CURRENT PRACTICE in Forensic Medicine

Volume 3

Editors
John A.M. Gall
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Tony received a PhD in occupational health from the University of Birmingham in 2000. He directs Advanced Trauma Life Support courses and regularly instruct on other accredited life support and resuscitation courses. He served as clinical director for HEMS for West Midlands Ambulance Service and continued to fly on air ambulances providing emergency medical and trauma services until 2013. In 1992, Tony was awarded the Diploma in Immediate Medical Care by the Royal College of Surgeons of Edinburgh. He was awarded the Queens Golden and Diamond Jubilee Medals for his pre-hospital emergency work.

Tony has written and exercised multi-agency major incident plans. He sat on government advisory committees for disaster and emergency planning. He is a medical advisor to the Ministry of Defence serving on SACMILL (Scientific Advisory Committee on Less Lethal Weapons). His PhD was for work on developing body armour for the police. This arose from his development work for the Home Office and the Police Federation on officer safety programmes, addressing protection from knives and bullets. Tony continues to work for the police on these programmes and is the first doctor to qualify as a police instructor for unarmed defensive tactics, safe prisoner restraint, handcuffing, tactical communication skills, incapacitant sprays, and knife defence. Through this interest, Tony has been able to offer opinions on use of force and injuries sustained during arrest and detention.

Tony has been involved in developing strategies to protect health workers against aggression and violence in the health service. He has completed studies for the Department of Health and other national bodies to identify ways of improving staff and subject safety. He is engaged in developing safe physical interventions and effective training strategies across a number of agencies. Tony served on the guidelines development group of the Joint Royal Colleges Ambulance Liaison Committee. He has published numerous articles in peer-reviewed professional journals.

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Juliet Cohen MA, MB, BS, DipRACOG, MRCGP, FFFLM
Dr Juliet Cohen is currently the head of doctors at the charity Freedom from Torture and an independent forensic physician examining patients for evidence of torture, trafficking, and domestic violence. She is a member of the Independent Forensic Experts Group and contributed to the new edition of the Istanbul Protocol, the UN Manual on the Investigation and Documentation of Torture, and other Cruel Inhuman and Degrading Treatment or Punishment as a primary drafter of Chapter 5. She has devised and delivered training on documentation of torture and understanding medical evidence, for doctors, judges, and Home Office asylum decision-makers. She has

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Neil Corney MSc
Neil Corney has been a research associate at the Omega Research Foundation since 1996. His work has included research and analysis of the human rights impacts of less-lethal weapons and analysis of the plastic baton round kinetic impact projectile in Northern Ireland. He was a member of the core Academic Working Group which developed the 2020 UN Guidance on Less Lethal Weapons and is currently the chair of the UK's National Taser Stakeholder Advisory Group (NTSAG) and attends the UK National Police Chiefs Council Less Lethal Weapon Working Group.

Stevan R. Emmett MB, ChB, DoHNS, DPM, D.Phil, MRSB, FFPM
Dr Steve Emmett is Chief Medical Officer at Defence Science and Technology Laboratory, Porton Down and is a Consultant & Fellow in Pharmaceutical Physician specialising in medical countermeasure drug development, pharmacology and toxicology. Steve is medical advisor to the advance development programme delivering future therapeutic interventions for historic and emerging chemical and biological threats to the UK. He qualified in medicine from the University of Warwick, has a D.Phil in Clinical Pharmacology from the University of Oxford and has held a number of academic positions and industry posts. Currently he supports and leads teams in medical aspects of research and development across the Dstl portfolio from the laboratory, through clinical development to licensure. Steve is a member of the UK Advisory Group on Military and Emergency Response Medicine and has over 20 years experience in CBRN medicine; incident management, clinical management, teaching and training. He continues to practice clinically in Emergency Medicine in the NHS and is honorary Senior Fellow in Medicine at the University of Bristol.

Sarah Forshaw LLB (Hons), QC
Sarah Forshaw QC is a leading barrister practising in criminal law. She was appointed Queen's Counsel in 2008 (interestingly, only the 193rd woman ever to be awarded silk). She acts for both prosecution and defence.

Sarah is the co-head of Chambers at 5 King's Bench Walk in Temple, London. In 2013, she was appointed leader of the South Eastern Circuit (the largest of the six geographical circuits of the Bar of England and Wales). In 2014, she was nominated for Crime Silk of the Year by Chambers and Partners and is listed as a Band 1 Silk in the current edition. Sarah has also occupied roles as chair of the Central London Bar Mess and director of education and training on the South Eastern Circuit. She was on the Working Group responsible for drafting The Advocate's Gateway toolkit on Memory and Sensory Issues in Witnesses and Defendants with Autism. She has been asked to speak on numerous occasions both within the profession and without, including at the Oxford Criminology Series, All Souls College.

