Medical Examiners Death Certification

Dr Alan Fletcher

November 2015

Objectives

- Describe the current and likely situation for medical certification of death
- Describe which cases need to be reported to the coroner
- Discuss ‘preventable death’

Case 1

- 8 year old boy with microcephaly is admitted with the latest in a long series of recurrent chest infections
- After initially recovering, becomes unwell with a hospital acquired pneumonia
- Early warning scores not acted on in a timely way
- Subsequently dies despite efforts to treat and family involved in final decision to limit treatment to comfort care

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The Report of the Morecambe Bay Investigation

Dr Bill Kirkup CBE

March 2015

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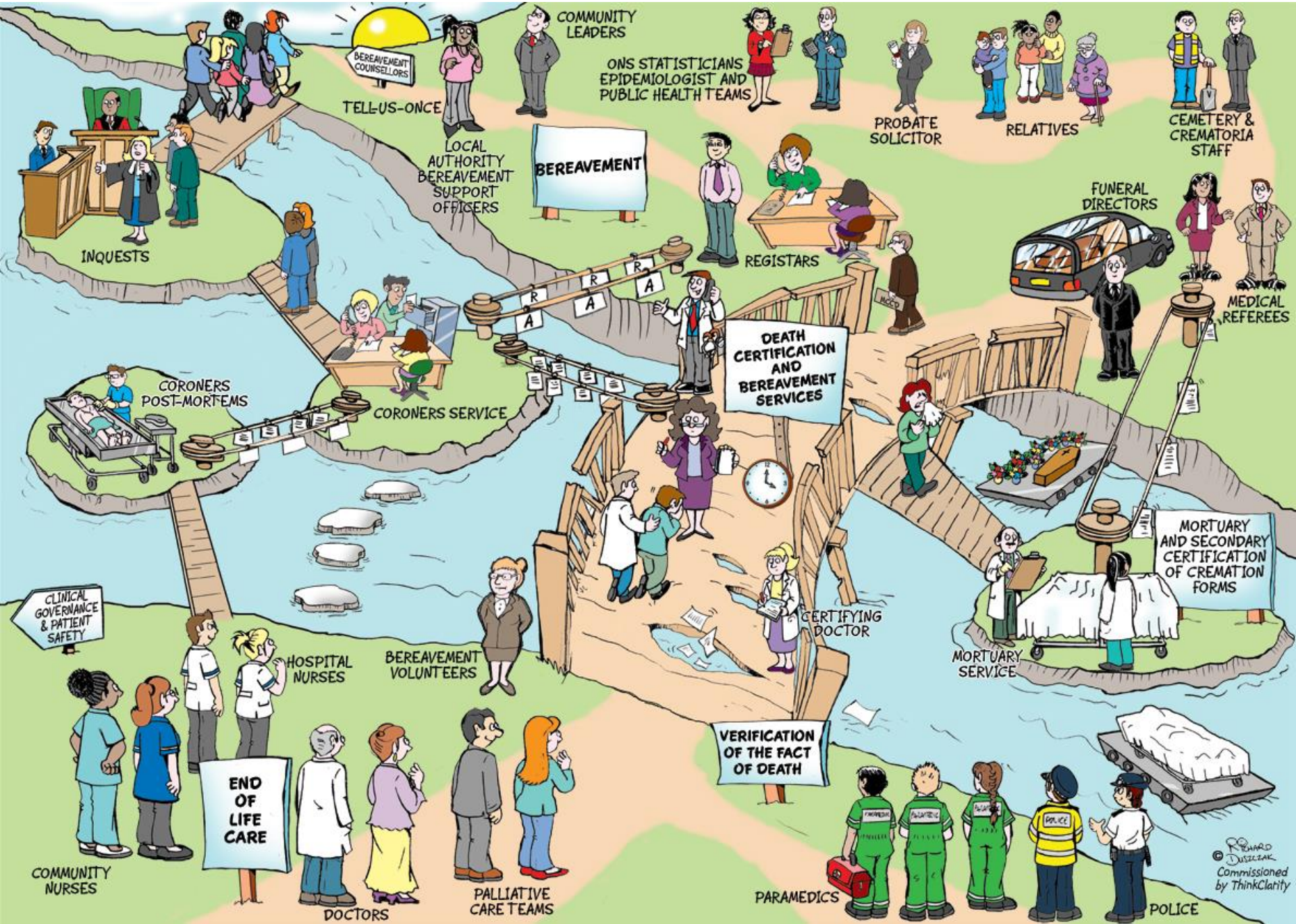
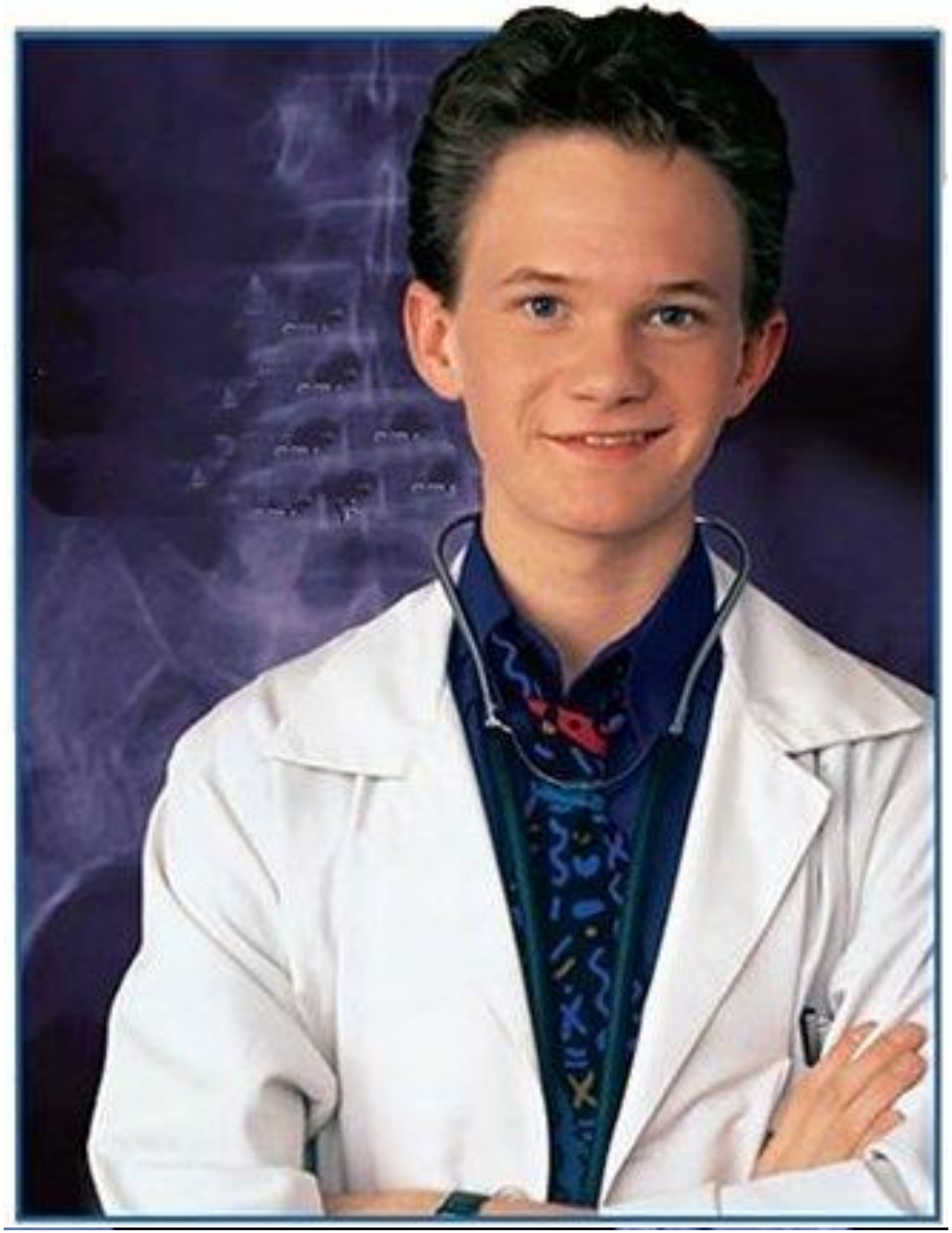




MED A 26 496472

BIRTHS AND DEATHS REGISTRATION ACT 1953

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

MEDICAL CERTIFICATE OF CAUSE OF DEATH

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

Registrar to enter No. of Death Entry

Name of deceased .....

