East Lancashire Hospitals NHS Trust
A University Teaching Trust

	DIVISIONAL DOCUMENT
	Standard Operating Procedure
DOCUMENT TITLE:	**Referral pathway for reporting Neonatal deaths to the Medical Examiner**
DOCUMENT NUMBER:	**SOP 69 v1**
DOCUMENT REPLACES Which Version	n/a
LEAD EXECUTIVE DIRECTOR DGM	Divisional General Manager
AUTHOR(S): Note should not include names	Bereavement Midwife, Lead Obstetric Consultant for perinatal mortality, Lead Neonatal Consultant for perinatal mortality, Quality and Safety Lead Midwife, Lead Medical Examiner

TARGET AUDIENCE:	All staff in NICU and Maternity
DOCUMENT PURPOSE:	To provide a standardised process for the referral of neonatal deaths to the Medical Examiner

To be read in conjunction with	Please see below
SUPPORTING REFERENCES	

CONSULTATION		
	Committee/Group	Date
Consultation	Women and Newborn QSB	
Approval Committee	Women's and Newborn Quality and Safety Board	Nov 2021
Ratification date at WNQSB	November 2021	
NEXT REVIEW DATE:	November 2024	
AMENDMENTS:		

Contents

Introduction

A national system of medical examiners was rolled out in England and Wales to provide much-needed support for bereaved families and to improve patient safety. This was a recommendation of the Shipman, Mid-Staffordshire and Morecambe Bay public inquiries.

Medical examiners are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

Acute healthcare Trusts in England were asked to set up medical examiner offices initially to focus on the certification of all deaths that occur in their organisation. At ELHT, this now includes ALL neonatal deaths.

The purpose of the 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.

The role of the medical examiner office is to examine deaths in order to:

- agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it
- discuss the cause of death with the next of kin/informant and establish if they have questions or any concerns with care before death
- act as a medical advice resource for the local coroner
- inform the selection of cases for further review under local mortality arrangements and contribute to other clinical governance procedures.

Purpose

This document aims to provide a standardised process for the referral of neonatal deaths to the Medical Examiners' Office at ELHT.
It is for use by Neonatal doctors and nurses and obstetric doctors and midwives in maternity services.

Flow chart 1

Process following Neonatal Deaths in LWNC

Neonatal Death on Central Birth Suite or NICU

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Ensure NOTIFICATION OF DEATH (NOD) is completed on **DATIX** as soon as possible (by nursing staff/ midwife/medical) including SBAR summary of case and next of kin details

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A discussion should take place within 3-4 hours of death, to identify if there are any immediate concerns or omissions/care issues that may have contributed to the baby's death.

- This should take place between the Obstetrician on call and Neonatology Consultant on call (If baby below 22 weeks gestation Neonatal input may not be required)
- **The Immediate review form (Appendix 1)** should be completed and emailed to ME
- Telephone call to the Medical Examiner (ME) to determine if a referral to coroner is required (contact details below)

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No immediate concerns or issues identified

- Medical Certificate Cause of Death (MCCD) to be completed by Neonatal Consultant following discussion with Obstetric Consultant (Or Obstetric Consultant if < 22 weeks)
- Discuss proposed cause of death with Medical Examiner
- **Speak to the parents and inform them of the cause of death, making sure they understand the certificate and agree. Advise that ME may contact them.**
- Scan and email MCCD to ME office, NICU bereavement team and Bereavement midwife (contact details below)
- Once the Medical Examiner has reviewed the case they will issue a identification number and the ME's office will release the paperwork (for the Registrar's Office and the baby to the parents)
- Write the ID number given by ME's Office on MCCD on top left hand side ideally in **RED** to evidence that the ME's Office has reviewed the case.
- Neonatal doctor to complete Cremation form 4 part A– to go with the baby
- Nurse/ bereavement team - Email Registrar's office, with the filled template letter (Appendix 3) and scanned copy of MCCD (with ID number on it)
- **Registrar will contact the family for registration**
- They will release 'Green Slip' release form for the funeral directors for the burial or cremation of baby.

