NHS
East London
NHS Foundation Trust

Primary Care Services

Standard Operating Procedure (SOP) for Reporting and Reviewing Deaths in Primary Care with the Expansion of the Medical Examiner Role into Primary Care and Community Health Services

Version 1

Version	1
Approved By (sponsor group)	Dr Ge Yu, P. Care Medical Director & Eileen Bryant, P.C Director of Nursing
Ratified By	Primary Care Quality Assurance Group
Date Ratified	11th December 2024
Name and Job Title of Author	Eileen Bryant, Director of Nursing Joanne Alder-Pavey Quality & Compliance Lead
Executive Director Lead	Edwin Ndlovu
Implementation Date	December 2024
Last Review Date	

Version Control Summary

Version	Date	Author	Comment
1	November 2024	As above	Discussed at QAG and approved on 11/12/2024

Contents

1. Introduction

The purpose of this document is to outline the process to be followed when reporting patient deaths in Primary Care, following the expansion of the Medical Examiner role into primary and community settings.

2. Aim

The aim of this document is to ensure patient deaths are reported and reviewed correctly in line with statutory processes, as well as with Trust Policy. This will ensure that the right deaths are referred to Coroners for further investigation.

3. Background

Since 2019, all Acute NHS Trusts have had appointed Medical Examiners (ME) to scrutinise most deaths in hospitals and some community settings. This was on a non-statutory basis and the reforms will see the practice enshrined in law and will apply to all deaths, whether they occur in healthcare settings or elsewhere.

The statutory roll out of the medical examiner system to the community and primary care was implemented on 9 September 2024 (under legislation in the 2022 Health and Care Act). The legislation means that all deaths become legally subject to either a ME's scrutiny or a Coroner's Investigation in a move to give bereaved families more transparency on the circumstances surrounding the death of someone.

The move to a statutory system in September 2024 will further strengthen those safeguards, with a plan to ensure that all deaths are reviewed, and the voices of all bereaved people are heard. With the new practice the ME will now always offer a conversation to the bereaved, providing an opportunity for them to raise questions or concerns with a senior doctor not involved in the care of the deceased.

The ME will scrutinise all deaths and will request a review if they feel this is required, either from their initial report, from family or services concerns. If a review is required the ME will notify the relevant practice or organisation.

The legislation also includes changes to the death certification process. There will no longer be a requirement for the attending doctor to have seen the deceased 28 days before death. This will allow a wider pool of doctors to be able to complete the Medical Certificate of the Cause of Death (MCCD).

4. What does this mean for GP practices?

The change in legislation means that all deaths in the community (except clear coroner referrals) need to be referred to the medical examiner office before a death certificate can be provided.

Referral to the medical examiner will be through SystemOne/EMIS. Practices should now be set up with the new IT system on SystmOne and EMIS to enable them to refer the deaths through to the medical examiner's office.

From the date of statute, the MCCD must be sent to the Registrar office by the Medical Examiner's office. The completed MCCD must therefore be sent to the ME office by the GP, and not direct to the Registrar office

The MCCD will be signed by the Medical Examiner before it is then sent to the Registrar.

The process should not cause undue delays for the bereaved and they will not need to do anything differently.

5. Expected Death

All expected deaths will be reported to the Medical Examiner. It is unlikely that any other actions will be required by the practice.

6. Unexpected Death

All unexpected deaths will be reported to the Medical Examiner and also added to InPhase as a Patient Safety Incident (LFPSE).

Inphase incidents are reviewed daily by a Patient Safety Reviewer (PSR) and are discussed in a Daily Grading Panel. A decision is made and the incident can be closed with no further action, or it can be processed using one of the decision making tools, 72 hour reports or Care Review Tool (CRT's)

7. 72-Hour Reports

Requests for 72 hour reports are sent to the Directorate by the central Incident Team and are returned to the same team when completed

Requests for 72-hour reports should be discussed within the practice team and allocated to the most appropriate colleague for completion. Findings should be discussed at the practice team meeting, and actions agreed before submission to the central team.

Reports are reviewed by a PSR before they are presented at a weekly Decision Making Panel (DMP). Authors may be asked to attend with support from the PSR. The decision could be to close or to further investigate as a Patient Safety Incident Investigation (PSII).

8. Patient Safety Incident Investigation (PSII)

If a decision is made that a PSII should be the response, the Directorate is informed and a Patient Safety Lead Reviewer is identified. A Co-Reviewer is requested from the Directorate to provide clinical support for the investigation.

9. Patient Safety and Learning Committee

When a PSII is closed it is presented at the Patient Safety Learning Committee. It is presented by a Lead Clinician with the PSR present.

The PSII is ether signed off and closed or a request is made for amendments or additions. PSII is sent to the Integrated care Board (ICB) for approval and closure. Once the PSII is closed, the service is responsible for the implementation of any actions agreed.

10. Learning from Incidents

Learning from incidents should be discussed locally and shared at the Quality Assurance Meeting for wider learning across the Directorate.

