A. Retired Blackpool Hospital pathologist

B. Nobel prize winner for science

C. Fictional character.

Who are they?

Why do we need them?

What do they do?

Dr M Brack Consultant cardiologist

Dr M Davidson Consultant palliative care

Dr T Gulfam Consultant endocrinology, HOD AMU

Mr J Heath Consultant surgeon

Dr A Kearns Consultant emergency medicine

Dr M Martin GP, Highfield surgery.

Medical examiners officers

Liz Pepper, lead MEO

Debra Brearton

Paula Dimery

Bathany Rhodes

Sarah Wignall

Shipmen Inquiry chaired by Dame Janet Smith

In January 2000, GP Harold Shipman was convicted of murdering 15 of his patients. It is likely that he killed over 200. Harold Shipman signed the death certificates of the patients he murdered.

The inquiry pointed out it is unsafe to have a single doctor certifying that a death is due to natural causes with no independent scrutiny.

Dame Janet's criticisms contributed to the passage of the Coroners and Justice act 2009, which made provision for the introduction of ME's.

Mid Staffordshire Inquiry, Sir Robert Francis QC 2013.

The inquiry heard evidence that suggested that the cause of death included In certificates relating to deaths occurring at the trust were often inaccurate or incomplete.

“Such deficiencies are unacceptable because they mislead the family of The deceased and the coroner”.

The report recognised the need for improvement in accuracy of the cause of death and identification of cases to be referred to the coroner.

Morecambe Bay Investigation Dr Bill Kirkup CBE, 2015.

The investigation found 20 instances of significant failures of care at Furness General Hospital, associated with three maternal deaths and the deaths of 16 babies at or shortly after birth.

Different clinical care would have expected to prevent the outcome in one maternal death and the deaths of 11 babies.

The report called for the immediate introduction of Medical Examiners.

Improve safeguards for the public by providing robust independent scrutiny.

Ensure that the right deaths are reported to the coroner.

Improve the quality of certification.

Offer an opportunity for relatives to ask questions and raise concerns.

Feed information to the quality assurance systems.

Provide general medical advice to the coroners.

or another person acting on behalf of a medical examiner.

B1. Name of deceased person and the date and time of death

Name: _____ _____ *(Forename)* *(Family name)*	Date and time of death: __/__/____ ____ *(Date)* *(Time)*

B2. Scrutiny of clinical records and other documented information

Information scrutinised: ☐ Full clinical record ☐ Summary clinical record ☐ Coroner documentation ☐ **Other**

Notes made by medical examiner during scrutiny:

Reference No.: _____/_____/____
(To be completed by medical examiner's office.

B3. Outcome of scrutiny by medical examiner

Death: ☐ Unexpected ☐ Sudden but not unexpected ☐ Expected ☐ Individualised end of life care plan

Case to be referred to HMC ☐ Yes ☐ No

Reason _____

_____

_____

Potential learning identified ☐ Yes ☐ No

Refer to ☐ Speciality M&M ☐ Clinical Governance ☐ Medical team ☐ Nursing ☐ Other please specify

Reason for review _____

_____

Structured Judgment Review case ☐ Yes ☐ No

Reason:

☐ Deaths where the bereaved or staff raise significant concerns about the care

☐ Deaths of those with learning disabilities or severe mental illness

☐ Deaths in a specialty, diagnosis or treatment group where an 'alarm' has been raised (for example, an elevated mortality rate, concerns from audit, CQC concerns)

☐ Deaths where the patient was not expected to die –for example, in elective procedures

☐ Deaths where learning will inform the provider's quality improvement work.

☐ Maternal or neonatal deaths

B5. Discussion with qualified attending practitioner (QAP) - *if required*

(If this discussion takes place before certification and the doctor has not provided in writing a preliminary view of the cause of death – or reason why no such view has been formed – then this information must be obtained and noted below at the outset of the discussion.)

QAP talked with: Name Role Date: / / Time:

Notes: *(If no preliminary view can be formed before requesting advice, make a note of the reason.)*

continuation sheet

☐ Cause of death provided before scrutiny or noted above is accepted without change

☐ Cause established by the medical examiner and documented is accepted by doctor

☐ Doctor and medical examiner have agreed the following alternative cause of death

☐ Death needs to be discussed with a coroner for reasons noted in B2

		Approximate interval between onset and death
1a		
1b		
1c		
2		

B6. Discussion with coroner/coroner's office *(if required)*

MEDICAL EXAMINERS

Friend or Foe

Nursing Times 2019.

