Witness Name: Dr Alan Fletcher
Statement No.: 2
Exhibits: 1 [AF2/1
Dated: 6 December 2024

THIRLWALL INQUIRY

SECOND WITNESS STATEMENT OF DR ALAN FLETCHER

I, Dr Alan Fletcher, will say as follows: -

1. This witness statement supplements my first witness statement (**INQ0014570**). At the time that I gave that statement, I was the non-statutory National Medical Examiner for England and Wales. Since 9 September 2024, I have held the statutory position of National Medical Examiner for England and Wales, following my appointment being continued and the terms of my ongoing appointment being approved by the Secretary of State for Health and Social Care.

2. In this statement, I describe the guidance that I published in July 2024 and which took effect from 9 September 2024, when the statutory medical examiner system came into force (by way of the Death Certification Reforms[1]). I published this guidance, the "National Medical Examiner's guidance for England and Wales"[2] [**Exhibit AF2/1,** **INQ0108660**], pursuant to Regulation 7 of the National Medical Examiner (Additional Functions) Regulations 2024. Regulation 7 requires the publication of standards for medical examiners. In addition, Regulation 6 enables the National Medical Examiner to publish guidance for English NHS bodies and Welsh NHS bodies in relation to (among other things) qualification requirements for medical examiners, their functions and appropriate training to be undertaken by medical examiners.

3. The statutory guidance updates the earlier guidance that applied during the non-statutory period of the medical examiner system. The Good Practice Series, which I described in my first statement (see in particular paragraphs 96-98), is incorporated into the statutory guidance. This includes No. 6 (Child deaths) and No. 12 (Escalating thematic issues), both

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[1] This is the collective term for the amendments to the Coroners and Justice Act 2009, the Medical Examiners (England) Regulations 2024, the Medical Examiners (Wales Regulations) 2024 and the Medical Certificate of Cause of Death Regulations 2024.

[2]

of which were exhibited to my first statement (as **INQ0012363** and **INQ0009270** respectively).

4. The following parts of the statutory guidance are likely to be of most interest to the Inquiry:

    a. Principles for medical examiners (Section 4 of the guidance); and

    b. Deaths of children including neonates (page 13, Section 4; and page 23, Section 7 of the guidance).

5. I have briefly summarised below the key points of note in relation to these aspects.

Principles for medical examiners

6. Section 4 sets out the principles for medical examiners. These supplement the statutory duties that all medical examiners have under applicable provisions of the Death Certification Reforms. These principles are the same as those I described in my first statement, except that they now have statutory force.

7. So, for example, there are now statutory provisions relating to the independence of medical examiners[3]. The guidance provides further detail and provides, for instance, that "being the overall trust or health board mortality lead or a member of the executive team or board of the NHS body that employs medical examiners" would not be considered sufficiently independent.

8. Transparency and openness to empower bereaved families is emphasised.

9. Appendix 3 of the guidance provides further requirements in relation to NHS bodies employing medical examiners, reflecting the Coroners and Justice Act 2009 (as amended). The NHS Standard Contract has also been updated to include a contractual requirement for NHS Trusts and NHS Foundation Trusts to establish and operate a Medical Examiner Office and to comply with Medical Examiner Guidance.

Deaths of children including neonates

10. Deaths of children including neonates is dealt with at page 13 and in more detail in Section 7 of the guidance at page 23.

11. At page 13, the guidance emphasises the additional requirements that apply for <u>all</u> deaths of children up to the age of 18 and including neonates.

[3] The Medical Examiners (England) Regulations 2024 and the Medical Examiners (Wales) Regulations 2024.

12. This is clearly stated as meaning that (in England) the statutory child death review process must be followed, with concerns notified to the child death review co-ordinator. Equivalent reference is made to Wales, where there are different (but similar) arrangements that apply. (I described the different arrangements that apply to Wales in my first statement).

13. Good Practice Paper No. 6 is referred to (with a hyperlink) in this part of the guidance and provides more detailed guidance on this topic for both England and Wales (with reference to the Welsh *Procedural Response to Unexpected Deaths in Childhood* ("PRUDiC") and the Child Death Review Programme in Wales). I described Good Practice Paper No. 6 in my first statement, at paragraphs 142 and 143.

14. Further detail on child death review is included in Section 7 of the guidance, as part of an overall Section dealing with how Medical Examiners work in partnership with Coroners, register offices and other statutory processes.

15. Section 7 makes the following key points in relation to child and neonatal deaths:

    a. The medical examiner system complements established statutory child death review processes;

    b. All deaths of children (including neonates) under 18 years of age should be notified to the relevant Child Death Overview Panel ("CDOP"). A hyperlink is included that provides the link with CDOP contact details;

    c. Medical examiner offices should provide information to support the child death review process;

    d. The statutory guidance *Child death review: statutory and operational guidance (England)* is referred to and hyperlinked.

Planned future work

16. I am currently at an early stage of work with the British Association of Perinatal Medicine ("BAPM") to co-develop a neonatal e-learning module for Medical Examiners. This is intended to complement work that BAPM are doing to develop their Framework for Practice on Neonatal Mortality Governance. In parallel, Good Practice Paper No. 6 will be reviewed and updated as necessary. This work is at an early stage and so I do not currently have a timeframe that I can provide to the Inquiry but I will keep the Inquiry informed as this work progresses.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: _____5 December 2024_____