Medical Examiner services

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- Why were ME services implemented?
- Who are medical examiners?
- Purpose of ME services
- What have we learnt so far?

It has been recognised through several healthcare enquiries that there should be a service that provides independent scrutiny of all deaths that are not investigated by the coroner.

Medical examiners are experienced doctors with additional training in death certification and records review, and have close working links with registration and coroners services

Purpose of Medical Examiner services

- Ensure that an accurate cause of death is recorded on the MCCD
- Ensure that unnatural or unexplained deaths are identified and are referred to the coroner
- Identify any concerns about treatment or care that might require further investigation
- Involve and support bereaved families through the bereavement administration process
- Support and education for certifying doctors

How have we set up our service?

- Hosted by UHP, but independent
- 8 ME's working on a sessional basis, supported by ME Officers
- Cover in place for normal working hours
- Generalist medical background
- Service set up in April 2020 for reviews of trust deaths
- Partial community rollout in April 2023 (21/31 practices)
- Service set to be statutory in April 2024
- Feed into trust learning from deaths
- Input into JD induction and training and service line support
- Weekly drop-in Teams channel

What have we learnt to date?

- Support for certifying doctors is helpful to complete some MCCD's, diagnostic uncertainty, inexperience
- Building a huge dataset (8182 deaths; 7375 in UHP, 807 in the community) which tells a story for example;
- Cremation - Burial ratio 88% - 12% (Nat Ave 78.4% cremation rate)
- Average time to complete MCCD after death, 4 days in the community, 2 days in the trust
- Place of death for community deaths (incomplete data)
  - Own home 34%
  - Care Home 46%
  - St Lukes Hospice 20%

- Within the trust over the past 3 years proportion of deaths referred to the coroner has nearly halved, and the proportion of those that result in Part A has halved too
- Most common reasons for GP coroners referrals – not seen within 28 days, cause unknown
- Most common reasons for Trust coroners referrals – trauma, complication of treatment, cause unknown
- Feedback from trust doctors excellent
- Feedback from bereaved families has been excellent