Date of death as stated .....

Age as stated to me 72 yrs

Place of death HOSPITAL

Last seen alive by me .....

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

Please ring appropriate digit(s) and letter

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

CAUSE OF DEATH

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

Bronchopneumonia

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

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

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

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

These particulars not to be entered in death register

Approximate interval between onset and death

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

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

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

Signature .....

Qualifications as registered by General Medical Council FRCA

ANAESTHETIC DEPARTMENT

Residence NORTHERN GENERAL HOSPITAL Date .....

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

MED A 26 496541

BIRTHS AND DEATHS REGISTRATION ACT 1953

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

MEDICAL CERTIFICATE OF CAUSE OF DEATH

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

Registrar to enter No. of Death Entry

Name of deceased .....

Date of death as stated to me ..... 2008 Age as stated to me 61

Place of death ..... pital

Last seen alive by me .....

1	The certified cause of death takes account of information obtained from post-mortem.	*Please ring appropriate digit(s) and letter*	a Seen after death by me.
2	Information from post-mortem may be available later.		b Seen after death by another medical practitioner but not by me.
3	Post-mortem not being held.		c Not seen after death by a medical practitioner.
4	I have reported this death to the Coroner for further action.		

[See overleaf]

CAUSE OF DEATH

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

		These particulars not to be entered in death register Approximate interval between onset and death
I (a)	Disease or condition directly leading to death† Aspiration Pneumonia	8 days
(b)	Other disease or condition, if any, leading to I(a) Quadriplegia	20yrs
(c)	Other disease or condition, if any, leading to I(b) Severe Head Injury due to road traffic accident	20yrs
II	Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition causing it.	

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

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

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

Signature .....

Qualifications as registered by General Medical Council ..... MBChB

Residence Northern General Hospital Date .....