Sarah Forshaw's busy practice is now broadly divided between murder trials and representing professionals facing other (often sexual) allegations, who would not otherwise be able to secure the services of Queen's Counsel under the Legal Aid regulations. In that latter capacity, she also routinely represents individuals facing regulatory proceedings following the conclusion of the criminal trial.

John A.M. Gall BSc (Hons), MB, BS, PhD, FFFLM, FFCFM (RCPA), DMJ (Clin & Path)
Dr John Gall is a consultant forensic physician; an associate professor, Department of Paediatrics, The University of Melbourne; director of Southern Medical Services; principal of Era Health; and is a staff specialist forensic physician with the Victorian Paediatric Forensic Medical Service, located at the Royal Children's Hospital and Monash Children's Hospital, Melbourne. He is the president of the International Association of Clinical Forensic Medicine. John qualified initially as a biochemist, completed his doctorate in the Department of Pathology at the University of Melbourne, and engaged in postdoctoral research in anatomy. He later read medicine at the University of Melbourne and undertook training in anatomical and forensic pathology and clinical forensic medicine. He has practised clinical forensic medicine for almost 30 years, initially as a forensic medical officer with Victoria Police and later as a consultant at the Victorian Institute of Forensic Medicine. John has been extensively involved in under- and postgraduate education both at the University of Melbourne and Monash University. He was an honorary senior lecturer in the Department of Forensic Medicine, Monash University, during which time he taught custodial medicine in the University's Graduate Diploma of Forensic Medicine. He also devised, developed, and administered an international continuing education programme in forensic medicine and, with co-authors, wrote and edited *Forensic Medicine Colour Guide* and the previous two volumes of this series. John has been involved in forensic medical research, and much of these findings have been published. In addition to forensic medicine, he practises in occupational medicine.

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Professor Felicity Goodyear-Smith is a general practitioner and distinguished fellow of the Royal New Zealand College of General Practitioners and a professor in general practice and primary health care at the University of Auckland, New Zealand. She is also a qualified forensic physician and has worked as police doctor and as expert witness for both the prosecution and the defence in the past, with particular expertise in issues around sexual assault. In 2008, she became a member and in 2014 a fellow of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians. Felicity has published over 260 scientific papers in peer-reviewed journals plus five books, 14 book chapters, and a number of other publications. Over 30 of her journal publications and three of her books pertain to forensic issues. The latter range from 'Sexual Assault Examinations – A Guide for Medical Practitioners', published in 1987 (second edition 1990) to 'Murder That Wasn't: The Case of George Gwaze' (2015), which explored the factors leading to George Gwaze being twice falsely charged and twice acquitted of the rape and murder of his 10-year-old niece. In 2015, Felicity also

published a chapter entitled 'Understanding Why and How False Allegations of Abuse Occur' in Ros Burnett's 'Wrongful Allegations of Sexual and Child Abuse'.

Nicholas Hallett MB, ChB, BSc, LLM, MRCPsych
Dr Nicholas Hallett is a consultant forensic psychiatrist at Essex Partnership University NHS Foundation Trust. He works on an acute inpatient medium secure admissions ward. He qualified in medicine in 2011 at the University of Bristol where he also completed a BSc in bioethics during his medical training. He has undertaken a postgraduate qualification at the Northumbria Law School in Newcastle where he was awarded an LLM in mental health law.

He has published a number of articles on medicolegal issues including the role of psychiatric evidence in the defence of diminished responsibility and the relevance of psychiatric evidence in the determination of criminal culpability. He has provided written and oral expert psychiatric evidence in criminal cases on numerous occasions including for cases of homicide. He teaches regularly on the Maudsley Training Programme in London on medicolegal topics including on giving medical evidence at Mental Health Tribunals. He is currently co-editing a new book on clinical topics in forensic psychiatry and criminal law.

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Dr Stanislav Lifshitz MD is an emergency physician with broad experience in trauma management, military medicine, and pre-hospital care. Combining experience of trauma with a solid grounding in physical interventions, he provides biomechanical support to medical risk assessments of use of force interventions. He has assisted in medical and safety reviews of physical and mechanical interventions across a broad range of organisations that include children's homes, mental health, and custodial services. His knowledge and experience allow him to provide advice on physical intervention in specific vulnerable populations in care.