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Immediate concerns or issues identified

ME will discuss with Coroner and get back to the medical team, if a Post mortem (PM) is required and /or further investigations required

- Follow Coroner's advice if further investigations required
- If PM not required, request that the baby can be released to the family

Inform parents of the decision from coroner

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Follow flow chart 2

- If the baby is going to the **mortuary**, the Cremation form, copy of MCCD and copy of NOD should go with the baby. (NB: if going for post mortem, a copy of all maternal and neonatal notes needs to go with the baby in addition to this.)
- If the parents are taking the baby **home** or the baby is going straight to the **funeral directors** from NICU or Central Birth Suite, Cremation form 4 should go with the baby. The SANDS 'Taking your baby home' consent form should be given to the family.

Flow chart 2

For ALL Neonatal deaths

Mortality review form (Appendix 2) to be completed within 48 hours by consultant involved and emailed to **familycare.incidents@elht.nhs.uk** and NICU palliative care team (contact details below)

Quality and Safety team will review and forward to Medical Examiner's Office, and inform them of any identified issues with care.

No issues in care identified
Coroner investigation not required

- **HSIB/RCA to be completed as required**
- **Neonatal mortality review to be completed**
- **PMRT to be commenced and completed**

If any care or service delivery issues that are likely to have had an impact on the outcome for the baby, (Grading outcome C or D)

- Findings should be discussed with Medical Examiner
- Any immediate learning that is identified must be acted upon at this stage (NICU/Obs team)

Coroner investigation is requested

- Coroner will instruct further investigation and inquest be held as directed
- The parents/family must be informed that
  - some issues in care have been identified
  - their case has been referred to the Coroner
  - the baby cannot be released to the family without the Coroner's permission
  - Coroner's Office will contact them by telephone
- Duty of Candour must be completed
- A Coroner's referral statement must be completed by the Consultants involved (these can be found on Sharepoint)
- Once completed, this should be emailed back to medicalexamineofficer@elht.nhs.uk
  - The Coroner may request a post mortem on the baby if the cause of death is unknown or suspicious, which would delay the release of the baby to the family
  - If a post mortem is not required, the Coroner will issue the relevant documents to the Registrar for the registration of the death and release of the body for burial or cremation while awaiting the outcome of the Coroner's Inquest.
- The ME's Office and the Coroner's office will ensure the midwife or nurse caring for the family is kept informed of progress.
- Once the Coroner has released the baby for burial or cremation, the baby can either be discharged via the mortuary or directly from Birth Suite or NICU

Family to be kept informed at all stages and debrief offered by team involved in care
Follow PMRT-Parent engagement Flow chart (Appendix-4)

Contact details

1. Medical Examiner's Officer – medicalexaminer@elht.nhs.uk
   Medical Examiner's Office tel: 01254735753: internal: 85753 (Mon-Fri 8.30-4.30) Sat(10am-12midday) Medical Examiner tel: 01254736673; internal; 86673
2. Registrar's office – burnley.registrars@lancashire.gov.uk
3. Safety and quality team – familycare.incidents@elht.nhs.uk
4. Bereavement Midwife – bereavementmw@elht.nhs.uk
5. NICU -Palliative care team: NICUpalliativecareteam@elht.nhs.uk

The Process

- Immediately following the neonatal death, a Notification of Death form (NOD) to be completed by NICU nurse or Midwife. This can be found on the OLI Homepage under the Datix tab.

