NCMD
National Child Mortality Database
Knowledge, understanding and learning to improve young lives

PCCS Paediatric Critical Care Society

The Role of Medical Examiners in Child Death Review

Wednesday 13th July 2022

1pm to 2pm

Presentation will start at 1.05pm to allow participants time to join

What will this webinar cover?

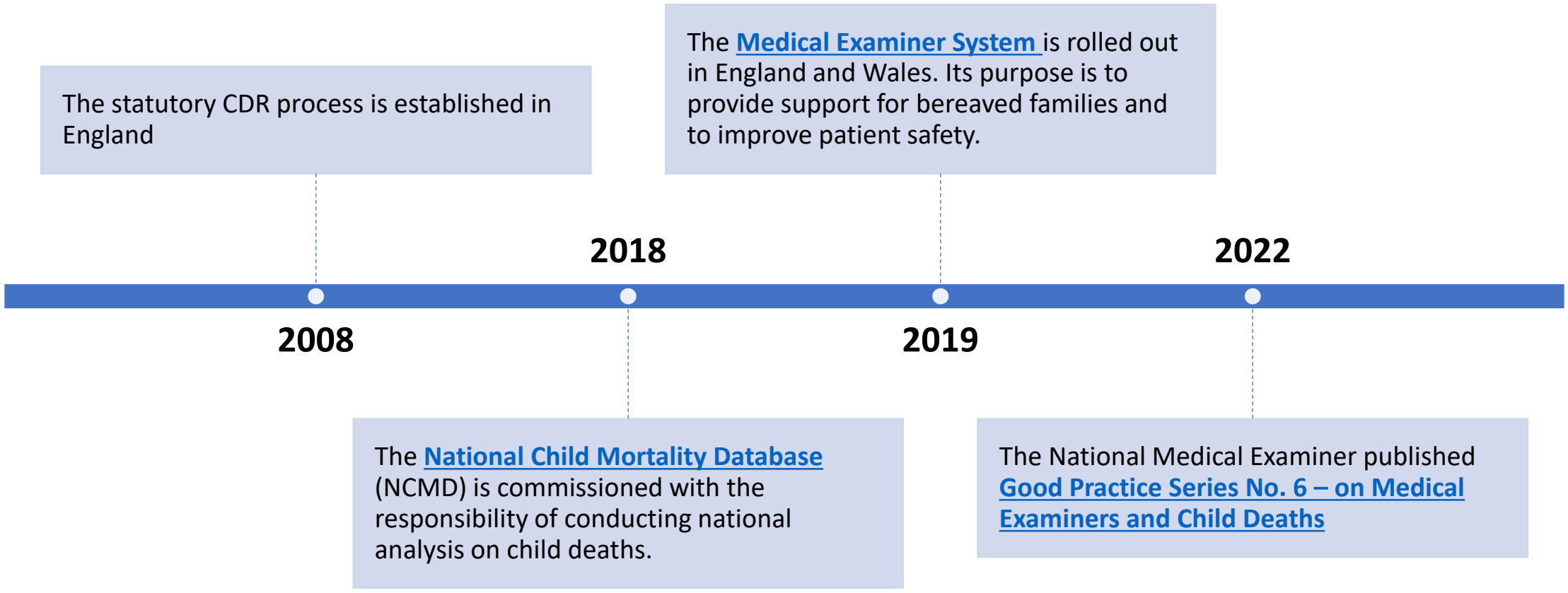
Presentation	Speaker	Time
How should paediatricians work with medical examiners when a child dies?	Dr James Fraser, President, Paediatric Critical Care Society	1.05pm to 1.20pm
CDOPs and Medical Examiners	Vicky Sleap, NCMD Programme Manager	1.20pm to 1.30pm
Medical Examiners and child deaths in Manchester	Dr Stephen Playfor, Medical Examiner and Consultant Paediatric Intensivist	1.30pm to 1.45pm
Q&A session	All	1.45pm to 2pm

How should paediatricians' work with Medical Examiners when a child dies?