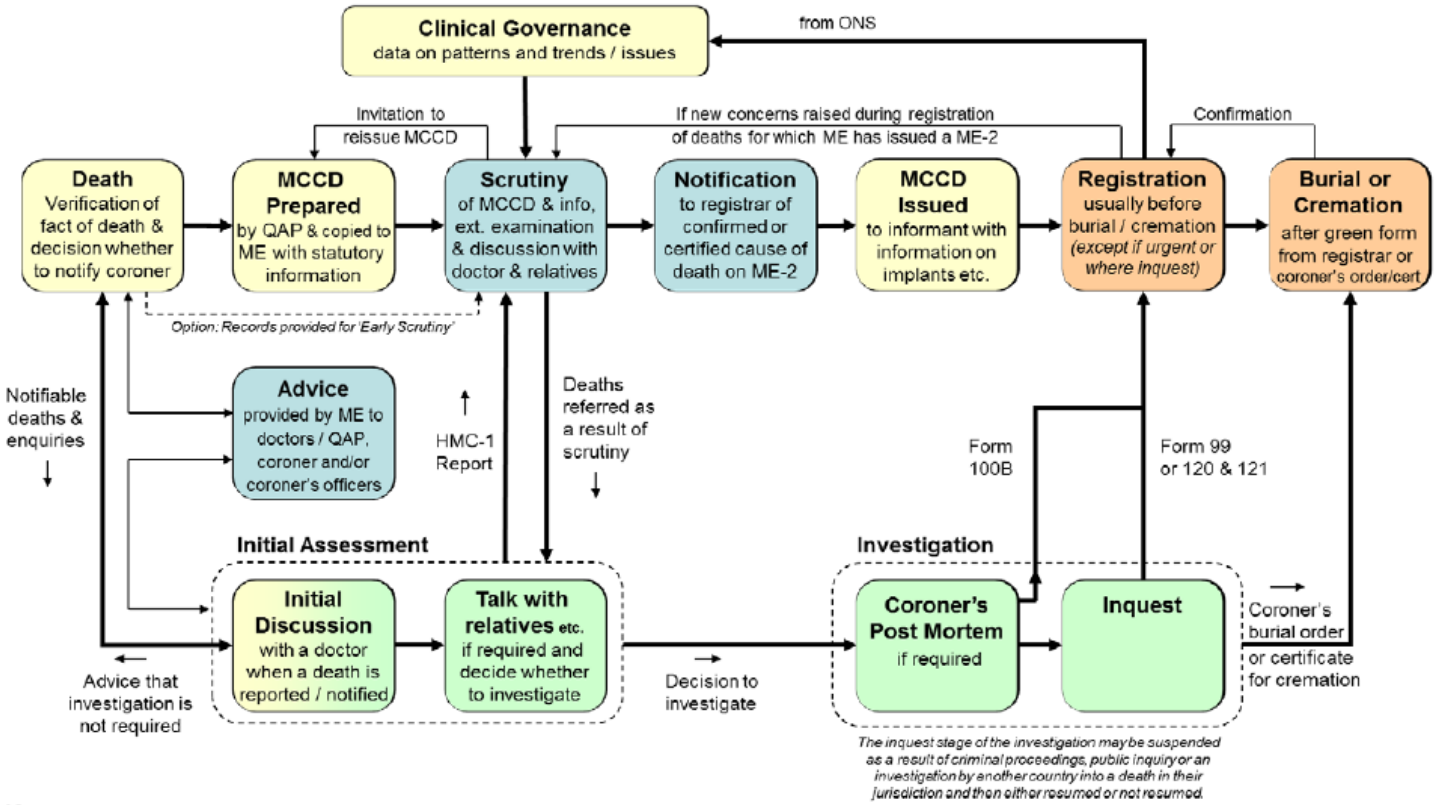
For deaths in hospital: Please give the name of the consultant responsible for the above-named as a patient.

Coroners and Justice Act 2009

CHAPTER 25

CONTENTS

Process


Clinical Governance
data on patterns and trends / issues
from ONS
Invitation to reissue MCCD
If new concerns raised during registration of deaths for which ME has issued a ME-2
Confirmation
Death
Verification of fact of death & decision whether to notify coroner
MCCD Prepared
by QAP & copied to ME with statutory information
Scrutiny
of MCCD & info, ext. examination & discussion with doctor & relatives
Notification
to registrar of confirmed or certified cause of death on ME-2
MCCD Issued
to informant with information on implants etc.
Registration
usually before burial / cremation
(except if urgent or where Inquest)
Burial or Cremation
after green form from registrar or coroner's order/cert
Option: Records provided for 'Early Scrutiny'
Notifiable deaths & enquiries
Advice
provided by ME to doctors / QAP, coroner and/or coroner's officers
HMC-1 Report
Deaths referred as a result of scrutiny
Form 100B
Form 99 or 120 & 121
Initial Assessment
Investigation
Initial Discussion
with a doctor when a death is reported / notified
Talk with relatives etc.
if required and decide whether to investigate
Coroner's Post Mortem
if required
Inquest
Coroner's burial order or certificate for cremation
Advice that investigation is not required
Decision to investigate
The inquest stage of the investigation may be suspended as a result of criminal proceedings, public inquiry or an investigation by another country into a death in their jurisdiction and then either resumed or not resumed.

Medical examiner purpose

- Timely referral to the coroner, right first time, every time
- Accurate medical certificate of cause of death (MCCD) completion
- Early detection of clinical governance concerns

Since 2008

- 15,000 cases
- Now approximately 80% of all deaths
- All acute hospitals including specialist children and cancer hospitals
- 30% of all community deaths
- On call service for faith community and transplant cases
- All within budget

New process

- All deaths not investigated by HMC
- Review of medical records and discussion with bereaved
- Up to 500 MEs
- New date ?