This should include;

- SBAR summary of case
- Contact details of Next of Kin
- Contact details of Doctors involved in care

- IMMEDIATE REVIEW of NEONATAL DEATH form should be completed and emailed to the Medical Examiner's Officer – medicalexaminer@elht.nhs.uk . (see Appendix 1).
    - This should involve a discussion between the Obstetric Consultant and the Neonatal Consultant on duty to identify any care or service delivery issues that HAVE HAD AN IMPACT ON THE CAUSE OF THE BABY'S DEATH. (if baby less than 22 weeks gestation neonatal inout may not be required)

- Either the Obstetric or Neonatal Consultant should then telephone the Medical Examiner on duty, giving brief details of the case, highlighting any issues that had an impact on the baby's death and the proposed cause of death.
    - Medical Examiner's Office tel: 01254735753: internal: 85753 (Mon-Fri 8.30-4.30)
    - Medical Examiner tel: 01254736673; internal; 86673

- Based on this discussion and the information that is given, the Medical Examiner will then advise if a referral to the Coroner's Office is required.

Follow Process A if a Coroner's referral IS NOT required

Follow Process B if a Coroner's referral IS required

Process A; Coroner's referral NOT required

- Neonatal Consultant to complete the Medical Certificate of Cause of Death for a Liveborn Child Dying within the First Twenty Eight Days of Life (MCCD)
- Discuss this with Obstetric Consultant on duty

- Both Consultants to provide a brief summary of the case and the care given
- **Speak to the parents and inform them of the cause of death, making sure they understand the certificate and agree.**
- Inform parents that the ME's office may contact them for further discussion
- Neonatal doctor to complete Cremation form 4 part A– to go with the baby
- Scan and email the MCCD and summary of care to the ME's Office along with parent's contact details - medicalexamineofficer@elht.nhs.uk
- Once the Medical Examiner has reviewed the case they will issue a reference number.
- Write the number given by ME's Office on the correspondence with Registration Office to evidence that the ME's Office has released the baby.
- Once the ME's office have reviewed this, they will release the paperwork for the Registrar's Office and the baby to the parents.

Once this has happened;

- Scan and email the MCCD along with parent's contact details to the Registrar's office – burnley.registrars@lancashire.gov.uk
- Send original certificate via post to the Registrar's Office.
- Registrar will contact the family for registration
- They will release 'Green Slip' release form for the funeral directors for the burial or cremation of baby.

If the baby is going to the mortuary, the Cremation form, copy of MCCD and copy of NOD should go with the baby. (NB: if going for post mortem, a copy of all maternal and neonatal notes needs to go with the baby in addition to this.)

If the parents are taking the baby home or the baby is going straight to the funeral directors from NICU or Central Birth Suite, Cremation form 4 should go with the baby. The SANDS 'Taking your baby home' consent form should be given to the family.

Process B; Coroner's Referral required

- The parents/family must be informed that some issues in care have been identified and that their case has been referred to the Coroner
- The family should be informed that the Coroner's Office will contact them by telephone
- Duty of Candour must be completed
- The ME Officer will email a Coroner's Referral Statement Form to the Neonatologist and Obstetrician for completion.
- Once completed, this should be emailed to medicalexamineofficer@elht.nhs.uk

- The baby cannot be released to the family without the Coroner's permission, and the family must be informed of this.
- The Coroner may request a post mortem on the baby if the cause of death is unknown or suspicious, which would delay the release of the baby to the family
- If a post mortem is not required, the Coroner will issue a form 100A to the Registrar for the registration of the baby and release of the body for burial or cremation while awaiting the outcome of the Coroner's Inquest.
- The ME's Office and the Coroner's office will ensure the midwife or nurse caring for the family is kept informed of progress.
- Once the Coroner has released the baby for burial or cremation, the baby can either be discharged via the mortuary or directly from Central Birth Suite or NICU

For all Neonatal Deaths, stillbirths and late miscarriages after 22 weeks gestation:

- A Family Care Mortality Review must be completed by the Neonatal Team and the Obstetric team within 48 hours of the death. (See Appendix 2)
- This must then be emailed to the Family Care Incidents mailbox familycare.incidents@elht.nhs.uk
- This will then be reviewed by the Quality and Safety Team
- They will send the final review form to the ME's Office
- If any care or service delivery issues are identified at this point, the case can still be referred to the Coroner and ME's Office informed
- Any immediate learning that is identified must be acted upon at this stage
- The case will then be reported to StEIS or HSIB if required
- The case will be subject to the PMRT process and the parents offered debrief/feedback as required.