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In addition to her academic work she also maintains a diverse portfolio of professional and case work. She works with families bereaved through homicide helping them with criminal justice and other processes; she advises statutory homicide

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Dr Curtis Offiah is a consultant radiologist with subspecialty expertise in adult and paediatric neuroradiology, head and neck radiology, trauma radiology, and forensic radiology. He has been employed as a full-time consultant position at the Royal London Hospital, part of Barts Health NHS Trust since 2006. The Royal London Hospital is a teaching hospital associated with Queen Mary's University London and Barts and The London School of Medicine and Dentistry and is one of the busiest major trauma centres in the United Kingdom. He has extensive experience in forensic radiology and post-mortem imaging with initial experience gained in North America and Europe. Dr Offiah holds the degrees of Bachelor of Science, Bachelor of Medicine, and Bachelor of Surgery and is a fellow of the Royal College of Radiologists and previously of the Royal College of Surgeons of Edinburgh.

Dr Offiah has research and expert experience in forensic issues relating to radiology, including imaging of blunt and penetrating trauma, radiological wound and injury mechanism profiling, post-mortem radiology, non-accidental injury, elder abuse, and intimate-partner violence. He lectures at national, post-graduate, and undergraduate levels and has lectured at the Royal Society of Medicine, Royal College of Radiologists Annual Scientific Meetings, Faculty of Forensic and Legal Medicine, and the British Association of Forensic Scientists. He holds a senior lecturer appointment at Cameron Forensic Medical Sciences, William Harvey Research Institute of Barts, and The London School of Medicine and Dentistry, Queen Mary University, London. He has published widely including a number of publications including peer-reviewed scientific research papers, reviews, and textbook chapters. He is on the Editorial Board of the National Journal of the Royal College of Radiologists (Clinical Radiology). Dr Offiah undertakes expert forensic radiology case work for numerous police authorities in the United Kingdom and abroad as well as on behalf of the British Military Police, the National Crime Agency, Independent Office of Police Conduct, and a number of HM Senior Coroners in the United Kingdom. He regularly gives expert evidence when required at court on behalf of the Crown Prosecution Service and on behalf of defence as well as at HM Coroner's Court.

J. Jason Payne-James LLM, MSc, FFFLM, FRCS, FRCP, FCSFS, FFCFM(RCPA), RCPathME, DFM, LBIPP Mediator
Professor Jason Payne-James is Specialist in Forensic & Legal Medicine and a Consultant Forensic Physician. He has been a forensic physician for over 30 years. His clinical and research interests are wide-ranging and include documentation and interpretation of injury, evidential sampling, wound and scar interpretation, sexual assault, intimate partner violence, clinical aspects of healthcare in custody, non-fatal strangulation, complaints against healthcare professionals, restraint and less-lethal systems, miscarriages of justice, death and harm in custody and torture and cruel, inhuman and degrading treatment. He is Lead Medical Examiner at the Norfolk & Norwich Hospitals University NHS Trust, Norwich, UK; expert adviser to the

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Keith J.B. Rix BMedBiol (Hons), MPhil, LLM, MD, MAE, FEWI, FRCPsych, Hon FFFLM

Prof Keith Rix's involvement in the forensic field began in the 1960s when he lived in hostels in London with ex-offenders and assessed prisoners for hostel admission. In 1983, he moved to Leeds as a senior lecturer in psychiatry. There he became a visiting consultant psychiatrist at HM Prison, Leeds, and established the Leeds Magistrates' Court Mental Health Assessment and Diversion Scheme and the city's forensic psychiatry service. He has provided expert evidence for over 35 years, including on a *pro bono* basis in capital cases in the Caribbean and Africa. He is also the editor of *A Handbook for Trainee Psychiatrists* and the co-author, with his wife Elizabeth Lumsden Rix, of *Alcohol Problems*. His RCPsych Publications textbook *Expert Psychiatric Evidence* (2011) has just been published in its second edition by Cambridge University Press as *Rix's Expert Psychiatric Evidence* on an edited and multi-author basis. He has also devised for the Royal College of Psychiatrists the *Multi-Source Assessment Tool for Expert Psychiatric Witnesses* (MAEP) which can be used by all expert witnesses. He is a former chairman of the Fitness to Practise Panel of the Medical Practitioners Tribunal and part-time lecturer in the Department of Law, De Montfort University, Leicester. He is a longstanding member of the Academy of Experts and a founding member and fellow of the Expert Witness Institute. He is now a visiting professor of Medical Jurisprudence, University of Chester, Honorary Consultant Forensic Psychiatrist, Norfolk and Suffolk NHS Foundation Trust and Mental Health and Intellectual Disability Lead, Faculty of Forensic and Legal Medicine of the Royal College of Physicians.