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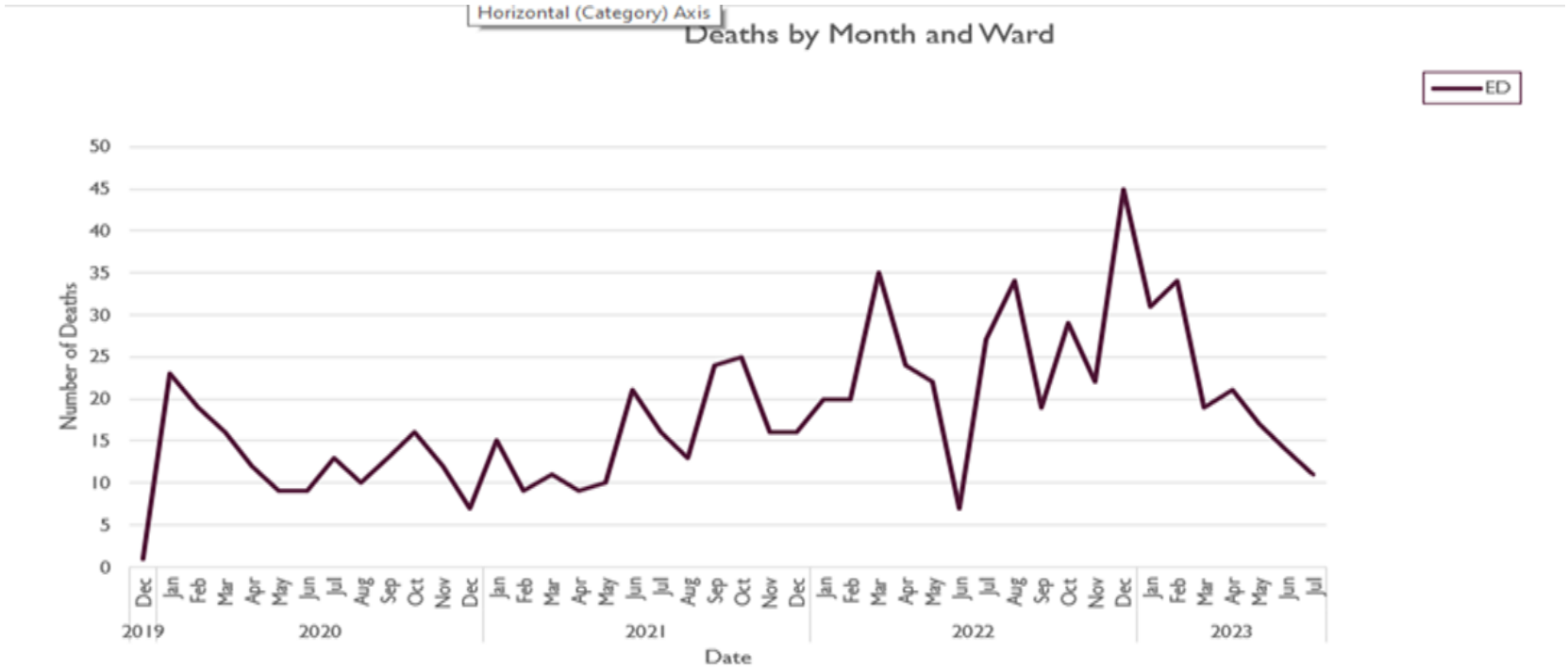