MEs are neither friend or foe. In Trusts with good governance MEs will not expect to uncover new problems at such a late stage.

Staff must be aware that MEs will report problems.

If necessary, they may also stop the certification and release of a body, and report a dearth to the coroner, who may follow up with an inquest.

Implications for health care professionals

Medical examiners look at the quality of many aspects of clinical management, especially treatment and care delivered by any registered staff.

They may look at patient records, charts, care plans, investigation results.

Concerns expressed by relatives may lead MEs to focus on certain aspects of care, such as drug administration or nutrition.

Although employers will continue to investigate poor standards all health professionals must recognise the legal role of MEs.

The process for certifying death has changed little since the nineteenth century.

The certification of death is usually delegated to junior doctors and is often not done well.

There is evidence that up to ten percent of death certificates are completed to a poor standard and just over half (55%) could be improved.

Recent ONS data found that if a certificate is checked by a Medical Examiner The underlying cause of death is recorded differently in 22% cases.

MED A 28 000000

BIRTHS AND DEATHS REGISTRATION ACT 1953

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

Registrar to enter No. of Death Entry

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.

Name of deceased .....

Date of death as stated to me ..... day of ..... Age as stated to me .....

Place of death .....

Last seen alive by me ..... day of .....

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.

I (a) Disease or condition directly leading to death† .....
(b) Other disease or condition, if any, leading to I(a) .....
(c) Other disease or condition, if any, leading to I(b) .....

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

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 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 .....

Residence ..... Date .....

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

Ia Intraperitoneal haemorrhage

Ib Ruptured metastatic deposit in liver

1c primary adenocarcinoma of ascending colon

II Non-insulin dependent diabetes mellitus

Ia. Cardiorespiratory failure

Ib. Ischaemic heart disease and chronic obstructive airways disease

Ic.

Ia. Hepatic failure

Ib. liver cirrhosis

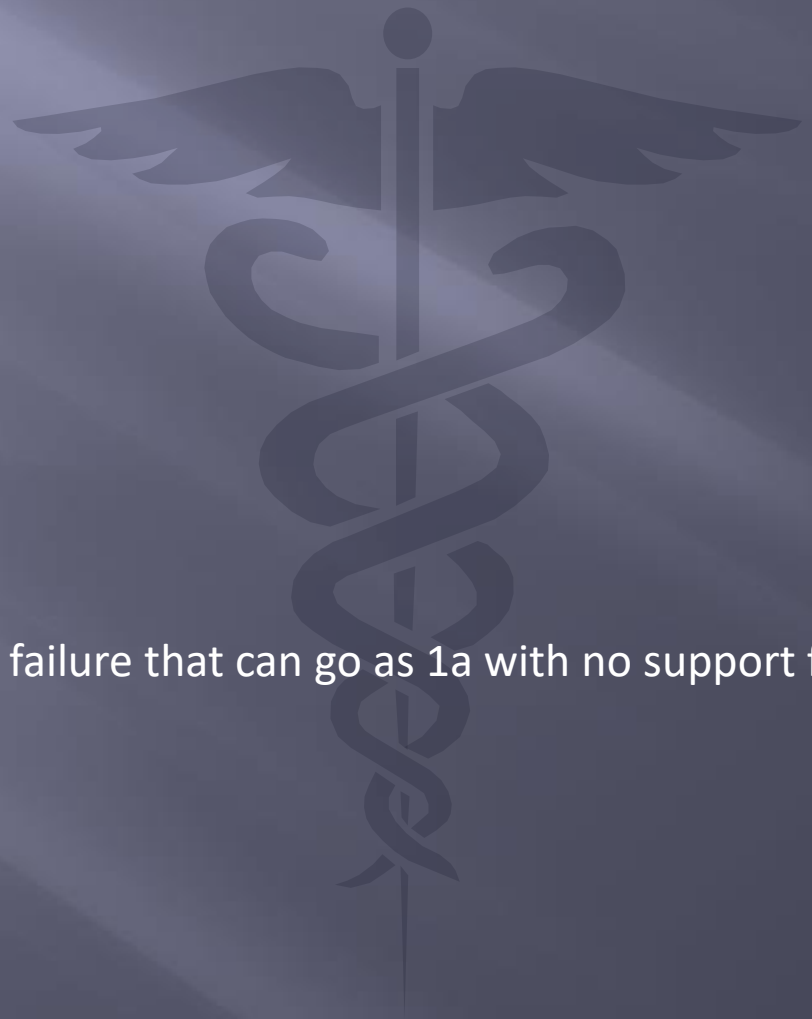
Ic. Chronic hepatitis C infection and alcoholism (joint causes of death)