Appendix 1

Immediate Mortality Review Family Care

(**MUST** be completed at on day of loss)

Date of incident		**eIR1 Number**	
Maternal RXR number		**Hospital Site (where incident occurred)**	
Neonatal RXR number		**Ward or Dept (where incident occurred)**	
NEONATOLOGY CONSULTANT ON CALL		**NICU BAND 7**	
OBSTETRIC Consultant on call		**BEREAVEMENT MIDWIFE (if available)**	

Brief Summary of Case -Description of what happened, state facts only (as known at the time)
Obstetric Consultant and Neonatal Consultant to discuss together

1. **Are there any immediate concerns about the care or service provision?**

2. **Are there any omissions or issues in obstetric care that may have contributed to this baby's death?**

3. **Are there any omissions or issues in neonatal care that may have contributed to this baby's death?**

Discussion with Medical Examiner by nominated person

- No issues identified; inform Medical Examiner and ask that the baby can be released to the parents the same day
- Issues identified; inform Medical Examiner who will discuss with the Coroner and decide if further investigations required prior to baby being released to the family
- Inform the Medical Examiner of any Family views or cultural/religious requirements

Appendix 2

Mortality Review Family Care

(With Guidance – Please delete any red text that is not applicable)

(**MUST** be completed within 48 hours of request)

Date of incident		**eIR1 Number**	
Maternal RXR number		**Hospital Site (where incident occurred)**	
Neonatal RXR number		**Ward or Dept (where incident occurred)**	
Authors of Mortality Review Review		**Author's Job Title**	
Late fetal losses 22+0 to 23+6	Y/N	**Antepartum Stillbirth > 24 weeks**	Y/N
Neonatal Death from birth at 22+0 – 28 days	Y/N	**Intrapartum Stillbirth > 24 weeks**	Y/N
Neonatal deaths 28 days – 1yr (having received neonatal care at ELHT)	Y/N	**Maternal Death**	Y/N

Summary of Case -Description of what happened including a brief timeline - be concise / state facts only (as known at the time)
Provide a concise, factual summary of the incident This should provide the reader with an overview of: • What took place prior to the incident occurring (set the scene of what was taking place) • What went wrong (what is the incident about? What is the area of concern/error/harm?) • Any relevant background information that helps explain the incident • Consider providing a very brief timeline of events if it helps explain the incident Keep it: • Specific and concise • Informative of actions that took place • Ensure all points stated are linked to the incident Do **NOT** include: • Person identifiable information • Subjective/state opinions • Abbreviations without the full term used first

Saving Babies Lives Care Bundle 2 (care an service delivery for all antepartum / intrapartum and neonatal deaths should be considered against the 5 elements)	
Smoking: provide detail	
Fetal Growth: provide detail	
Fetal movements: provide detail	
Intrapartum monitoring: provide detail	
Pre-term birth: provide detail	
Birth weight:	**Gestation at birth :**
Birth weight centile on customised growth chart:	**Age when baby died:**
Description of any issues identified and the immediate actions taken to ensure patient safety	

What actions have been taken following the incident to immediate reduce the impact to the individual and/or system:

- Action to maintain safety: *i.e. Security attended ward to provide support, Bay area closed due to infection and deep clean arranged.*
- How has the risk to either the patient/system been reduced: *i.e. Urgent appointment has been made for the patient and advice given, Booking system checked to ensure no further patients missed from list.*
- How was a safe environment re-established if required: *i.e. faulty equipment labelled not for use, removed and reported.*
- What systems, processes or policies were followed: i.e. Safer Handling Policy, Fire Policy, Safeguarding Children Policy.
- Who has been informed of the incident: *i.e. Incident escalated to matron, Duty manager informed of incident and advice sort. Incident reported to pharmacy for follow up, support and advice.*