Dr James Fraser

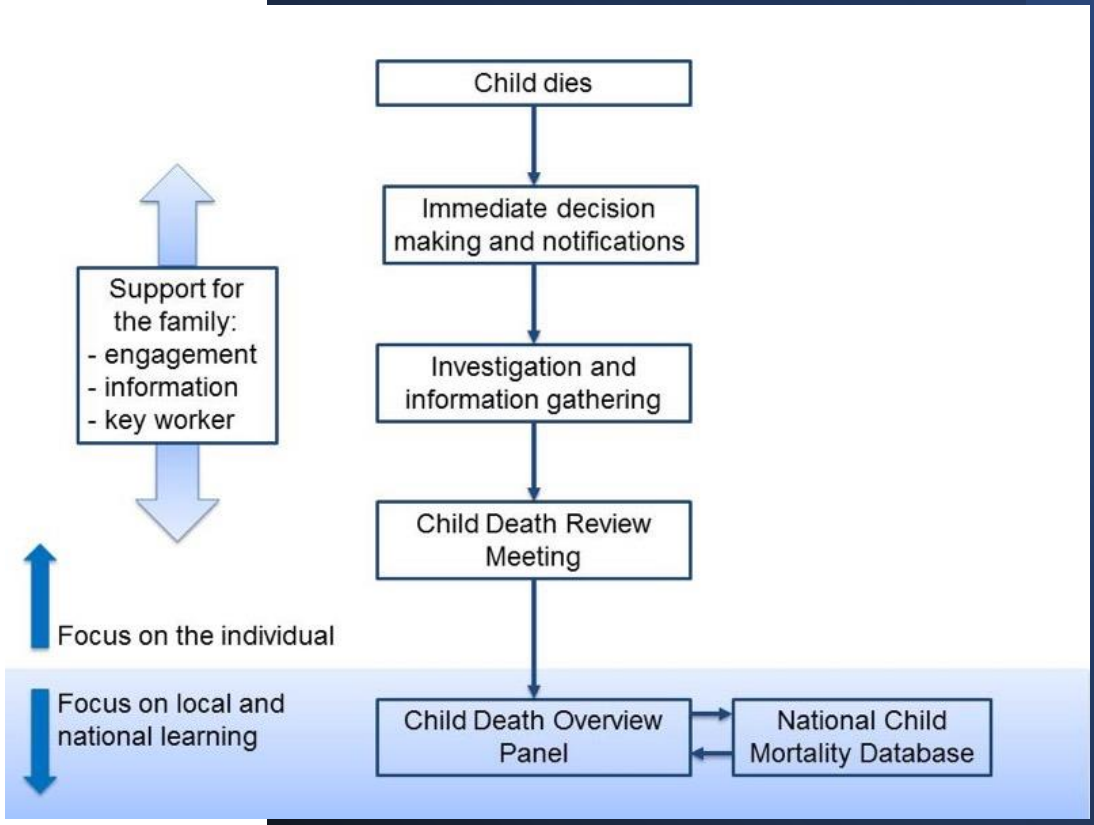
President, Paediatric Critical Care Society

Background


The statutory CDR process is established in England
2008
The National Child Mortality Database (NCMD) is commissioned with the responsibility of conducting national analysis on child deaths.
2018
The Medical Examiner System is rolled out in England and Wales. Its purpose is to provide support for bereaved families and to improve patient safety.
2019
The National Medical Examiner published Good Practice Series No. 6 – on Medical Examiners and Child Deaths
2022

CDR Statutory Requirements

- The Children Act 2004 describes a statutory requirement for the deaths of all children in England, who die before their 18th birthday, to be reviewed
- Working Together to Safeguard Children (2018) and the Child Death Review Statutory & Operational Guidance provide detailed guidance on processes to be followed when a child dies
- Any professional requested to provide information to a Child Death Overview Panel (CDOP) for the purposes of reviewing a death must do so.