Respiratory failure

Liver failure

Renal failure

Multiorgan failure

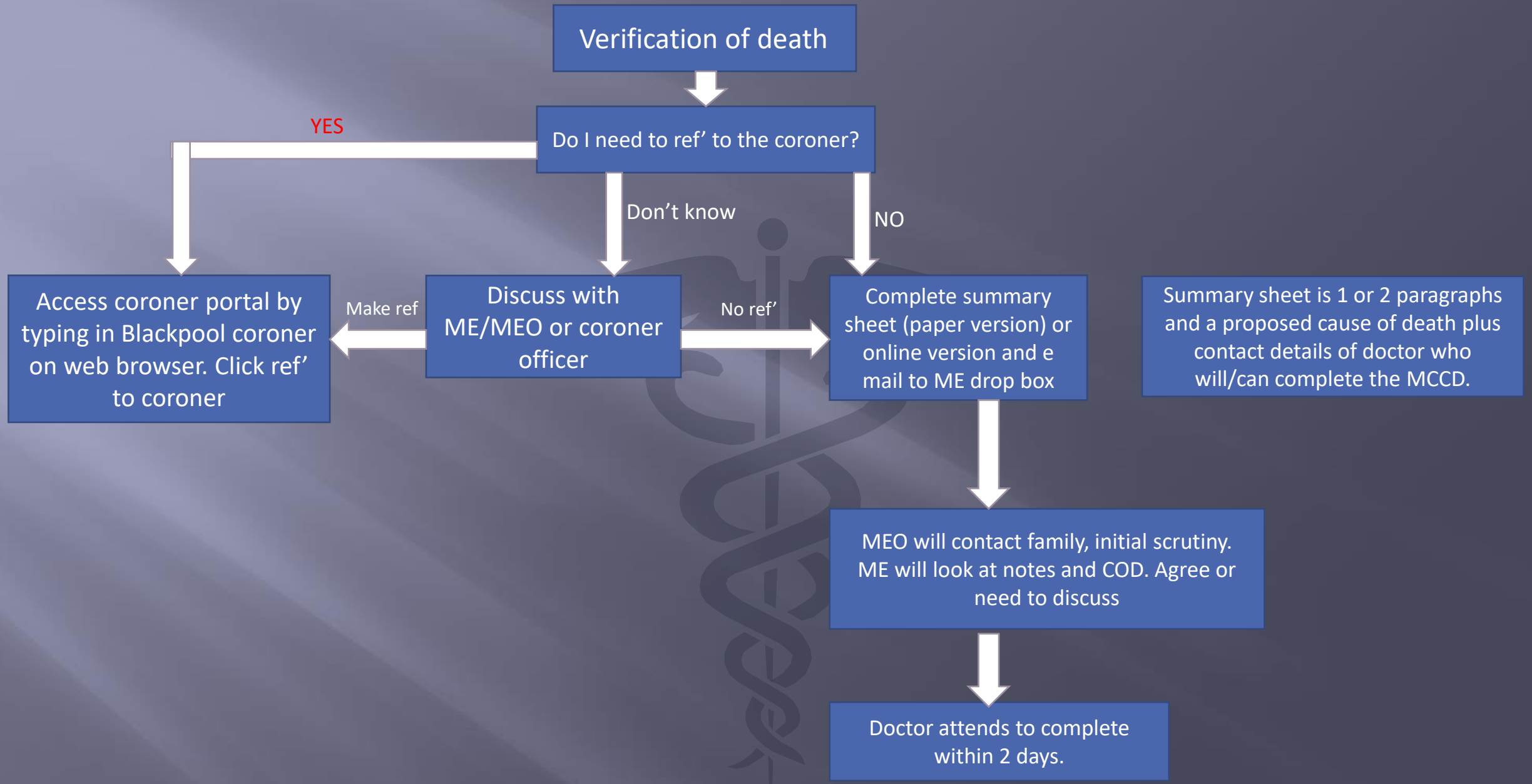


Cardiac failure is the only failure that can go as 1a with no support from 1b

1(a) Sepsis Of unknown origin

1(a) Upper gastrointestinal haemorrhage. Spontaneous upper gastrointestinal haemorrhage