Duty of Candour - Description of any communication with the patient and or family

- All patient safety incidents that are graded as moderate or above level of harm are subject to Duty of Candour regulation
- Duty of Candour should be carried out within 10 days of the occurrence of such an incident
- Has an open and honest discussion as well as an apology taken place with the patient/relatives? (an apology is not an admission of guilt)

Is Duty of Candour required?	Y/N
Have all the parameters on Datix in relation to Duty of Candour been completed?	Y/N
Has a **signed** Duty of Candour letter been:	
Sent / given to the patient?	Y/N
Filed in the hospital records?	Y/N
A written apology documented in te hospital notes	Y/N
Reason for Duty of Candour	*Document reason here*
Clinician who completed Duty of Candour	Document name here

Description of any support provided to the staff involved

- Detail any impact on staff involved in the incident and what support has been provided
- For further information refer to the Trusts "supporting staff" guidance

Confirm level of harm caused to patient (ie moderate / severe) as recorded on Datix

When deciding on the level of harm consider:

- Has any physical/actual harm occurred?
- Has any injury occurred – how long is it likely to last?
- Has the incident changed the Patient's outcome?
- Has the incident meant further treatment was needed?
- Has it caused any pain/suffering?
- Has it increased Patient's Hospital stay?
- If things were done differently/intervention had taken place, would the outcome result have been different?

Please refer to the National Patient Safety Agency (NPSA) levels of harm available in the incident record on Datix to understand what each level of harm means

Checklist	
Has the Medical Examiner's Office been informed?	Y/N/not appliable
Has the patient been counselled for post-mortem if so by whom?	Y/N Name of clinician
Has the patient consented for post-mortem?	Y/N

Have the parents been debriefed by a senior obstetrician?	Y/N Name of clinician
Is the stillbirth certificate completed accurately?	Y/N Name of clinician competing the stillbirth certificate
Have the family been informed about the Perinatal Mortality Review process? Please document any concerns and/or questions the family may have and give an information leaflet before discharge. Inform Quality and Safety Team.	Y/N Detail concerns here
Does this case meet the HSIB criteria? (Intrapartum Stillbirth at Term -includes any sign of labour including latent labour). If yes, ensure family aware of HSIB and leaflet given/ HSIB letter signed and document any concerns and/or questions family may have**.**	Y/N Detail concerns here
Have the Quality and Safety Team been informed?	Y/N

Governance office use only			
Date rapid review requested		**Date rapid review received**	
Reviewed and approved by		**Date approved**	
Manage as a SIRI Y/N		**STEIS reportable Y/N** (include number)	

This rapid review form must be completed within 48 working hours of request and:

- Sent to the Divisional Quality and Safety Lead / Midwife for quality check
- Submit the completed mortality review to **familycare.incidents@elht.nhs.uk**, with a notification email cc in Matron, Deputy Head of Midwifery and Named Consultant.

Appendix – 3

Letter to registrar template

Lancashire Women and Newborn Centre
Burnley General Hospital
Casterton Avenue
Burnley
Lancashire
BB10 2PQ
Tel: 01282 804255

To the registrar

Dear Sir / Madam,

RE: Baby Name:_____ DoB_____

This baby died on _____.
The case has been discussed with the Medical Examiner and they are in agreement that the baby can be released for burial or cremation. Please find enclosed the MCCD, with the reference number from Medical Examiner's Officer.