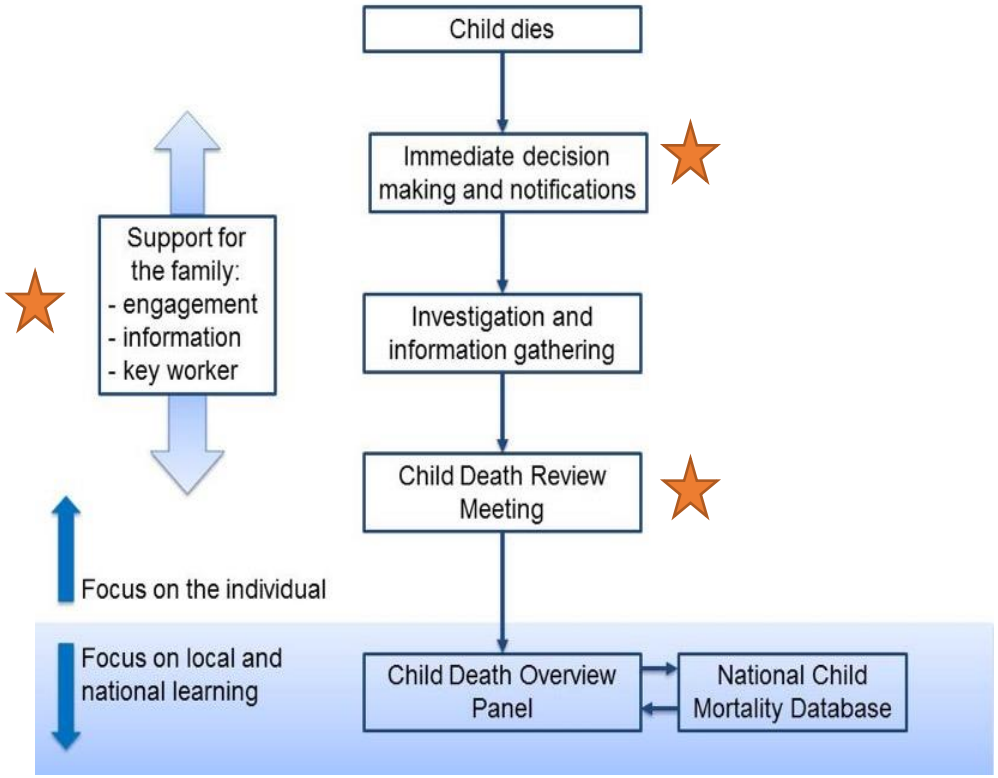


Medical Examiner Statutory Requirements

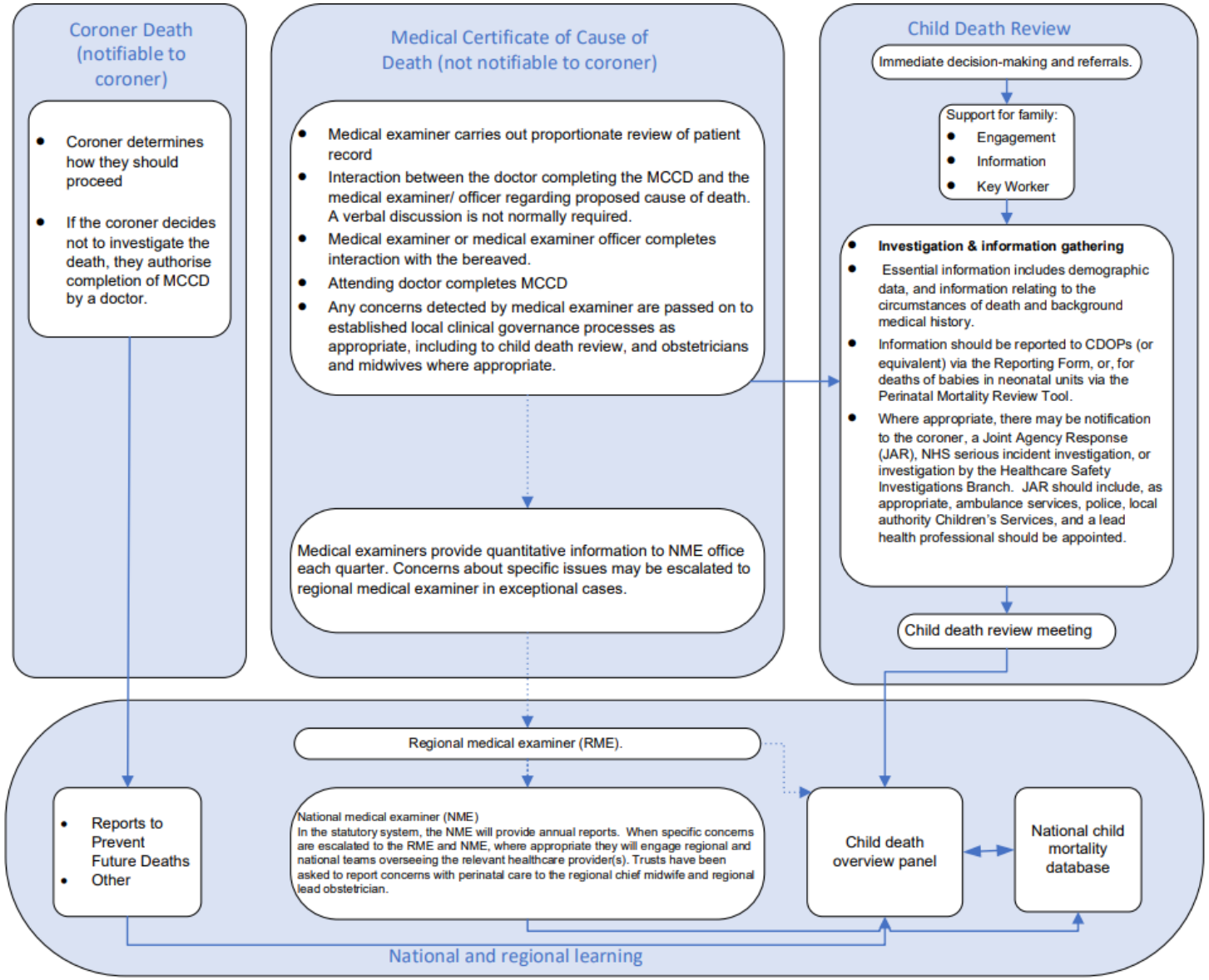
- April 2019, NHS England and NHS Improvement introduced a non-statutory national ME system to provide independent scrutiny on non-coronial deaths NHSE/I medical examiner system
- Its purpose is to:
  - Provide greater safeguards for the public
  - Ensure appropriate direction of deaths to the coroner
  - Provide a better service to the bereaved and an opportunity for them to raise concerns to a doctor not involved in the care of the deceased
  - Improve the quality of death certification
  - Improve the quality of mortality data
- Medical examiners are senior medical doctors trained in the legal and clinical elements of death certification processes. They should not review deaths in which they or their clinical team provided care. They should not be their hospital's mortality lead.
- Publication of the Health & Care Act 2022 made the medical examiner process statutory.

Alignment of ME and CDR processes

- National medical examiner good practice series: child deaths
- The purpose of the Good Practice Series document is to ensure processes are coordinated and to avoid duplication and confusion
- Common purpose: the bereaved are at the centre of each process
- Main difference: need for ME to scrutinise death < 5 days requires proportionate review of medical records
- It is important that local arrangements are made to include the ME within existing CDR arrangements taking note of the recommendations in the Good Practice Series



Medical Examiners and CDR Process in England



Expectations of Medical Examiners/Hospital mortality leads

Work collaboratively to establish effective local arrangements to best align the ME and the child death/ perinatal mortality review processes, which maximise support for bereaved families while minimising potential duplication and distress. This will involve:

