**National Medical Examiner System**

As a result of several high-profile public inquiries, the role of Medical Examiner (ME) was established to provide an independent review of non-coronial deaths.

The aim of the Medical Examiner Service is to:

* Provide bereaved people with an opportunity to give feedback about the care their loved one received, ask questions and raise concerns.
* Enhance safeguards for the public and healthcare providers through improved and consistent review of non-coronial deaths.
* Improve the quality and accuracy of medical certificates of cause of death and, ensure that coronial referrals are appropriate and accurate.
* Support local learning and improvement by identifying matters for clinical governance and related processes.
* Align with initiatives such as Learning from Deaths

The role of the Medical Examiner (ME) is to review non-coronial deaths in order to:

* Agree the proposed cause of death with the attending doctor and ensure the accuracy of the medical certificate of cause of death (MCCD)
* Discuss the cause of death with bereaved people or informant in lay terms and establish if they have feedback they would like to give about the care, that could have impacted or led to the death. These conversations can be allocated to the Medical Examiner Officer (MEO) at the Lead ME’s discretion.
* A medical advice source to the local HM Coroner
* Highlight a selection of cases where concern has been raised by either family, healthcare staff or the ME, for further review under local mortality arrangements and other clinical governance procedures.

In Somerset, the Medical Examiner Service was set up in 2020 and initially reviewed deaths in the acute hospitals. The reviews are carried out by a team of senior doctors, including hospital specialists and GPs. The MEs are supported by Medical Examiner Officers (MEO) who carry out a lot of the background work, including liaising with families. In 2021 ME review was extended to include deaths occurring in mental health inpatient units and community hospitals.

The referral process for all Community Hospital and Mental Health inpatient areas is simple and straightforward. When a patient dies the certifying doctor just needs to complete the Summary of Death form on the ‘End of Life’ tab on the patient record on. Once completed, they just tick the box at the end of the form and save. An email notification will then be sent automatically to the Medical Examiner Service to alert them of the death.  The ME will not need to routinely contact the certifying doctor if they are satisfied with the cause of death provided following the review of the summary, the patient records and discussion with next of kin. They will only make contact if they need to query something or need further information.  An ME2 form will be returned via email to the doctor stating the agreed cause of death and this should be saved onto the ‘Documents’ section on their record.

In April 2024, it is expected to become a legal requirement for all non-coronial deaths to be reviewed by an ME, including those occurring in the community and the Somerset Medical Examiner Service has been gearing up to review these additional cases. After discussion with the Senior Coroner for Somerset Mrs Samantha Marsh, it is expected that any death which has a clear cause but falls under the coroner’s jurisdiction, should be reviewed by a ME prior to the referral being made. This ensures the accuracy of the cause of death whether it is a Part A 100 or an inquest. Therefore, if the cause of death is reportable to HM Coroner, then an Electronic Death reporting Form (EDRF) will need to be completed as usual and the name of the ME who reviewed the case added to the form.

Now services are established in acute settings across England, NHS England & NHS Improvement asked that the ME Services work towards extending the service out to include deaths which occur in their wider community, but not including those deaths that are dealt with directly by HM Coroner eg sudden unexplained deaths. NHS England has provided enough funding to each Trust to ensure there are enough ME’s and MEO’s to deal with the number of predicted deaths in our community, as well as the acute deaths and work is ongoing to include all deaths being certified by GP practices.