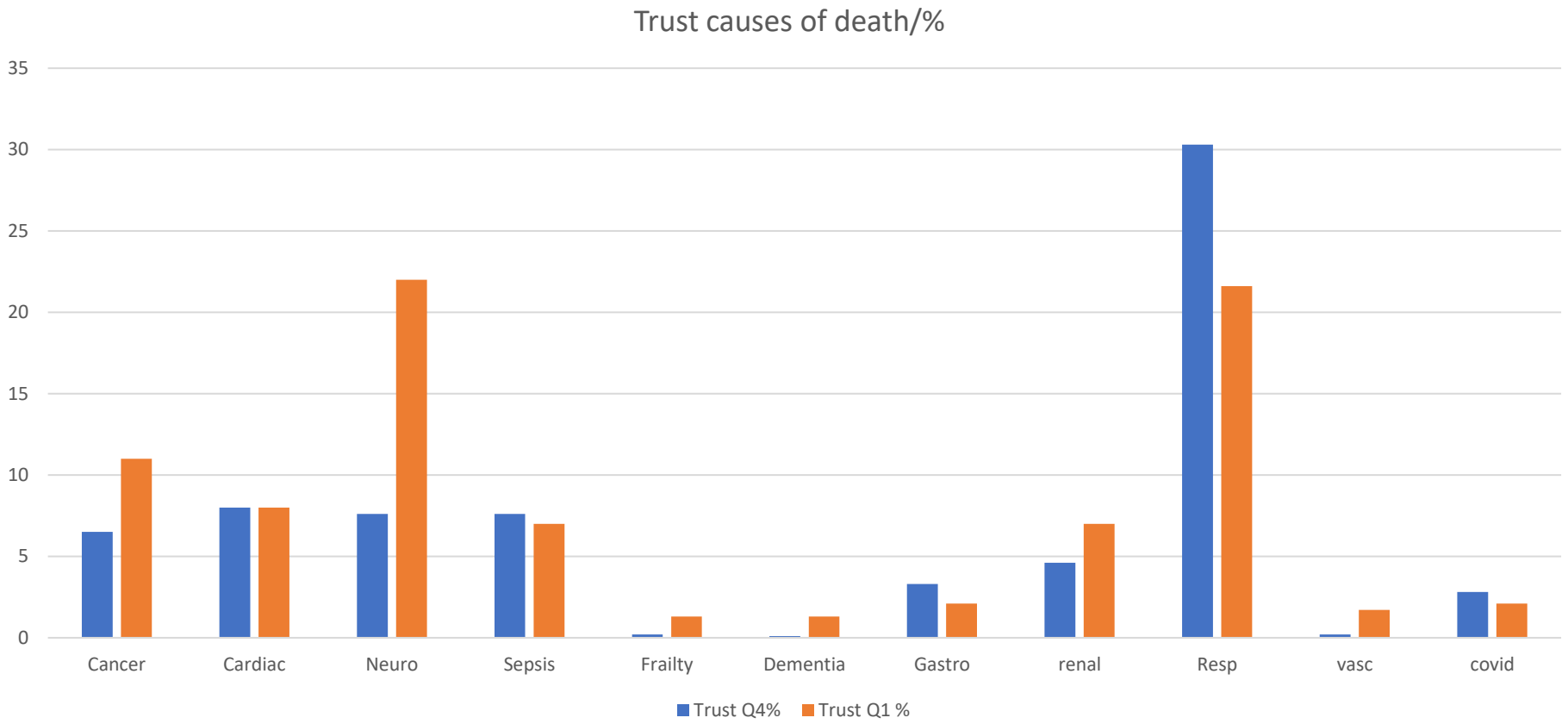
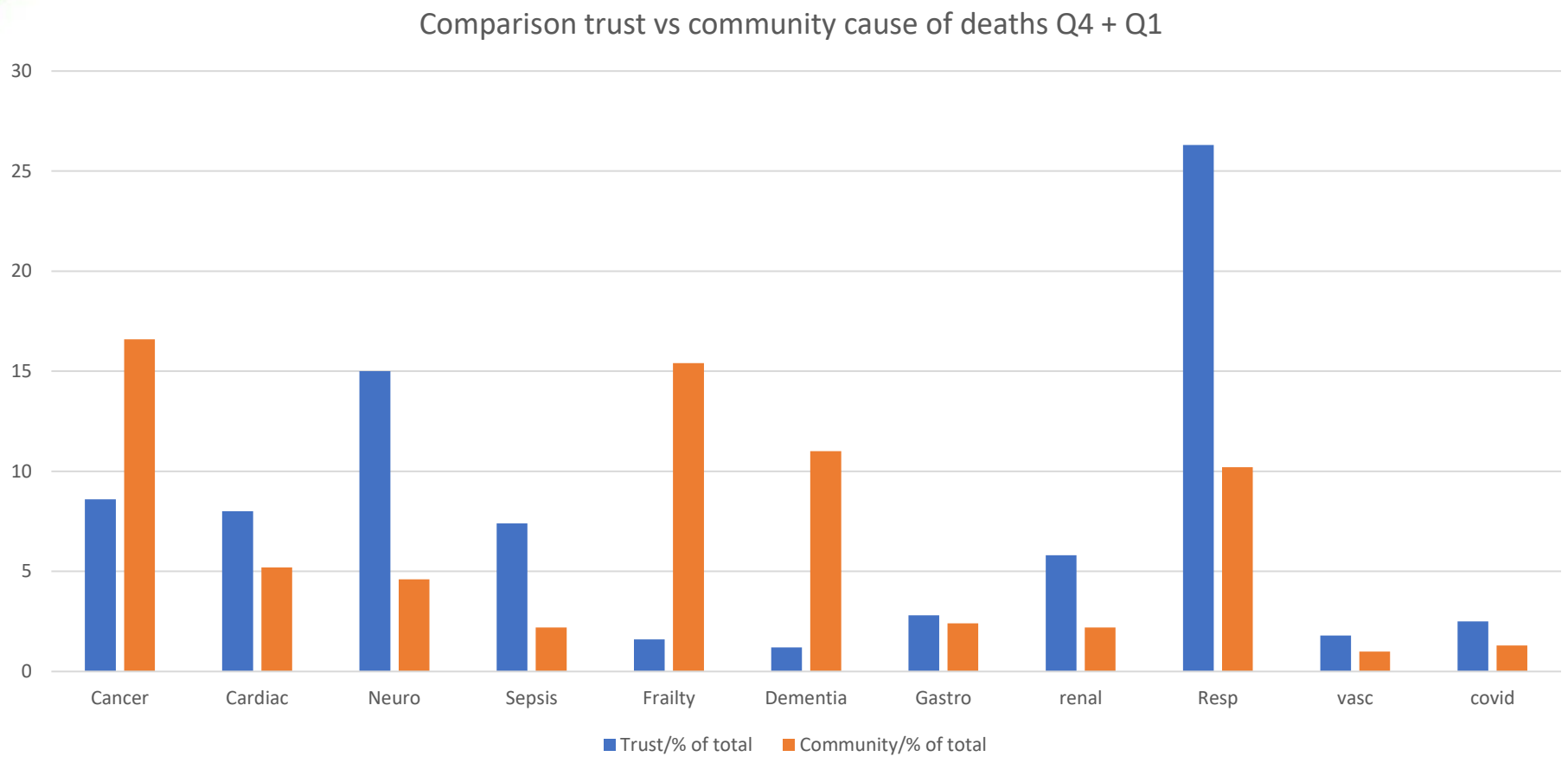
- Hotspots e.g. Emergency department