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A scientist, geneticist, statistician, academic, editor, and author of a prize-winning medical textbook and published author of peer-reviewed scientific publications, Denise Syndercombe Court was trained in systematic reviews and evidence-based approaches of medical and scientific publications. From 1990, she was a senior lecturer in forensic haematology at Barts and The London School of Medicine and Dentistry. In 2012, she moved to King's College London where she is now the professor of forensic genetics. She has more than 30 years of experience in scientific research, forensic evidence examination, and DNA interpretation with a sound knowledge of the civil and criminal justice process, including court presentation as an accredited expert witness. She runs an ISO17025 laboratory dealing with all matters of DNA

and is an active researcher in new molecular techniques for human identification. She represents the United Kingdom on the European DNA Profiling Group (EDNAP), is a member of the International Society for Forensic Genetics, secretary general of the British Academy of Forensic Sciences, a member of the Forensic Regulator's DNA Working Group, a member of the Home Office Biometrics and Forensic Ethics Group, and a member of the BSI Committee on Standards in Forensic Science.

Caroline Watson BA Hons (Cantab), MB BChir, MRCGP, DRCOG, QTS
Caroline Watson is a general practitioner and qualified school teacher. She studied medical sciences at Gonville and Caius College, Cambridge University, and qualified from Cambridge University School of Clinical Medicine in 1993. She developed an interest in health education and communication, working with under- and postgraduate medical students, patient groups, community volunteers, and school children. She then trained as a primary school teacher, qualifying in 2010, and combined careers in medicine and teaching. Caroline worked with homeless patients in Cambridge before starting in prison medicine in 2011. She set up a multi-disciplinary prison pain clinic in 2014 and developed an interest in providing multi-faceted support for patients with complex pain, while reducing the risk caused by dependence-forming medicines. She co-authored RCGP Safer Prescribing in Prisons, Second Edition (2019), and was appointed RCGP Clinical Champion for Healthcare in Secure Environments in the same year to produce a toolkit of resources for clinicians working in secure environments. During 2020, she wrote COVID-19 guidance for clinicians working in secure environments, co-authored a COVID-19 pictorial resource for patients, aimed at overcoming language, literacy, and learning disability barriers and produced Covid information for patients published in *Inside Time*, the national prison newspaper. Since then, she has continued writing a monthly health column for *Inside Time*.

She was a co-author of *Tackling Causes and Consequences of Health Inequalities: A Practical Guide (Matheson J et al, 2020)* and has contributed to work on dependence-forming medicines for Public Health England, NHS England, and NICE. Caroline is a clinical advisor for RCGP and for NHSEI Health and Justice team and contributes to the Royal College of Psychiatrists Advisory Group of Quality Network of Prison Mental Health Services. She is on the steering committee of the NHS East of England Palliative and End of Life Network. Caroline has led workshops on leadership, pain management, safer prescribing in prisons, and educational resources. She has spoken at the 6th and 7th RCGP SEG Health and Justice Summits 2019, 1st Virtual Health and Justice Summit 2020, 24th Annual Conference SMMGP RCGP 2020, and NHS Education for Scotland Education and Training Group for Prison Healthcare. She has also contributed to a number of webinars with RCPsych QNPMHS, SMMGP, and NHSEI.

Preface

Forensic medicine continues to be an evolving field in which many issues of controversy arise, certain subjects become the focus of attention, and some subjects arise that had been rarely considered previously. This may be because of new research, new technology, new laws or regulations, and a revision of old concepts and beliefs. There is considerable overlap between the clinical and pathological aspects of forensic medicine and the more general fields of toxicology, fitness to drive, forensic psychiatry and psychology, and forensic biology. This third volume provides a practical update on areas relevant to contemporaneous clinical practice and with a focus for debate in selected topics. We hope the content reflects our wish to ensure that all chapters are either of direct relevance, specific interest or bring new knowledge to readers. Each chapter is written by those with particular expertise or interest in the field and who have been directly involved in the matters about which they write. Every chapter reflects topics that have come to the fore in the past two years and which, in our opinion, are going to be of great relevance to healthcare professionals and other practitioners from a multi-professional and international audience. Some chapters may be jurisdiction specific, but all have been chosen because they have wider applicability.

This volume contains a range of current, new, and controversial subjects, including chapters that provide information on the new Medical Examiner system in England and Wales, riot-control weapons, chemical warfare, non-fatal strangulation, coercive control and the homicide timeline as part of intimate partner abuse, the current use of DNA in crime detection, and the expansion of radiological imaging to assist in the assessment of soft tissue injuries. The needs and problems of the older person in detention are addressed as is the increasingly discussed issue of elder abuse. The controversial areas of false allegations of sexual assault and abusive head trauma in young children are covered and intended to stimulate discussion.

As always, the views expressed in this volume are those of the chapter authors and do not necessarily represent those of the editors or the publishers. We hope that this new volume will once again stimulate discussion and reflection on practice, even if the reader may have different opinions from some of the views expressed here. We are always happy to hear from you.