- Establishing process for notification of ME for non-coronial deaths
- Establishing process for proportionate review of medical records
- Establishing process for discussion of proposed wording of MCCD with attending paediatrician/neonatologist. This might not necessarily require a verbal discussion
- Establishing process for sensitive liaison with bereaved families; for example, this might include the key worker/ bereavement nurse/identified medical lead introducing the ME role to the family with an offer to contact the ME should the family have concerns. Such discussion is ‘entirely voluntary’
- Establishing process for facilitating learning opportunities through, for example, invited attendance at Child Death Review meeting when desired of considered helpful

CDOPs and medical examiners

Vicky Sleap
NCMD Programme Manager

13 July 2022

NCMD
National Child Mortality Database

Knowledge, understanding and learning to improve young lives

Medical Examiners: Who are they?

- Senior doctors (at least 5 years post-registration).
- The majority are consultants or experienced GPs and will be practising in England or Wales.
- Employed within NHS acute Trusts in England
- You can find out who your local medical examiner is by contacting the regional medical examiner teams whose contact details can be found here

Building relationships between CDOP and MEs

- The Royal College of Pathologists Good Practice Series sets out recommendations for how MEs should work with CDOPs
- Due to the requirement to carry out their duties within 5 days of the death, ME involvement with the CDR process will necessarily happen within that timescale
- CDOPs should proactively contact their ME and arrange to discuss local processes to ensure all parties are clear about their roles and the steps that will take place after the death of a child
- Consider setting up a local SOP or MOU to record the details of what is agreed

What information can they give CDOP?

- Medical Examiners will be able to confirm the details on the MCCD and whether a coroner's investigation is needed
- They do not need to complete a statutory reporting form.
- If clinical governance issues are identified details of this should be obtained through the reporting forms in the normal way
- These issues should be discussed at the CDRM in the normal way with the ME being invited to attend where relevant
- MEs can also be invited to CDOP meetings as a co-opted member where relevant

Regional and National Medical Examiners

- 7 regional medical examiner offices
- East of England
- London
- Midlands
- North East & Yorkshire
- North West
- South East
- South West

Regional Medical Examiners (RMEs)

- Local MEs may escalate any concerns to regional MEs.
- Themes or patterns identified by MEs have generally required action at provider, local or system-level.
- Common issues identified by MEs included:

  - hydration

  - failure to respond to infections in a timely manner

  - end-of-life care pathways, particularly in supporting people of minority ethnic heritage and avoiding unnecessary admissions

- CDOPs should form relationships with their RMEs who can feed any governance concerns into the CDOP
- RMEs may attend CDOP meetings where relevant to ensure open exchange of information