Causes of death in UHP Q4 vs Q1



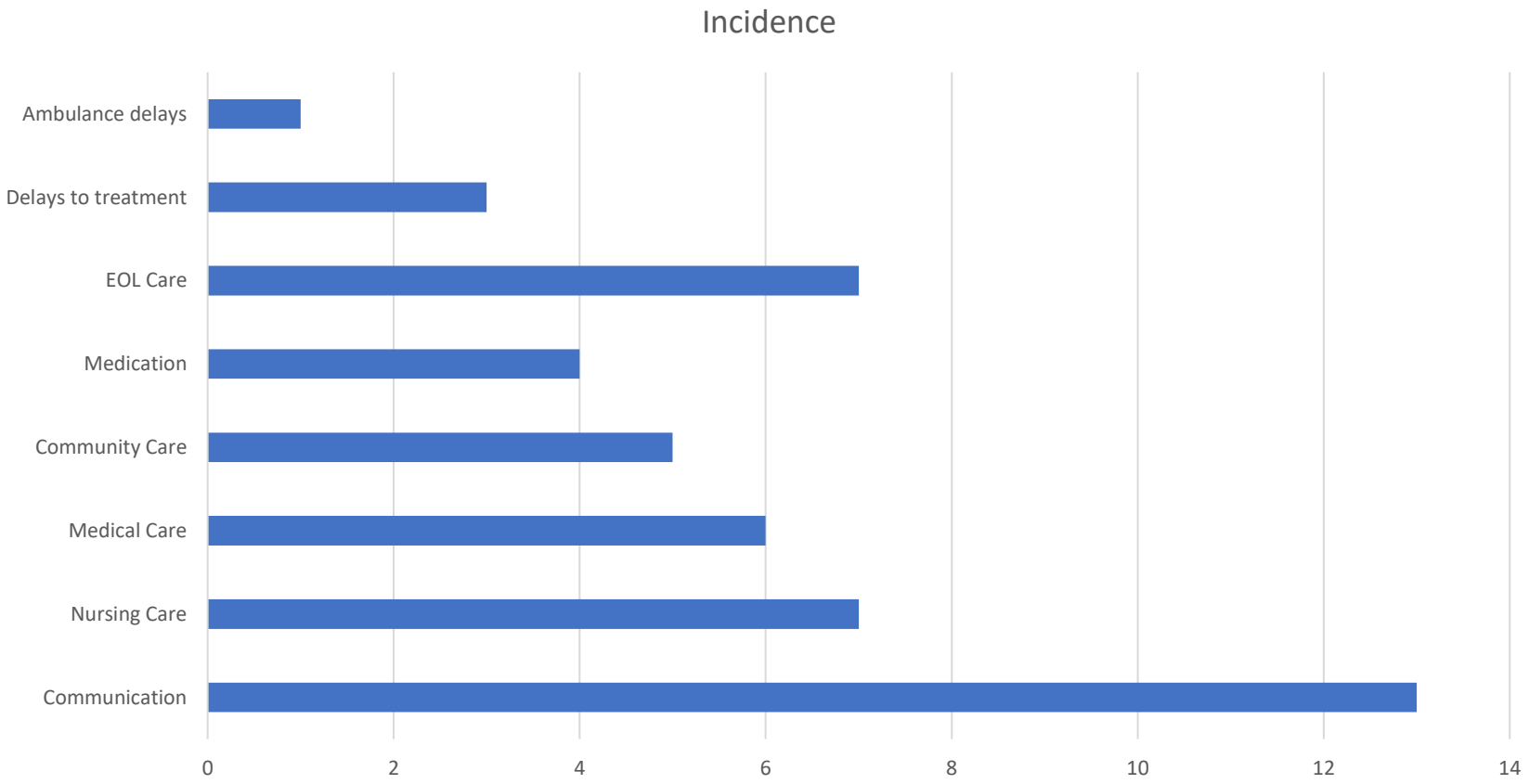
Comparison of causes of death trust vs community Q4 + Q1



Feedback from families

- 90-95% of families have no concerns to raise
- Positive feedback is matched with negative feedback
- Feedback is sought at first contact, usually soon after death
- ME can help with factual information and timeline, etc, anything else if passed on to clinical teams
- Formal governance processes in the trust, less formal in the community
- Support offered to families after bereavement is very variable, ME's provide a consistent offer
- Some recurring themes – useful for future learning, though all underpinned by good communication.