John AM Gall, Melbourne

J. Jason Payne-James, Southminster

May 2022

1 The new Medical Examiner System in England and Wales: its role in the medicolegal investigation of death

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Introduction

Perhaps, the first thing to mention when discussing the new Medical Examiner (ME) System in England and Wales is that MEs do not do autopsies and may come from a wide variety of clinical backgrounds. This may cause confusion in many other jurisdictions, with other healthcare professionals and the lay public, where the term 'ME' is often used interchangeably with 'forensic pathologist'.

Similarly, an explanation is needed to ensure that the role of Her Majesty's Coroner (HM Coroner) in England and Wales is not confused with other coronial systems in other jurisdictions. In England and Wales, a coroner holds a judicial post and requires legal experience and qualifications. The office of the coroner was originally established in 1194 as a form of tax collector but over the years has evolved into an independent judicial officer, charged with the investigation of sudden, violent, or unnatural death.

An ME in England and Wales is an independent, senior doctor who reviews (scrutinises) deaths that are not investigated by the England and Wales coronial system. Thus, the ME system in England and Wales has become an essential part of the medicolegal investigation for all deaths which are not overseen by the coronial system (the majority of deaths). The ME system works very closely with coronial services. There were over 500 000 deaths in England and Wales in 2019 (ONS 2020a), and over 200 000 were reported to HM Coroners of which over 80 000 had post-mortem examinations (Ministry of Justice 2020). Those not reported to HM Coroner will in future all be reviewed by the ME system. Overall, the numbers of deaths have been distorted upwards by the coronavirus pandemic for 2020/2021 and are in excess of 600 000. Most coronavirus deaths are considered as natural deaths unless other factors (e.g. failure to supply appropriate personal protective equipment by employers) may be involved in which case coroners may become involved.

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This chapter explains the role, function, and aims of the newly introduced ME system in England and Wales. This system is a new process established to improve the medicolegal investigation of death. It has been developed to address perceived gaps in the review of all deaths, to identify patient safety issues, and to prevent previously identified scenarios where the concerns of families and whistleblowers about care of the deceased have been ignored. The ME system in England and Wales is currently on a non-statutory footing, but that is likely to change to a statutory basis by 2022/2023 (Payne-James and Lishman 2022).

Background

There have been many concerns expressed over the years about the medicolegal investigation of death, and a number of UK reports and committees have identified shortcomings in the process suggesting, in particular, that opportunities for improving patient safety have been missed with the potential for concealed homicide.

All doctors in the United Kingdom should be aware of Harold Shipman, an apparently respected general practitioner (family physician) from Hyde in Greater Manchester, UK, who, over a period of 20 or more years, was likely responsible for the murder of around 250 of his patients. The events raised two main questions – what made an apparently respectable doctor turn to murder on such an horrific scale, and most significantly, why did nobody in authority realise what was happening (Home Office/Department of Health 2007)? The Shipman Inquiry was initiated to investigate Shipman's activities and established that he was able to conceal malpractice and kill many of his patients because the systems in place permitted him to avoid questions and suspicion despite him certifying the causes of death of many of his patients.

The Shipman Inquiry was established in January 2001, following Shipman's conviction the previous year for the murder of 15 of his patients (not all cases were included in the criminal proceedings). The Inquiry had a broad remit and was tasked with investigating the extent of Shipman's unlawful activities, enquiring into the activities of the statutory authorities and other organisations involved, and making recommendations on the steps needed to protect patients for the future. In a series of six reports published between 2001 and 2003, the Inquiry made a number of recommendations for the reform of various British systems. It called for coroners to be better trained and underlined that better controls on the use of Schedule 2, 3, and 4 drugs by doctors and pharmacists were needed (Misuse of Drugs Regulations 2001). It also recommended that fundamental changes be implemented in the way that doctors were overseen by the General Medical Council (GMC) (the body with responsibility for regulating registered medical practitioners in the United Kingdom).

The Inquiry also established that there were flaws in the system for reviewing cremations where doctors (medical referees), whose role was to independently certify the cause of death (Ministry of Justice 2012), did not recognise Dr Shipman as anything but a respected colleague and thus perpetuated his dishonest accounts of his patients' deaths. For those patients undergoing burial, Dr Shipman was not required to consult any other medical practitioner and utilised the lack of medical knowledge of registrars of births and deaths for his causes of death to be accepted

and registered. The system, as it was, depended on the integrity and honesty of a doctor, and there was no robust and independent oversight. These concerns reiterated and reinforced other reports or inquiries which had also noted that existing arrangements for death certification were confusing and provided inadequate safeguards against possible criminal activity.