11. Care Review Tool (CRT)

The CRT is a Structured Judgement Review (SJR) tool used to review the case notes for patients who died following an expected death, but can also be used to review the care provided for patients who have died unexpectedly. All unexpected deaths of patients under multiple services, or who have been discharged within the last 6 months, will require consideration for further review and the CRT can support that process and can also help to

determine if a PSII is required in addition to identifying any learning around the care provided.

The CRT is completed by a PSR within the Governance & Risk team and has a guideline of 10 days for completion.

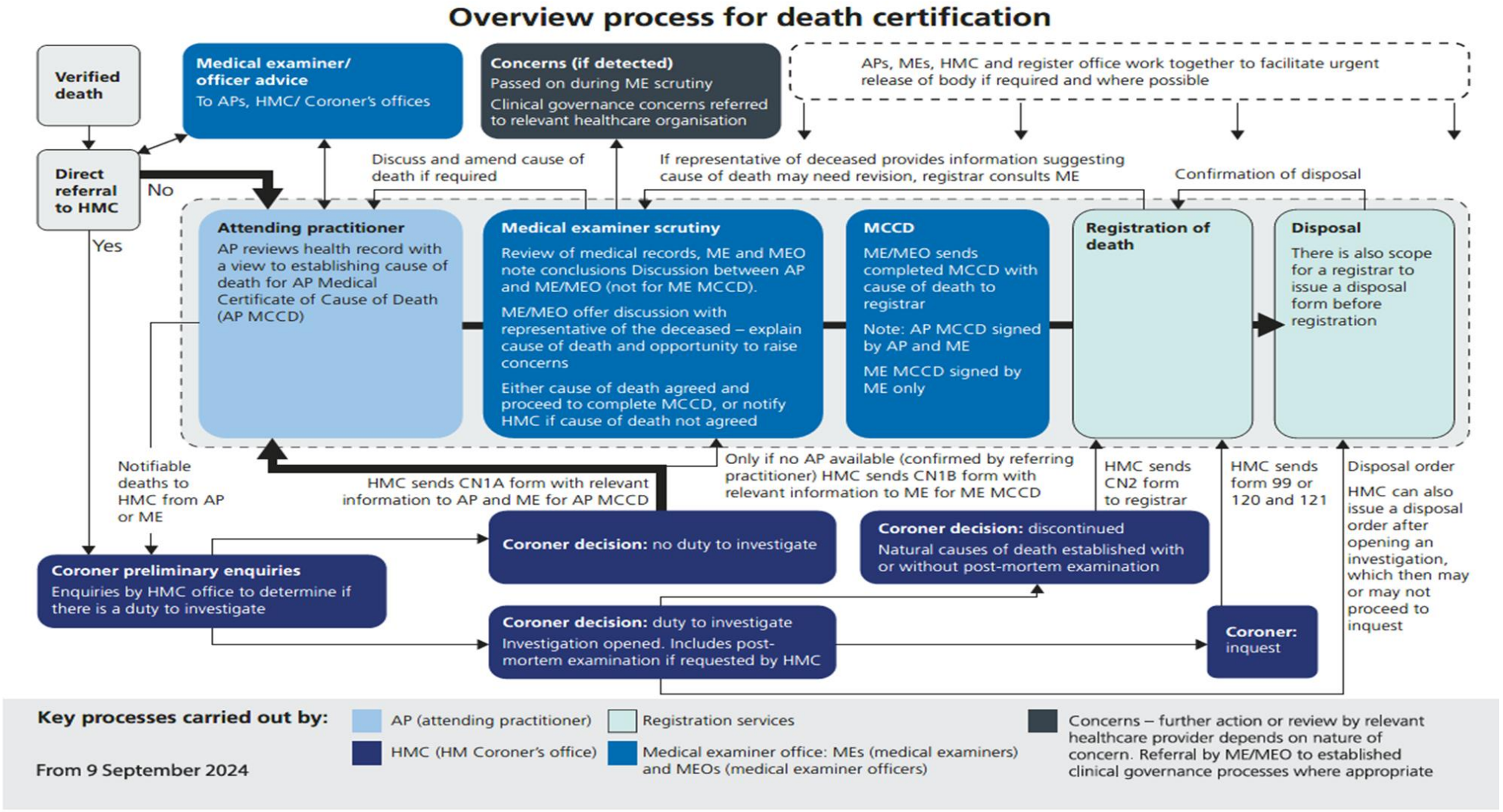
The CRT is then taken to a Sign off Panel (SoP) and the decision is made to close or to escalate for further investigation, PSII

PSII, CRT and 72 hour reports are all documents that are requested to be presented at Coroner's Inquest

Please note there is a specific pathway to be followed once a child death has been once a child death has been notified. The practice will be linked into any local processes for this as appropriate

NHS East London NHS Foundation Trust

12 New Medical Examiner process



NHS East London NHS Foundation Trust

13 Reporting Deaths Process Flow Chart