date collected……

Cause of death:

1a

1b

1c

11

Admitted with: Family Present: Yes / No

Tissue Donation: Doctors:

Palliative Care: Yes / No Nurses:

Appendix 2: Inquest Form FGH

Inquest Form FGH

HM CORONER for CUMBRIA
Doctors Statement for the Coroner for an Inquest without Post Mortem Examination
· Name of Deceased:
· Address:

· Date of Birth: Date of Death: Age:
· Place of Death:
· Please confirm the patient's body has been seen after death by a Doctor:-
1. You
2. Another, if so please name:-
3.
CAUSE OF DEATH (On the balance of Probabilities) - (no abbreviations)
1(a) Disease or condition directly leading to death: ……
1(b) Other disease or condition, if any, leading to
(a):……..
1(c) Other disease or condition, if any, leading to
(b):……
2 Other significant condition contributing to the death but not related to the disease or condition causing it:…….....
Relevant past history: ……
……
……
I confirm that I am aware of the requirement to disclose any and all circumstances relevant to the cause of death to the Coroner. I am not aware of any reason why an Autopsy is required.
I hereby certify that I was in medical attendance during the above named deceased's last illness and that the particulars and the cause of death written above are true to the best of my knowledge and belief.

· Signature: ……..
· Name: ……..……
· Qualifications as registered by GMC: ……
· GMC Number: …… Telephone No: ……...
· Contact Address: Furness General Hospital, Dalton Lane, Barrow-in-Furness

Appendix 3: Inquest Form RLI

CLINICIAN'S STATEMENT FOR THE CORONER IN AN INQUEST

WITH NO POST MORTEM

I am Dr …….....*(**M/F**) (please state your full name and circle if you are male or female).*

I am based at ……Hospital /GP Practice.

I have attended ..... (*full name of deceased and "known as names"*) whose date of birth was .../.../..... during their last illness.

The deceased had the following underlying illnesses relevant to the cause of death (*include medication if causing a relevant side effect*)**:**

The deceased's recent medical history leading up to their death was as follows:

On the balance of probabilities I believe that the following conditions **caused** the death

1a)

b)

c)

On the balance of probabilities I believe that the following conditions **contributed** to the death:

2)

I confirm that the body does not contain a cardiac pacemaker or other electronic or radioactive implant

I confirm that I am aware of the requirement to disclose any and all circumstances relevant to the above person's death voluntarily to the Coroner to ensure that he makes a fully informed decision on the cause of death.

....
Clinicians's signature Date

GMC/NMC number .....

Appendix 4: Monitoring

Section to be monitored	Methodology (incl. data source)	Frequency	Reviewed by	Group / Committee to be escalated to (if applicable)
4.1.3.38	Medical Examiner database and quarterly return	Quarterly	Lead Medical Examiner and Lead Medical Examiner Officer	Medical Examiner monthly Team Meeting

Appendix 5: Values and Behaviours Framework

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that is truly **respectful and inclusive,** where we are **compassionate** towards each other**,** and with our **ambitious** drive we truly support an **open, honest and transparent** culture.

Appendix 6: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Medical Examiner Office,	
Lead Assessor	Ruth Benn	
What is being assessed?	Medical Examiner's Office Process	
Date of assessment	01/11/2022	
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Network for Inclusive Healthcare?	YES
	Staff Side Colleague?	NO
	Service Users?	NO
	Staff Inclusion Network(s)?	NO
	Personal Fair Diverse Champions?	NO
	Other (including external organisations): Clinical Directors & Associate Directors of Operations Group	

1) **What is the impact on the following equality groups?**

Positive:	**Negative:**	**Neutral:**
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination / harassment / victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Positive	Supporting process in place to review every patient with a learning disability
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Positive	Where possible, faith deaths will be prioritised by the Medical examiner service
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. carers, veterans, people from a low socioeconomic background,	Neutral	

people with diverse gender identities, human rights)		

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	
3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.** ➢ This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups ➢ This should be reviewed annually.	

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review once approved/noted by Trust Procedural Document Group.
For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.