The term ME is referred to at para 17.29 of Dame Janet Smith's third report (The Shipman Enquiry 2002) in which reference is made to establishing the role of Medical Coroner ('*17.29 The Society of Registration Officers suggested that the office of medical coroner should be a statutory post, independent from the NHS, with accountability passing up to a Chief Medical Coroner (the Society favoured the term 'Medical Examiner') at the head of a free-standing national agency')*. That same report also referred to the Finnish system of death certification in the following terms at 18.122 '*The most impressive aspect of the Finnish system of death certification was the emphasis on the importance of accurately ascertaining the cause of death, even where the death was apparently natural. This is of considerable significance, not only for the deceased's family, but also for society generally; it has significant implications for public health'*. The Shipman Enquiry recommended that a new national coroners' service under a chief coroner should be established at arm's length from national government, replacing the current system of local coroners appointed and funded by local authorities. This service would be responsible for the final certification of death and for deciding whether further investigation was necessary in all deaths, and the new system would contain both medical coroners who would be responsible for establishing the medical cause of death and judicial coroners who would carry out further investigations where necessary (e.g. in the case of suspicious deaths). It was these proposed 'medical coroners' which evolved into the present ME with the role of ME being formally introduced to the England and Wales jurisdiction by the Coroners and Justice Act 2009 (Table 1.1). The 'Luce Review' – 'Death

Table 1.1 Relevant sections in the 2009 Coroners and Justice Act introducing the Medical Examiner into legislation.

Medical examiners
19 (1) [Local authorities] (in England) and Local Health Boards (in Wales) must appoint persons as medical examiners to discharge the functions conferred on medical examiners by or under this chapter.
(2) Each [local authority] or Board must—
(a) appoint enough medical examiners, and make available enough funds and other resources, to enable those functions to be discharged in its area;
(b) monitor the performance of medical examiners appointed by the [local authority] or Board by reference to any standards or levels of performance that those examiners are expected to attain.
(3) A person may be appointed as a medical examiner only if, at the time of the appointment, he or she—
(a) is a registered medical practitioner and has been throughout the previous 5 years and
(b) practises as such or has done within the previous 5 years.

Table 1.2 Recommendations from 2013 Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry relating to Medical Examiners.

275	Independent medical examiners. It is of considerable importance that independent medical examiners are independent of the organisations whose patients' deaths are being scrutinised.
276	Sufficient numbers of independent medical examiners need to be appointed and resourced to ensure that they can give proper attention to the workload.
277	Death certification. National guidance should set out standard methodologies for approaching the certification of the cause of death to ensure, so far as possible, that similar approaches are universal.
278	It should be a routine part of an independent medical examiner's role to seek out and consider any serious untoward incidents or adverse incident reports relating to the deceased to ensure that all circumstances are taken into account whether or not referred to in the medical records.
279	So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant or another senior and fully qualified clinician in charge of a patient's case or treatment.
280	Appropriate and sensitive contact with bereaved families. Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.
281	It is important that independent medical examiners and any others having to approach families for this purpose have careful training in how to undertake this sensitive task in a manner least likely to cause additional and unnecessary distress.

certification and investigation in England, Wales, and Northern Ireland: the report of a fundamental review' (TSO 2003) came to broadly similar conclusions as the Shipman Inquiry. It was, however, to be more than 20 years after Harold Shipman was convicted and 10 years after the Coroners and Justice Act before a national roll-out of MEs was begun, and then, not in the structure envisaged in the Act. In the interim, other hospital-based scandals were the subject of major enquiries.

Perhaps, the most significant for the (at that time non-existent) ME system was the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013) which identified numerous, serious failing in care between 2005 and 2009. The Report chaired by Robert Francis QC made 290 recommendations, of which a number made specific reference to the need for an Independent Medical Examiner (IME) system. Table 1.2 shows the recommendations about MEs. The Report recognised that '*Significant changes have occurred in the coronial court system since the events under review, including the appointment of a Chief Coroner and the creation of the new post of Independent Medical Examiner (IME)*'.

Other hospital-based scandals have highlighted poor care or deaths that may have been prevented had an effective system of independent scrutiny been in place at the time.

Table 1.3 Intended benefits of the introduction of the Medical Examiner System to England and Wales.

- It will be fair – all deaths will be scrutinised in a robust and proportionate way regardless of whether they are followed by burial or cremation;
- It will be independent – a medical examiner will scrutinise all medical certificates of cause of death (MCCD) prepared by the attending doctor;
- It will be transparent – families will have the cause of death explained to them, including clarification of medical terms, and be able to ask questions or raise concerns;
- It will be robust – there will be a protocol that recognises different levels of risks depending on the circumstances and stated cause of death;
- It will be accurate – the medical examiner will be an experienced doctor, capable of ensuring that the MCCD is completed fully and accurately, providing the NHS, the Office for National Statistics, local authorities, and wide range of other users with better quality cause of death statistics to inform health policy, the planning and evaluation of health services and international comparisons;
- It will be efficient – it will help to make sure that the right cases are reported to coroners; and
- It will improve safety – the new system will allow easier identification of trends, unusual patterns, and local clinical governance issues and make malpractice easier to detect.

