

# Integration of a Medical Examiner Service to Support Deaths on a Hospice Inpatient Unit



**Dr Jo Hayes**, Specialty Registrar in Palliative Medicine **Dr Anneka Burge**, Specialty Doctor in Palliative Medicine, **Dr Bernadette Lee**, Consultant in Palliative Medicine, **Princess Alice Hospice, Esher, Surrey**

**Acknowledgements:** **Miss Tanaya Sarkhel**, Lead Medical Examiner and Consultant Orthopaedic Surgeon, **Miss Ruth Richardson**, Specialty Registrar in Orthopaedic Surgery, **Clare Walker**, MEO, **Ashford and St Peter's Hospitals NHS Trust**

## Background

In response to several public inquiries, the Government reformed the process of death certification in England and Wales. Medical Examiners (ME) have been recruited in hospitals to conduct independent medical scrutiny of cause of death and engage with bereaved families to understand their concerns. The ME initially contacted the Hospice with an aim to expand the service to include all Hospice deaths in the area.

## Method

- A pilot programme was developed through multi-professional discussions, to refer all Hospice inpatient deaths to the local medical examiner office (MEO).
- Electronic patient record sharing from the Hospice to the hospital was established, with support from the Information Governance and IT teams.
- A referral algorithm was created.
- Regular virtual meetings were scheduled to discuss issues and action points. The ME team visited the Hospice.

## Results

1. Early adjustment in the process ensured that deaths could be registered within 5 days. The coroner referral process was streamlined.
2. There was a temporary increase in coroner referrals due to the crematorium doctors stipulating referral of all patients who had surgery or procedures within one year. The MEO helped resolve this issue.
3. The MEO provided prompt and valuable telephone advice for complex causes of death and whether referral to the coroner was required.
4. Scrutiny improved accuracy of causes of death. It also provides Mortality Review which feeds into the National Guidance on Learning from Deaths in line with the NHS.
5. Most importantly, the ME provided independent support for the bereaved, answering questions about the events surrounding a death, giving the Hospice feedback on several occasions.

## Conclusions

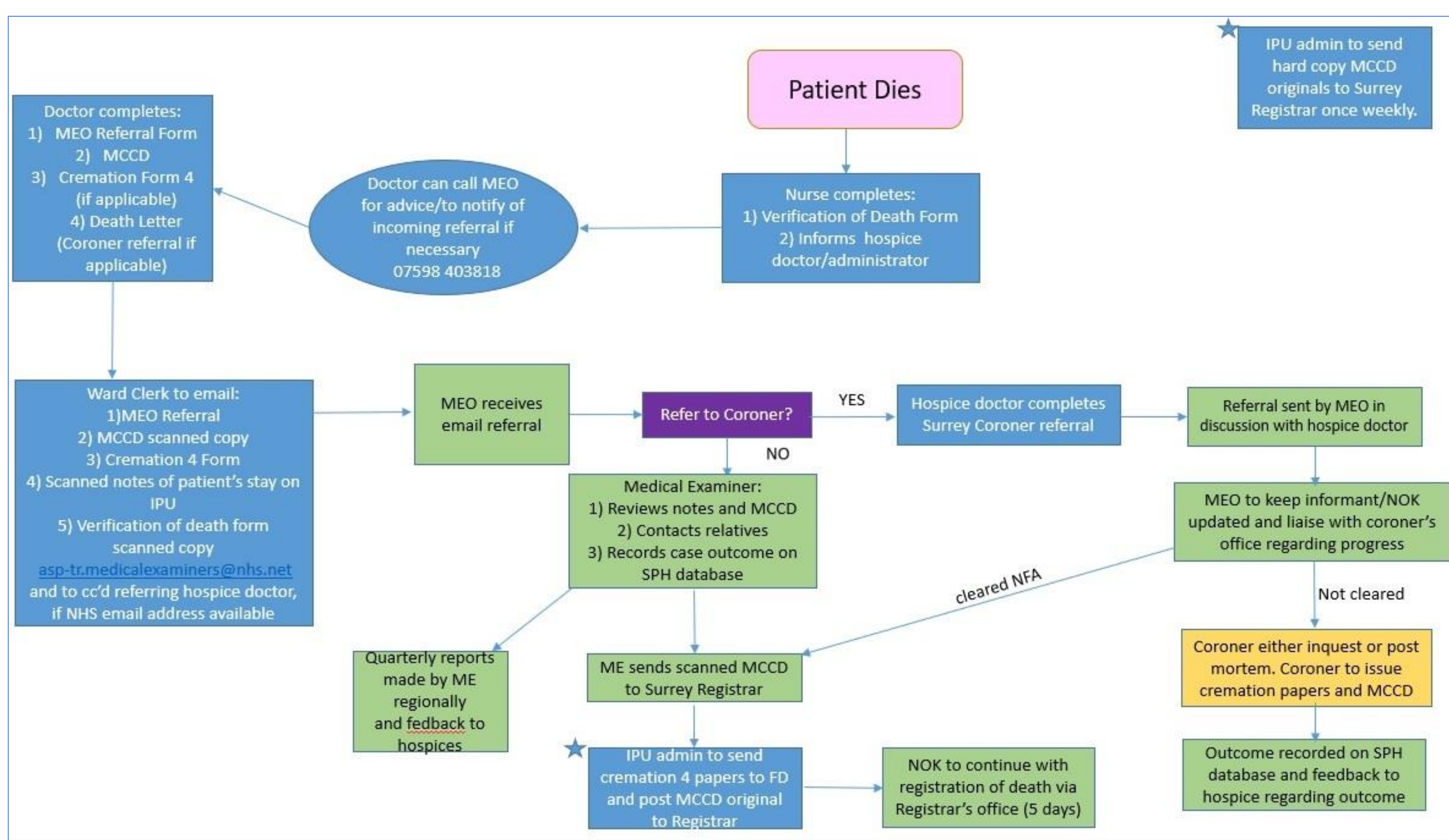
- The pilot programme was an overall success. The MEOs provide the Hospice with another route for collectible feedback.
- The ME process is now well integrated into the Hospice post-death procedures.
- The MEO is using this positive experience in the roll-out of scrutiny of all community deaths via General Practice in 2022.

## Number of referrals from IPU 1/02/2021 – 8/12/2021

Total deaths	Coroner referrals	100A/ NFA*	100B**	Inquest
177	27	23	1	3

\*No further action, cause of death accepted

\*\* Proceed to post mortem



Hospice medical examiner referral algorithm

For further information contact: [jo.hayes@nhs.net](mailto:jo.hayes@nhs.net) or [anneka.burge@nhs.net](mailto:anneka.burge@nhs.net)

