# **Further Information sources**



#### **BACKGROUND TO MEDICAL EXAMINERS**

A national network of medical examiners was recommended by the Shipman, Mid-Staffordshire and Morecambe Bay public inquiries. The College campaigned for their implementation and continues to play a key role in key role in influencing government's work around implementation of the service.

As the lead medical royal college for medical examiners, the College provides <u>medical examiner training</u>, information on <u>setting up a medical examiner system</u> and advice on <u>how to become a medical examiner</u>.

#### **EXTENDING MEDICAL EXAMINER SCRUTINY TO NON-ACUTE SETTINGS**

We welcome the roll out of the medical examiner system to cover deaths in non-acute and community settings.

It is another important step towards creating a world-leading system of death investigation and patient safety improvement, with every death in England and Wales that is not reported to a Coroner being scrutinised by an independent medical examiner.

Crucially it will also give all bereaved families the opportunity to ask questions or raise concerns about the care of a loved one.

https://www.rcpath.org/discover-pathology/public-affairs/medical-examiners.html

'What do Medical Officers do?' (Video of GPs and MEs talking about the benefits of the ME scrutiny system)



https://youtu.be/ClkmdLP7ZB0

# **Further Information sources**

### Death certification and medical examiners - House of Commons Library (parliament.uk)





### **NHSE Links and documents**

NHS England » Information for non-acute NHS trusts on extending medical examiner scrutiny to non-coronial deaths in the community

NHS England » Information for primary care on extending medical examiner scrutiny to non-coronial deaths in the community

NHS England » System letter: Extending medical examiner scrutiny to non-acute settings (contains flow-charts at ANNEXES A & B)

NHS England » The national medical examiner system

The stated purpose of the medical examiner system is to:

provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths ensure the appropriate direction of deaths to the coroner

provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased

improve the quality of death certification

improve the quality of mortality data.