Source: Taken from Department of Health (2016). Public Domain(OGL).

The Report of the Morecambe Bay Investigation in 2015 (Kirkup 2015) which examined concerns raised by the occurrence of serious incidents in maternity services including the deaths of mothers and babies concluded: '. . . *a mechanism already in use in other countries has been put forward to scrutinise all deaths in this way that would by its nature pick up maternal and neonatal deaths. This is the appointment of medical examiners, initially proposed by Dame Janet Smith as a recommendation of the Shipman Inquiry, subsequently endorsed by the Luce review, put into enabling legislation in 2009 but not yet implemented. It is our view that implementing these proposals should be reactivated as the best means to provide the necessary scrutiny, not just of maternity-related deaths, but of all deaths*'.

The Department of Health (2016) published a consultation: Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Policy and Draft Regulations. The intended benefits of the new ME system to the public, health service, and local authorities were as listed in Table 1.3.

After the 2016 Consultation, an inquiry into the Gosport War Memorial Hospital (2018) found that lives of over 450 patients were shortened while in the hospital, despite repeated concerns raised by families who questioned about how their deceased loved ones had been treated and also similar concerns having been raised by nurses about prescribing practices of opiate medicine.

In June 2018, Jeremy Hunt (then Health Secretary) announced that he was rolling out the appointment of the MEs (The Guardian 2018). This implementation

appears to have been finally precipitated by the case of Hadiza Bawa-Garba, a trainee paediatrician, convicted of gross negligence manslaughter and struck off following the death of a child in her care, Jack Adcock. The Medical Practitioners Tribunal Service suspended Dr Bawa-Garba for 12 months on 13 June 2017. The GMC successfully appealed, and Dr Bawa-Garba was struck off on 25 January 2018. On 13 August 2018, Dr Bawa-Garba won an appeal against being struck off, restoring the one-year suspension. Many healthcare professionals have raised concerns that Dr Bawa-Garba was being unduly punished for failings in the system, notably the understaffing on the day and inadequate supervision. Linked with this, Sir Norman Williams' report 'Gross negligence manslaughter in healthcare. The report of a rapid policy review' (2018) was instigated to consider the wider patient safety impact resulting from concerns among healthcare professionals that simple errors could result in prosecution for gross negligence manslaughter, even if they occur in the context of broader organisation and system failings. Amongst other recommendations, the Williams report noted '*The Government is introducing a system in England and Wales, where all non-coronial deaths are subject to a medical examiner's scrutiny. The introduction of medical examiners is designed to deliver a more comprehensive system of assurance for all non-coronial deaths. While not specifically concerned with gross negligence manslaughter, the introduction of medical examiners aims to improve the quality and appropriateness of referrals of deaths to coroners and to increase transparency for the bereaved and offer them an opportunity to raise any concerns. The panel supports this aim and the introduction of medical examiners*'.

Thus, from April 2019, a national system of MEs was introduced to acute NHS trusts (and some specialist trusts) in England and local health boards in Wales. These Medical Examiner Services (MESs) were to be provided by ME offices based within (predominantly) the hospital settings. It is fair to say that this action to provide support for bereaved families and to improve patient safety has to be considered a direct response to the repeated and (in some cases) historic recommendations in reports and public inquiries. And although Shipman and Mid Staffordshire and Morecambe Bay were the key drivers there were other examples where concerns raised by families and/or healthcare professional whistleblowers had been repeatedly ignored (Ockenden 2022).

It will be noted that the new ME system was being established in 2019/2020, and barely 9 months into this development health services were suddenly facing unprecedented pressures caused by the Covid-19 (coronavirus) pandemic. In response to the pandemic, the Coronavirus Act 2020 provided easements to improve the flow of excessive deaths. Despite the massively increased workload, and the option of pausing development, many MESs opted to progress throughout, and MESs played an important role in the pandemic response in a variety of ways including supporting frontline clinicians in writing Medical Certificate of Cause of Deaths (MCCDs) or becoming full-time certifiers releasing frontline doctors from an administrative task so that they could prioritise frontline caring duties. In part, this was driven by the consideration that at times of pressure, more mistakes or errors might be made, and this was exactly the time when competent and independent oversight was required. Guidance was issued by NHS England and NHS

Improvement about Coronavirus Act easements which simplified and streamlined many death certification functions and enabled the ME system to be even more relevant (NHS England & NHS Improvement 2020; ONS 2020b). In March 2022 some of these easements were removed (for example allowing any medical practitioner to complete the MCCD), whilst some were retained including the requirement for a deceased patient to have seen a doctor within 28 days of death (previously 14 days) and the permanent abandonment of the Cremation Form 5. (National Health Service 2022).