Parents Details:

Mother :
Name: _____
Telephone:_____
Email:_____

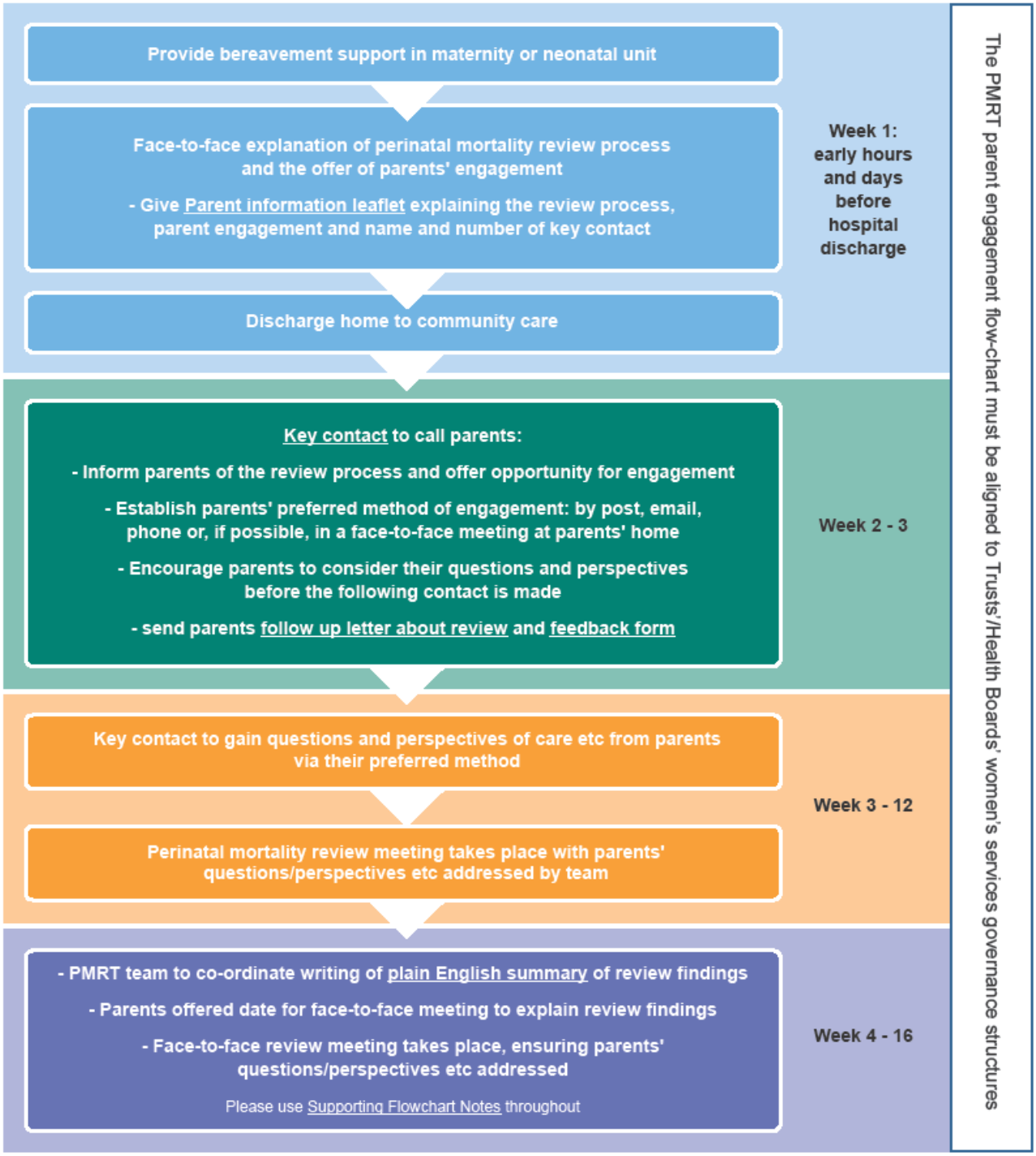
Father:
Name: _____
Telephone:_____
Email:_____

Kind Regards,

Appendix 4

PMRT Parent Engagement Flow Chart

for reviewing deaths from 22 weeks gestation (>500grammes) up to 28 days after birth and post neonatal deaths where the baby spent time in NICU but may have died elsewhere



MBRRACE-UK

PMRT

Appendix 5

Parent Information Leaflet

When your baby has died

What happens now?