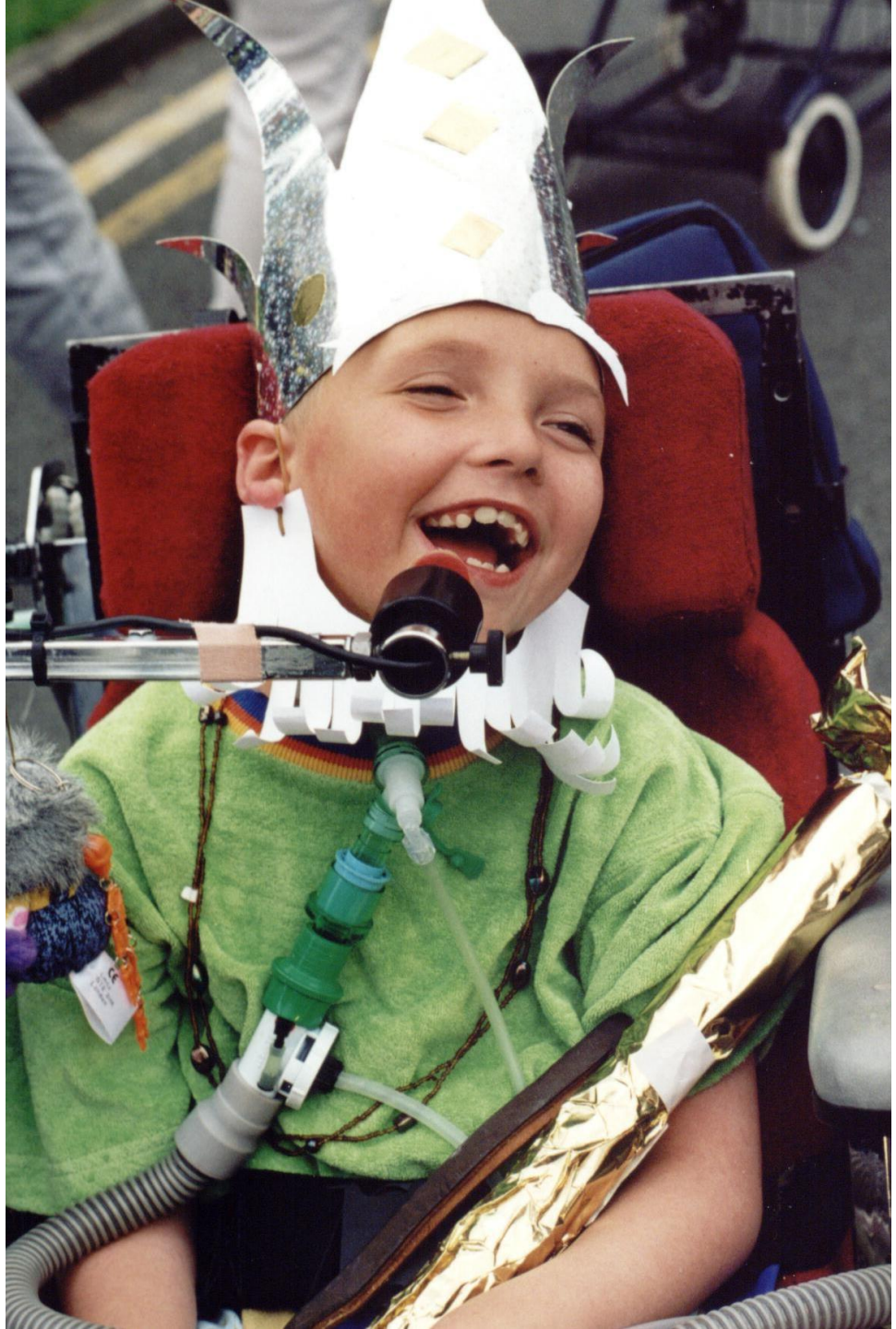
National Medical Examiner

- Dr Alan Fletcher appointed in March 2019
- Provides professional and strategic leadership to regional and trust-based medical examiners.
- Responsible for producing annual reports
- National Medical Examiner Report 2021
- NCMD will work with the NME to ensure any themes or patterns relating to deaths of children, identified by MEs, can be investigated using CDOP data and any necessary action taken
- NCMD will also ensure CDOPs are alerted to any issue identified by the NME office