- CDOP

Responsibility for service

Training

http://www.e-lfh.org.uk/projects/medical_examiner/index.html

Welcome to e-Learning for Healthcare

e-LfH e-Learning for Healthcare

Log in to your e-learning

'An extraordinary project in terms of breadth and skill of content'

e-Learning Age – Judges citation

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MedicalExaminer

e-Learning for Healthcare

A web based educational resource supporting the new Government reforms of the systems of death certification and coroners practice

Menu

- Project home
- More information
- Who's involved
- Meet the team

Home

Medical Examiner is an e-learning project commissioned by the Department of Health and delivered by e-Learning for Healthcare (e-LfH) and the Intercollegiate Working Group on Training for Medical Examiners. The project supports the implementation of the Government's reform of the process of death certification in England and Wales.

It will help deliver the curriculum developed by the Working Group providing much of the essential training required by newly recruited Medical Examiners.

The training modules will train Medical Examiners in conducting independent medical scrutiny of cause of death, in providing advice on the process of referral to the coroner and, where invited, in providing medical advice to Coroners themselves.

The legislative framework for implementing these important reforms is included in the Coroners and Justice Bill. The Bill was introduced in Parliament on 14 January 2009.

In partnership with

The Royal College of Pathologists

Pathology: the science behind the cure

DH Department of Health

e-LfH is a Department of Health Programme in partnership with the NHS and Professional Bodies

NHS

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Recruitment

Effect on coroners

Effect on hospitals and GPs

Effect on the bereaved

Money

Case 1

- 8 year old boy with microcephaly is admitted with the latest in a long series of recurrent chest infections
- After initially recovering, becomes unwell with a hospital acquired pneumonia
- Early warning scores not acted on in a timely way
- Subsequently dies despite efforts to treat and family involved in final decision to begin end of life pathway

A day in the life of a medical examiner

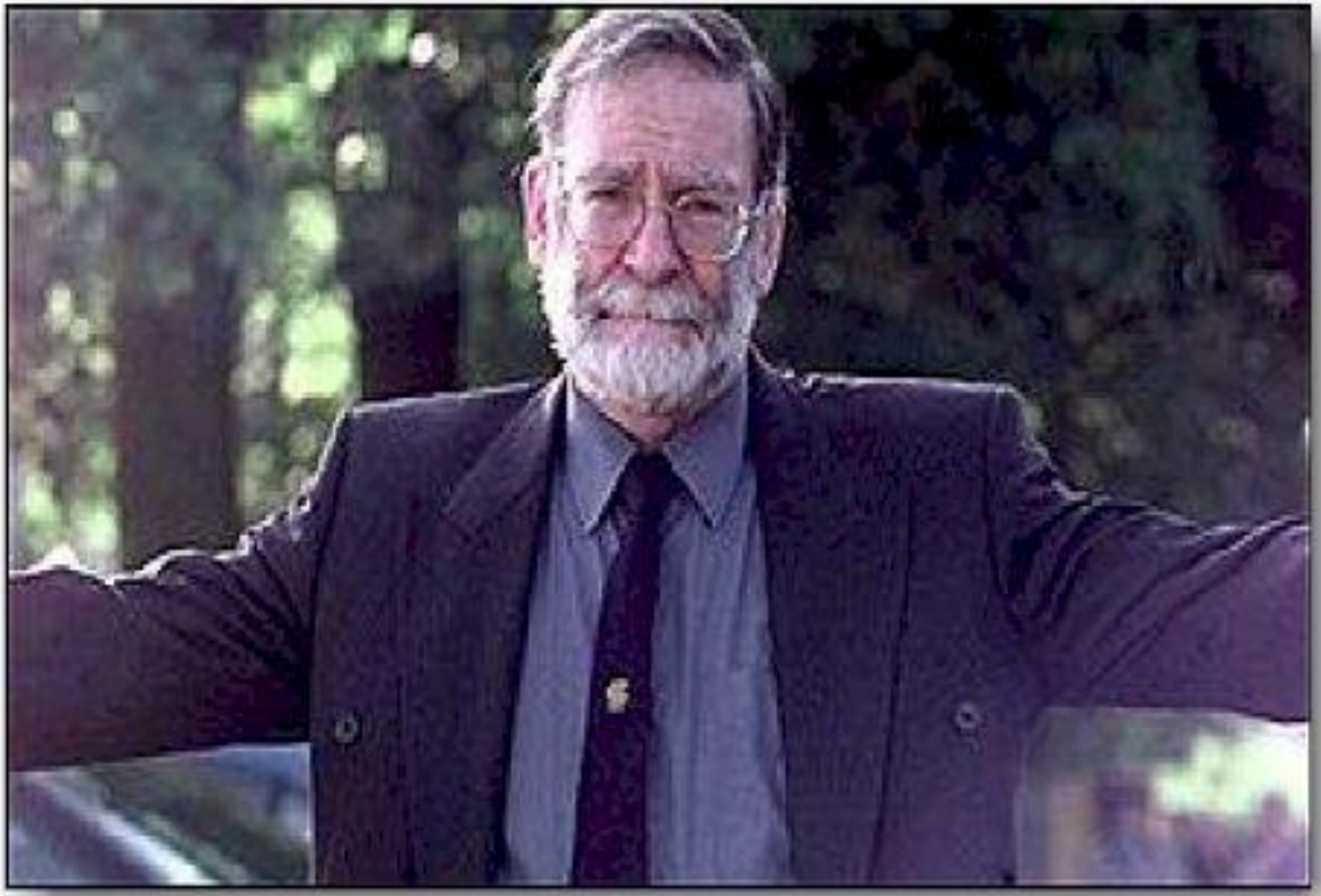
- 13 year old boy with recurrent AML develops pneumonia after his 3rd cycle of palliative chemotherapy. Neutrophils 0.1. Dies despite best efforts with powerful antibiotics on ITU.