1(a) Intracranial haemorrhage Spontaneous intracranial haemorrhage


Verification of death
Do I need to ref' to the coroner?
YES
Don't know
NO
Access coroner portal by typing in Blackpool coroner on web browser. Click ref' to coroner
Make ref
Discuss with ME/MEO or coroner officer
No ref'
Complete summary sheet (paper version) or online version and e mail to ME drop box
Summary sheet is 1 or 2 paragraphs and a proposed cause of death plus contact details of doctor who will/can complete the MCCD.
MEO will contact family, initial scrutiny. ME will look at notes and COD. Agree or need to discuss
Doctor attends to complete within 2 days.

Summary of Death Certification

The information provided in this form is confidential

This form must be completed by the attending doctor independently to the review by the medical examiner. Section 2 **must** be completed so that a record of the attending doctor's view on the primary cause of death is recorded to ensure transparency of the process.

1. Name of deceased person and the date and time of death

Name: _____ _____ *(Forename)* *(Family name)*	Date and time of death: ____/__/____ ____ *(Date)* *(Time)*

2. Synopsis of circumstances, medical history and preliminary view of the cause of death

This information is to provide information to support your proposed cause of death or referral to the coroner. Please include information regarding any concerns raised.

☐ *continuation sheet*

Do you have any concerns about the quality of care this patient received? ☐ Yes ☐ No *If 'yes' please detail above*

(If no preliminary view can be formed make a note of the reason.)

		Approximate interval between onset and death
1a		
1b		
1c		
2		

NHS/Hospital No.: _____ Reference No.: _____/_____/____
(To be completed by medical examiner's office.)

3. Advice from medical examiner, coroner or their respective officers *(if applicable)*

Spoken with: _____ Date and time: __/__/____ at _____

Notes:

Outcome:

6. Doctor's decision and action

☐ I feel able to complete the MCCD with no need for coroner referral *(Only valid for a doctor that attended the deceased.)*

☐ I feel this case requires referral to the coroner for further action for the following reason _____

_____

A Medical Certificate of Cause of Death (MCCD) must not be issued for registration purposes until the cause of death has been formally confirmed by a medical examiner.

7. Medical practitioner's name and contact details

Full name *(print)*: _____ GMC No.: _____

Location/department: _____

Personal phone/bleep No.: _____ Alternative/out-of-hours contact No.: _____

Signature: _____ Date: __/__/____

(The doctor providing the information in this form needs to be available to respond, if asked, to any enquiries from a medical examiner or officer.)

ADMISSION DOCUMENTATION
Inpatient - Medical/ Surgical Patient
(delete as appropriate)

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

FILE IN SECTION 4

ADMISSION/REFERRAL DETAILS:

Call Taken by:			
Date:	__/__/__	Time (use 24 hr clock) :	__:__
Source of Referral:	GP ☐ A&E ☐ OPD ☐ PCAU ☐ Other ☐		
Ward admitted to:			
Admission Date:	__/__/__	Admission Time:	__:__
GENDER:	Male ☐ Female ☐	AGE:	
G.P. NAME:		G.P. PRACTICE:	

Write patient details or affix Identification label

Hospital Number:
Name: J[redacted]
Address: [redacted]
Postcode:
Date of Birth:
NHS Number: [redacted]

PRESENTING COMPLAINT(S)

SoB

HISTORY OF PRESENTING COMPLAINT(S)

3/7 SoB - sudden onset, Denies any pain
- Says she has had leg swelling
- Says she doesn't think she was unwell
- Reports normal urinary habits
- Denies cough, palpitations

Patient says she weighs approx 90 kg.

ALLERGIES (MEDICATIONS, LATEX, RUBBER, METALS, FOODS, ETC)

Statin,

Clerking Doctor:		GMC Number:				Grade:	
Signature:							
Consultant:		Bleep:		Date:	__/__/__	Time (use 24 hr clock):	__:__

INITIAL ASSESSMENT MANAGEMENT PLAN

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

CLINICAL/ WORKING DIAGNOSIS

AS per Registrar -
- Acute pulmonary oedema 2° to LVSD.
- CAP
- Needs to be covered for IE

OTHER INVESTIGATIONS/MANAGEMENT PLAN | REMEMBER: DO NOT TICK THE ACTION UNTIL IT IS COMPLETED

NBM ☐ Starting:_____

AS per [redacted]
- Arterial line
- ABG.
- Furosemide 80mg IV.
- GTN injection
- IE empirical - IV antibiotic regimen
- Blood Cultures
- Departmental Echo.