Structure and function of the Medical Examiner system in England and Wales

The ME role was formally introduced in the Coroners and Justice Act 2009. Its nature has changed and developed since then, prior to implementation – and MESs have been based within National Health Service acute hospitals (by whom MEs and Medical Examiner Officers (MEOs) are employed) reviewing deaths within acute hospital services. The changes to the proposed service (i.e. not including the community initially) did not go unnoticed, and the (then) Chief Coroner stated that he was '*disappointed that the scheme that was consulted on in 2016 which covered all deaths will not currently be implemented' (Health Services Journal* 2018) and felt that the ultimate objective should be a structure as envisaged in the 2009 Act. It also appears for pragmatic, practical, and financial reasons that the ME system was moved to the NHS rather than being funded by local authorities.

However, at last, a national service (rather than a small number of local pilot services) was to be introduced across the NHS in England and Wales. The ME system introduced in 2019 aims (National Medical Examiner 2020) to:

- provide bereaved families with greater transparency and opportunities to raise concerns;
- improve the quality/accuracy of medical certification of cause of death;
- ensure referrals to coroners that are appropriate;
- support local learning/improvement by identifying matters in need of clinical governance and related processes;
- provide the public with greater safeguards through improved and consistent scrutiny of all non-coronial deaths and support healthcare providers to improve care through better learning; and
- align with related systems such as the National Learning from Deaths Framework and Universal Mortality Reviews.

MEs supported by MEOs scrutinise (review) all deaths that do not fall under the HM Coroner's jurisdiction across a local area. MEs are trained, independent, senior doctors. Any practising, or recently retired, medical practitioner who has been fully registered for at least five years and has a licence to practise with the GMC can apply to be an ME, but the National Medical Examiner (NME) advises that MEs should be consultant grade doctors or other senior doctors from a range of disciplines or GPs with an equivalent level of experience. The Royal College of Pathologists in the United Kingdom is the lead medical Royal College for MEs and is currently responsible for training MEs and MEOs. Training is currently a combination of e-learning and face-to-face, and successful completion permits ME membership of the Royal College of Pathologists. MEs and MEOs are employed in the NHS system but have an additional, separate professional line of accountability to regional and national ME teams. Independence is overseen by the NME supported by seven regional teams of Regional MEs and Regional MEOs.

The role of the NME is to provide professional and strategic leadership to the Regional ME teams who in turn support a network of MEs at acute hospital trusts. The NME is intended to support safeguards for public, patient safety monitoring and informs the national learning from deaths agenda and will produce an annual report (National Medical Examiner 2020, 2021a). Most trusts will have a lead ME and a number of other MEs who may come from a range of different medical specialties. MEs generally work part time.

Current guidance suggests that in order to provide adequate cover to scrutinise 100% of death, one whole-time equivalent ME and three whole-time MEOs will be require to adequately cover 3000 deaths. These figures have been determined from pilot studies that have been in place since about 2008. As the MES can be considered to be in the 'adolescent' stage of development, it is likely that these figures will be refined as the availability and expertise of the MES become more widely recognised.

The initial phase of introduction of MESs has been to England and Wales acute hospital, and all were asked to set up (starting in April 2019) MEOs focussing on deaths within their own organisation on a non-statutory basis. Initially, adult deaths were the priority, with only some MES teams reviewing neonatal and child deaths. In an ambitious plan, it was originally intended that every non-coronial death in England and Wales would be scrutinised by MES teams by the end of 2022. Unsurprisingly this target has probably slipped to the latter part of 2023. In June 2021, a circular was sent out (NHS England & NHS Improvement 2021) outlining what local health systems must do to enable consistent scrutiny of deaths across all healthcare settings. Some MESs are on track to achieve this, but some have not yet achieved 100% scrutiny of adult hospital deaths, let alone those of the community. For practical reasons, the MES teams in hospital will also act as the hubs for scrutiny of community deaths (e.g. at home, in nursing homes, and private and community hospitals). There are a number of hurdles to the community roll-out, compounded by multiple electronic notes systems, varying IT governance issues, including access to community medical records and communicating with healthcare professionals in the community. Multi-professional working groups developing pilot studies have made progress with this. The NME has provided information for primary care physicians about the progression of the MES (NME 2021b).