Feedback from bereaved families - themes



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Communication

- Bad communication from nurses on the ward.
- Hospital Dr called me at 12.45 and said the Dr needed to speak to me and to come in. He questioned lots about his history and what was wrong with him when I came in wanted to know about his history then the Dr said to me “I’m sorry to tell you but he died at 9.00am”
- Moved ward family not informed, tried calling original ward and got no answer, therefore got no updates. Only found out that hospital had concerns from demented fathers carer.
- I wasn’t being kept up to date during his admission at all only times when father phoned me but he was out of sorts as he was on medication
- nobody could give clear and concise information about the next steps of his treatment.

Communication

- The medical team were arguing with the surgical team, family overheard this. Staff seemed not to care; Professionals were so dismissive
- She asked what was happening next and he told her very bluntly on the phone Nan was dying! Which was a real shock as no one had mentioned this. She does not think even her Nan was aware this was the end and she was dying. Granddaughter missed her by 10 minutes.
- Was not told he was on a syringe driver – was not told end of life.
- Family need some reassurance as they didn't get much confidence from the Consultant.
- Communication was really bad. Has no idea what has happened.
- Concerned that she wasn't contacted by ED about his deterioration. Would have liked to have been called in
- Everybody on the ward was complaining about communication

EOL Care

- family asked why he was not resuscitated the Dr said he was for DNR family have not signed anything and have no record of this. Dad would have wanted resuscitation.
- They are worried that she was left to die on her own.
- she was sent from Derriford to Mount Gould for rehabilitation, so we thought she was getting better within a matter of hours she was sent back to Derriford and died.
- Had no dignity at the end – thinks it could have been handled a bit better. Lots of ward moves and nobody knew what was going on. So uncomfortable at the end. Daughter kept asking what was happening but nobody had any answers for her
- Numerous concerns about her end of life care, mum really did suffer at end of life

Nursing Care

- He had nil by mouth on his chart so nothing to eat or drink for 4 days. He was shouting for water. Wants to know if he died of starvation.
- He doesn’t think she had the care she should of care. He had to feed her, food and drink was left out of the way, she couldn’t reach it. Not positive she was getting all of her medication
- Son had to keep chasing for anything to get done.
- Drs in ITU told them the level of care had a massive gap between the two wards.
- Felt he was on the wrong ward and should have been moved to palliative care.
- The day before he died, he couldn’t even swallow a small tablet and they brought him a whole tray of food! I could not believe it.

Medical Care

- Felt like they should have called in the palliative care team a lot sooner.
- Fed mum her meal by family members, and then before the evening was out she had died; told by the nurse on the phone that Mother was ‘aspirating’.
- If the CT scan was done the clots would have been picked up and they could have treated with blood thinners.
- We don’t know what happened, family feel something has been missed and this has also been felt by the consultant.
- Very concerned about missed cancer

Community Care

- frustrated about the circumstances that lead to death and missed opportunities, Delay in antibiotics – Friday, GP. Derriford also discharged him and did not prescribe antibiotics
- Wished the GP surgery would have acted sooner they left it too late
- when he started becoming ill wife stated she needs antibiotics, the care home told the patient to wait 7 days and refused to call an ambulance due to the infection. He then was fitting.
- Dr's should have sent him in earlier. He was in agony and tried to commit suicide that day he went in as he was in so much pain.
- Very unhappy about the care home. Very badly dehydrated in the care home and kidneys affected.

Medication

- patient wasn't able to self-medicate due to her deterioration, no one said to her or to husband what was happening about her being given her medication, he isn't convinced all of her medication was being given.
- He was on Fentanyl patches, this had to be taken off for the MRI scan and was never replaced, he should have been weaned off but wasn't, wasn't replaced for 5 days
- He was supposed to be on blood thinners. They're saying the cause of death was possibly a blood clot.
- The last time he was in Derriford he was given a form of penicillin. He is allergic to this. Ended up with crash team being called due to this and they resuscitated at that time.
- Concerns regarding medication he should have received.

Delays to treatment

- lots of concerns about hospital. Waiting for the scan that could have saved him for 3 days.
- Concerns about the time it took for things to happen – eg urgent MRI scan took over 7 days.

What next for Medical Examiner services

- Not yet clear what the statutory service will look like.
- More practices have joined the service over the past month
- Likely electronic MCCD.
- Phasing out of crem forms.

Any Questions?


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