Observation Frequency: 8 hourly ☐ 4 ☐ 2 ☐ 1 ☐

Fluid Balance Monitoring: 8 hourly ☐ 4 ☐ 2 ☐ 1 ☐

Parameters for medical review:

(e.g. failure to achieve target spO2 94% or systolic blood pressure <100mmHg)

Senior Clinician Review/Advice required: ☐ **Referral to Other Speciality:** ☐

Plan if Condition Deteriorates:

Other:

Primary VTE Assessment completed ☐ (refer to page 9 to complete VTE assessment)

Does the patient have a health and welfare lasting power of attorney in place? Y ☐ N ☐ Unknown ☐

Has the patient drawn up an advanced decision to refuse treatment regarding this management plan?

Y ☐ N ☐ Unknown ☐

Resuscitation Status: . **DNACPR documentation completed?** Y ☐ N ☐

Estimated Discharge Date: ___/___/_____

Clerking Doctor:		GMC Number:				Grade:	
Signature:							
Consultant:		Bleep:		Date:	___/___/_____	Time (use 24 hr clock):	___:____

Venous Thromboprophylaxis (VTE)
Risk Assessment for ALL Adult Inpatients and Outpatients with restricted mobility (e.g. casts, splints, traction) - excluding pregnancy

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Patient's Name:		**Hospital or Identifying Number:**	
Date of Birth		**NHS Number:**	

THE VTE ASSESSMENT MUST BE COMPLETED ON ALL ADULT INPATIENTS
Primary Assessment - Completed within 4 hours of admission or at pre-op assessment
Secondary Assessment - Completed at least 4 hours after primary assessment and within 24 hours of the primary

Risk factors – tick all appropriate and then sign, date and time primary or secondary assessment at bottom of the page	**Primary Assessment**	**Secondary Assessment**
Expected to have reduced mobility relative to normal state and /or significantly reduced mobility for 3 days or more , this includes surgical and trauma patients		
Total anaesthetic + surgical time > 90 minutes		
Surgery involves pelvis or lower limb and total anaesthetic + surgical time > 60 minutes		
Acute surgical admission with inflammatory or intra-abdominal condition		
Active cancer or cancer treatment		
Age > 60 years		
Critical care admission		
Dehydration		
Known thrombophilias		
Obesity (BMI > 30 kg/m2)		
One or more significant medical comorbidities (for example: heart disease; metabolic, endocrine or respiratory pathologies; acute infectious diseases; inflammatory conditions)		
Use of oestrogen-containing contraceptive therapy or use of HRT		
Personal history or first-degree relative with a history of VTE		
Varicose veins with phlebitis		
Patient has no risk factors for VTE		

Haematology		
Exclude any patient known to be thrombocytopaenic or likely to be within the next 7 days	Yes ☐ Signed:_____	
Does the patient have any contraindications to dalteparin?	Yes ☐ No ☐	Yes ☐ No ☐
Does the patient have any contraindications to anti-embolism stockings?	Yes ☐ No ☐	Yes ☐ No ☐

If yes to both of above seek senior advice (Registrar or above) and record advice in notes

What is to be prescribed?		
Weight < 50kg - dalteparin 2500 units sc OD		
Weight <100kg – dalteparin 5000 units sc OD		
Weight 100-150kg – dalteparin 5000 units sc BD		
Weight > 150 kg - dalteparin 7500 units sc BD and contact haematology for advice		
No dalteparin is to be prescribed		
Anti- embolism stockings		

Primary Assessment - Completed within 4 hours of admission or at pre-op assessment for elective patients

Signature:					
Print:					
Bleep:		**Date:**		**Time** (use 24 hr clock)	

Secondary Assessment - Completed at least 4 hours after primary assessment and within 24 hours of admission