Please accept our condolences for the death of your baby. The days following your loss can be very difficult and emotional, and unfortunately there are decisions and arrangements to be made at this time. This leaflet has been produced to provide with some information to support you through this process. It outlines some of the practical matters and legal requirements and some more general advice and information.

Medical Examiner

The Medical Examiner Team review all deaths that happen in this hospital, and this includes any babies who have died.

The Medical Examiners are a team of senior doctors who are trained and employed independently to the Hospital to review the causes of death and ensure that the Medical Certificates of Cause of Death (MCCD) are completed accurately, that deaths are investigated appropriately and to offer the opportunity for families to discuss any issues or concerns with the care that was given.

They work closely with the Coroner's Office and Her Majesty's Coroners who independently investigate all deaths where the cause is unknown, where there is reason to think the death may not be due to natural causes, or which need an inquiry for some other reason. They do not investigate all deaths. If necessary, they will hold an inquiry in order to establish the cause of death.

After a baby has died, the doctors who have cared for you and your baby will discuss your care with the Medical Examiner, and will describe what has happened and state the likely cause of your baby's death. They will review your care in order to identify any issues that may have had an impact on your baby's death.

If there are no issues with the care you and your baby received, and there is a clear cause of your baby's death, the Medical Examiner will advise the doctors to complete the Medical Certificate of Cause of Death, and you will be able to register your baby and plan their funeral.

If there are any concerns, the Medical Examiner will discuss your care with the Coroner who may wish to investigate the cause of your baby's death and hold a Coroner's inquest. Sometimes they may ask for a post mortem to be performed before your baby's funeral can be arranged. There may be a delay in registering your baby if there is a Coroner's Inquest, but they will provide the paperwork and allow your baby to leave the hospital as soon as they can so you can arrange the funeral.

The Coroner's Office will contact you and let you know what is happening.

Deciding about a post mortem

Making the decision whether or not your baby has a post mortem can be very difficult.

There is lots of information about this in the SANDS Bereavement booklet you should be given. Your doctors will also talk to you about this.

If the Coroner is conducting an investigation, they may request a post mortem, but the Coroner's Office will discuss this with you.

Registering you baby

The birth and the death of your baby will need registering at the Registry Office. We will forward your details to the Registrar and they will contact you to arrange this.

We will send the MCCD to the Registrar so they have all the details. If there is a Coroner's investigation, the Coroner's Office will send the necessary information to the Registrar so you can register your baby.

The Registrar will then issue the paperwork you need for your baby's funeral. They can give this directly to your funeral director if you wish.

Arranging a funeral

Your baby will need a funeral, and you will need to identify a funeral director.

Please see the attached leaflet with funeral advice and information.

Leaving Hospital

If your baby is having a post mortem, they will go to the hospital mortuary before they are transferred to Manchester Children's Hospital. Once this has been completed, your baby will be returned to Blackburn Hospital and your funeral director will be contacted to collect your baby.

If your baby is not having a post mortem, you have a choice of options;

- Your baby can go to the hospital mortuary and your funeral director can collect them from here.
- Your baby can go straight to the funeral directors from Central Birth Suite or NICU.
- You may wish to take your baby home, even if just for a short period. Your funeral director will support you with this, and a 'Cold Cot' is available for you to use at home.

Perinatal Mortality Review

At our hospital, we look into the death of any baby and use a Perinatal Mortality Review Toolkit to structure this review. Please see the attached leaflet which explains this process. As part of this, you will be given a named contact to get in touch with if you have any needs, questions or concerns.

Contact Information

Bereavement Midwife –Tel:07595090617
NICU – 01282804255
Central Birth Suite – 01282 804232
Complaints email – complaints@elht.nhs.uk
Medical Examiner's Office – tel; 01254 735673