The Royal College of Pathologists
Pathology: the science behind the cure

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Medical examiners and child deaths

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Recommendations for medical examiners – deaths of children

Medical examiners should:

1. Work closely with paediatricians (including paediatric mortality leads in England, and where appointed in Wales) and neonatologists, to establish effective interactions between medical examiners and the local child death review process that maximise the support for bereaved families and minimise potential distress and duplication. Medical examiners should also be conscious of local reporting arrangements for perinatal deaths. Processes and ways of working should ensure all parties are clear about their roles and the steps that will take place after the death of a child, and avoid any potential misunderstandings. In England, this could include the key worker introducing the medical examiner role to the family, for example with general information or an agreed template letter, to inform bereaved families about the medical examiner or medical examiner officer contacting them.

2. Provide independent scrutiny of deaths of children and neonates not taken for investigation by a coroner, as they would for other non-coronial deaths. After the death of a child, medical examiners (or medical examiner officers with delegated authority) should make contact with bereaved families to offer the opportunity of discussion with an independent person in the usual way. Deaths of children will then receive equivalent independent scrutiny to that provided for all other non-coronial deaths, and families who are bereaved after the death of a child will have equal access to a discussion with an independent person.

3. Recognise that, while all deaths require sensitive interactions with bereaved people, the death of a child is likely to be particularly traumatic. Medical examiners and medical examiner officers should ensure that bereaved families are informed clearly that participation in a discussion is entirely voluntary.

4. Take advice from child and neonate bereavement leads on their approach to bereaved parents, and participate in training opportunities. Training is available from organisations such as Child Bereavement UK.

5. Work closely with paediatricians (including paediatric mortality leads) and neonatologists, obstetricians and midwives, to establish processes to capture and disseminate learning, and ensure that actions to improve care for patients are identified and implemented.

6. Pay particular attention to proposed causes of neonatal death. These should fully reflect the broad clinical background of each death, and medical examiners should exercise due care during their usual scrutiny before the death is registered to consider peripartum issues and antenatal care. Again, interactions with obstetricians or midwives and proportionate review of their records, if feasible before completion of the MCCD, may be an important part of scrutiny.

7. Participate in meetings or discussions for child death reviews where desired or considered helpful. In England, this reflects arrangements set out in the statutory Child Death Review guidance; medical examiners should also consider joining child death overview panels if invited to do so, though this needs to be balanced with other review processes such as mortality reviews. In Wales, information sharing/discussions could take place with the Child Death Review Programme. It should be noted that the National Medical Examiner's Good Practice Guidelines state that medical examiners cannot also be their host organisation's mortality lead.