Signature:					
Print:					
Bleep:		**Date:**		**Time** use 24 hr clock)::	

arget
Hourly

			N						(A)							(-ve)
	nBM		83.34		2				85.34	4		NG	100		140	54.66
	nBM		83.34						0.68	200		NG	50		390	-219.32
	nBM		83.34		2				256.02	40		NG	50		480	22 8
04:00	nBM		83.34						341.36	95		NG	100		675	-333.64
	nBM		83.34		2				426.7	40		NG	0		715	288.3
	nBM		83.34		2	IV	120+10		742.04	30		NG	100		845	-102.96
	nBM		Break		-				742.04	30		NG	0		875	-132.96
	nBM	IVF	83.34	Insulin	2					95			0		465	
	nBM		83.34		2					50						
	nBM		83.34		2					60						
	nBM		83.34		2					40						
	nBM		83.34		2					150						
	nBM		83.34		2	45	120+10+10			20						
	nBM									10						
	nBM		VF	83.34	2											
	nBM			83.34	2					50	Pyles tube 200					
	nBM			83.34	2					50						
	nBM	Omeprazole IID		83.34			PI	D		55						
	nBM			83.34	2		T									
	nBM															
	nBM															
	nBM									120						
	nBM									100						

INTRAC

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	N					(A)	UP						
						T							(+ve/-ve)
01:00	NBM.	125		100 IV paracetamol		225	0						
		125				350	0					260	
		125				475	260	CRAMP. SOR					
04:00		125				600	0					3	
		~~125~~ 83.3				683.3	100	CRAMP. SOR					
		~~83.3~~		100 WATER									
		83.3					~~150~~					510	
							150						
	NBM						150					660	
10:00							50					710	
							50					76	
							50					810	
							50					860	
7:00							60					920	
9:00													
							166					1080	
24:00													

Nasogastric,

				N					(A)				(ve/-ve)
										150	CHAM[illegible]		
01:00	[illegible]												
02:00													
05:00													
												390	
				125	INS	1			250	240		396	
	NBM			125	INS	2			375	0		390	
	NBM			125	INS	2		850	~~350~~	0		390	
	NBM			125	INS	2			975	0		390	
	~~350~~	H2O		125	INS	3			1100	0		5 0	
	0			125	INS	3			1425	120			
	~~Juice~~	20 0		125	INS	3			1650	0			
	Juice	200		125	INS	3			1975	0			
	100	Fed		125	INS	4			2300				
	200	J		125	INS				2362.5				
	Tea	200		~~125~~ 62.5					2425			796.	1897.5
				~~1062.5~~					2687.5	280	(Bladder Scan SM).		
19:00				625									
	H2O	200											
												890	+1899.
									2787.5	100.			
	100												

Abbreviations:

A Coroner is required to investigate certain deaths where there is reason to suspect that:

The death was violent

The death occurred at a time when the deceased was in state detention

The death was unnatural

The cause of death is unknown.

What do we mean by unnatural?

Doctors must report to the coroner cases where the death was caused or contributed (meaning It made a significant contribution) to by the following.

An accident (whenever this occurred)
An unnatural event that caused admission eg hanging, drugs overdose
A medical error, mis prescription, failure to diagnose error during surgery etc.
An industrial disease such as asbestos leading to mesothelioma.
A prisoner located in hospital for treatment
A person recently released from detention in last 24 hours by the police/prison
The deceased not seen at any point in their last illness by a doctor
Medical mis management: does it appear that the death would not have occurred but for some failure

"a death becomes unnatural where it was wholly unexpected and would not have occurred but for some culpable human failing".

2021 statistics

- Deaths reported – 1159
- Post mortems – 568
- Inquests – 286
- Drug / alcohol – 34
- Suicide – 24
- Industrial disease – 11
- Accidents – 48
- Natural causes – 79
- Open - 2
- Narratives – 69
- Ave time to conclude – 16 weeks

HOW CAN I AVOID AN INQUEST?	EXPLAIN MEDICAL TERMS	DUTY OF CANDOUR	PROVIDE DETAIL
HOW CAN I GIVE GOOD EVIDENCE IN COURT?	NOT ABOUT BLAME	GIVE YOUR OWN EVIDENCE	VISIT IN ADVANCE
CAN MY RECORDS KEEPING HELP ME?	UNEXPLAINED GAPS	RECORD WHAT INSTRUCTION YOU ARE GIVEN	RESPOND TO FAMILY CONCERNS
COMMON THEMES?	ESCALATION AND DELAY	COMMUNICATION WITH FAMILY	AGENCY STAFF & SUPERVISION
FAMILY CONCERNS	SEPSIS	LEARNING LESSONS	FALLS – WHAT HAPPENED AND WHY?


Anathomia mā
dini Emēdata p
doctorē melerstat