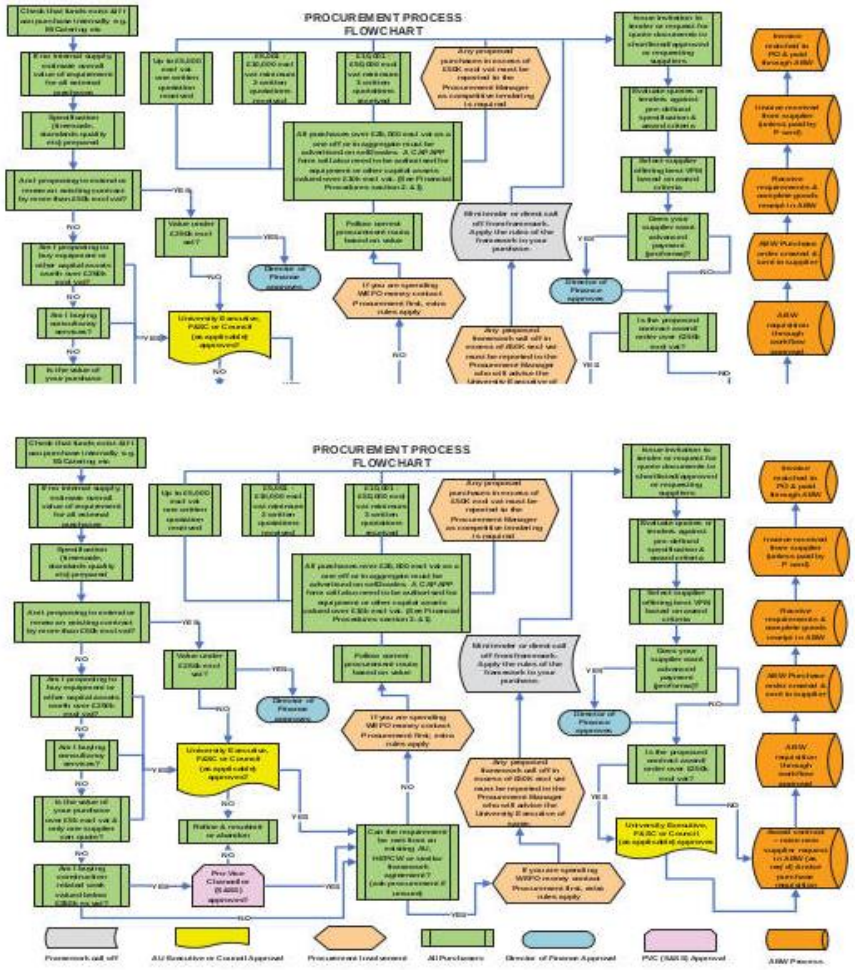
Medical Examiners and Child Deaths in Manchester

Stephen Playfor
Medical Examiner
Consultant in PICU

13 July 2022



Child process



Adult process

Child process	Adult process
~100 deaths/year	~2000 deaths/year
~60% in PICU Almost all others in Haem-Onc wards Most MCCDs written by Consultants Greater proportion of faith deaths Greater level of routine scrutiny More incident reporting	More widespread; ICU, ED, Interventional Cardiology, Renal, AMUs Most MCCDs written by Junior Doctors Confliction of Medical Examiners

Child process

~100 deaths/year

Adult process

~2000 deaths/year

Clinical Team

HM Coroner

Clinical Team

Bereavement Office Staff

Bereavement Office Staff

Child Death Review Process

Key Workers

SUDC/Safeguarding

Medical Examiners

Child process

Adult process

M Coron

Child Death Review Process

Key Workers

SUDC/Safeguarding

Medical Examiners

Child process

~100 deaths/year

Adult process

~2000 deaths/year

Clinical Team

HM Coroner

Clinical Team

Bereavement Office Staff

Bereavement Office Staff

Child Death Review Process

Key Workers

SUDC/Safeguarding

Medical Examiners

Child process

~100 deaths/year

Adult process

~2000 deaths/year

Clinical Team

HM Coroner

Clinical Team

Bereavement Office Staff

Bereavement Office Staff

Child Death Review Process

Key Workers

SUDC/Safeguarding

Medical Examiners

The role of HM Coroner

Role of the Medical Examiner

- Proportionate review of the medical record
  - Experience and clinical context
  - Review of clinical incidents
  - Clinical governance issues
- Discussion with the attending doctor
  - Assistance in writing MCCD
- Discussion with the bereaved family
  - Communication skills
  - Trauma

Role of the Medical Examiner

- Proportionate review of the medical record
  - Experience and clinical context
  - Review of clinical incidents
  - Clinical governance issues
- Discussion with the attending doctor
  - Assistance in writing MCCD
- Discussion with the bereaved family
  - Communication skills
  - Trauma

Any Questions?