- 18 year old young man with advanced terminal cancer receiving palliative care. Receives the wrong dose of haloperidol in syringe driver and becomes acutely unwell and deteriorates further. Mistake recognised and rectified but dies 2 days later.

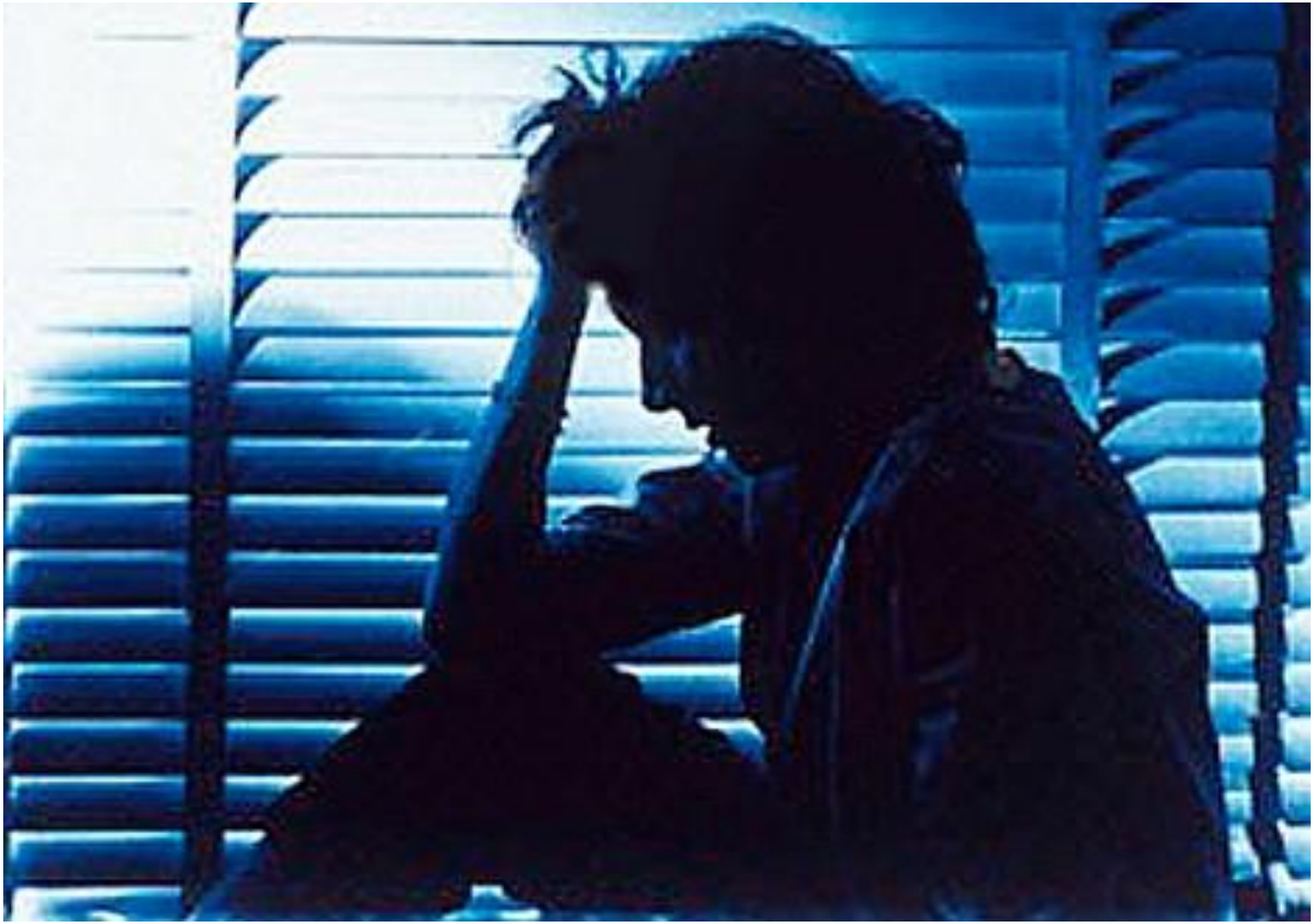

WATCH
FOR
ICE

- 6 year old boy with severe cerebral palsy trips in playground and suffers a tibial fracture and rib fractures. He is admitted but deteriorates because of a chest infection that rapidly progresses to pneumonia. On ITU he develops empyema and dies despite best efforts including chest drains.

- 14 year old boy suddenly collapses on sports day at school during a race. Initially in VF, he achieves ROSC after 40 minutes and is admitted to ITU. It becomes clear after 3 days that he has extensive hypoxic brain injury and brainstem death criteria are fulfilled. A request for organ donation is agreed by the coroner.



- 8 year old boy with severe CF is admitted with a chest infection. Hypoxic and evidence of pneumonia quickly develops. LFTs moderately deranged. On the ward on day 3 alert for change in EWS – unconscious. BMG 0.7 mmol/L, resuscitated and taken to ITU. Never fully recovers and dies a few days later of progressive respiratory failure.



- 5 year old girl refugee from sub Saharan Africa has significant and advanced HIV infection. Develops a severe opportunistic infection and dies on ITU despite all efforts to treat her PCP. Family are unhappy about HIV appearing on her MCCD.

- 5 year old girl is referred with a rapidly growing cerebral glioma. Cure is impossible and palliative treatments do not work. She is cared for magnificently and dies in her parents' arms
- Family allege the GP and the doctors at the DGH didn't spot early signs of the tumour

Objectives

- Describe the current and likely situation for medical certification of death
- Describe which cases need to be reported to the coroner
- Discuss ‘preventable death’

'From the outset, we must all acknowledge - as the report does - that the tragic events in Grantham were the product of a malevolent, deranged, criminal mind. 'Everything else must be seen in that light. The Clothier report does identify and criticise failures of management and communication in the hospital and it is important that lessons are learnt from these throughout the National Health Service. . . . However, it refutes any suggestion that Allitt could easily have Been detected or stopped.'

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