NHS England

To: **Tim Suter**

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 January 2026

Dear Tim

Thirlwall Inquiry – Supplementary questions – National Medical Examiner

Thank you for your letter of 16 January 2026 on behalf of the Chair of the Thirlwall Inquiry.

As you will be aware, I was appointed National Medical Examiner in December 2025. In order to best assist the Inquiry, I have read the evidence given by Professor Alan Fletcher OBE, the previous National Medical Examiner, including the transcript of his oral evidence that you referred me to.

My response to the questions in your letter of 16 January is as follows.

Please explain how Medical Examiners ("MEs") are alerted to each hospital death, and how the system enables them to identify any patterns or potential connections between deaths, including where deaths occur months apart or on the same ward.

1. I have answered this question in two parts, starting with the request to explain how Medical Examiners are alerted to each hospital death.

<u>How are Medical Examiners alerted to each hospital death?</u>

2. As the previous National Medical Examiner, Professor Alan Fletcher, explained in his first witness statement, "*Medical examiners are senior doctors in England and Wales who, in the period before a death is registered (five days), provide independent scrutiny of deaths not taken for investigation by a coroner*." [INQ0014570, paragraph 7].

3. The death certification reforms, which came into force from 9 September 2024, provide the statutory basis for independent review of all deaths, either by a medical examiner or coroner. Professor Fletcher updated the Inquiry in his second witness statement [INQ0108659] following the commencement of the statutory scheme and in this statement, he referred to the guidance he had published, namely the "National Medical Examiner's guidance for England and Wales" [INQ0108660]. This guidance remains the same as it was at the time of Professor Fletcher's second statement.

4. It is now a legal requirement that all deaths are independently reviewed, either by a medical examiner or a coroner before it is registered (see INQ0014570, paragraphs 32-35 and INQ0108659, paragraphs 6-9, oral hearing transcript, 12 December 2024, page 2). In the case of deaths not investigated by coroners, it is not possible to register a death without a Medical Certificate of Cause of Death with statutory declarations completed by an attending medical practitioner and medical examiner.

5. There are 125 medical examiner offices in England and 4 in Wales. The process for alerting medical examiners to deaths will vary depending on local arrangements and will also depend on where the individual dies (for example, in the hospital hosting the medical examiner office, a hospice or care home, or at home) (see paragraphs 7-8 and 101 of INQ0014570 and oral hearing transcript, 12 December 2024, page 7).

6. However, for all deaths not investigated by a coroner, the Medical Certificate of Cause of Death Regulations 2024 require attending medical practitioners to: review relevant health records and other information to establish the cause of death; prepare and sign the attending practitioner's Medical Certificate of Cause of Death ; make available to the medical examiner the Medical Certificate Cause of Death and relevant health records/any other information reviewed; be available, as far as reasonably practicable, to respond to the medical examiner's enquiries.

<u>How does the Medical Examiner System enable Medical Examiners to identify any patterns or potential connections between deaths, including where deaths occur months apart or on the same ward?</u>

7. The mechanisms for identifying patterns and trends will vary according to local arrangements and the systems established by each medical examiner office, which in many cases will be linked to the electronic records systems available at the host NHS organisation. Medical Certificates of Cause of Death are based on paper documents (which may be scanned for efficiency) but there is not currently a digital Medical Certificate Cause of Death system, and there is not a national case management IT system for medical examiners (see paragraphs 79-84 and 106 of INQ0014570, oral hearing transcript, 12 December 2024, page 64). Consequently, the arrangements at each medical examiner office need to be configured to make use of the systems available locally.

8. However, the National Medical Examiner's guidance and applicable Good Practice guidance published by the Royal College of Pathologists sets clear expectations around the following:

    a. Sharing of thematic issues and patterns, to inform learning and improvement;

    b. Responding to reasonable requests for information;

    c. Escalation of trends or patterns of concern, with regional medical examiners having a key role in this respect. I have enclosed a current regional medical examiner job description, which sets out the role expectations, in case this is of assistance to the Inquiry. You will note that the Key Functional Responsibilities include

        i. "To provide professional advice in complex cases…This may include requesting audits, studying mortality review processes and investigations regarding formal complaints about patient care";

ii. "To support local and regional analysis of Medical Certificate Cause of Death information to identify trends, patterns and unusual features of deaths…";

iii. To link with the National Medical Examiner to share any trends or patterns of concern regarding a locality or an organisation in order to facilitate prompt consideration, investigation and action".

d. The need for medical examiners to "remain vigilant for extremely rare but serious cases where there may be reason to suspect professional misconduct or criminal activity or intent". It is made clear that "Where there is reason to suspect criminal activity or intent, the police and relevant regulatory authorities must be informed".

9. The National Medical Examiner's guidance covers these points in detail, including the following instruction: "*Medical examiners should share themes, repeating issues and patterns such as clusters of cases displaying similar characteristics to inform learning and improvement. Medical examiner offices should respond positively to reasonable requests for data and intelligence regarding such trends from individuals or bodies who would reasonably be expected to request such information. Medical examiners should only decline where the information is available through other sources, or providing it would impose an unreasonable administrative burden on the office. Information governance requirements mean some types of information cannot be shared, but data such as patterns and trends will usually be aggregated or anonymised to enable dissemination without any information governance issues arising.*

Medical examiner offices should share anonymised trends or patterns of concern regarding a locality or a healthcare provider with the relevant regional medical examiner in England or Lead Medical Examiner for Wales, to facilitate prompt consideration, investigation and action. As appropriate, the regional medical examiner in England or Lead Medical Examiner for Wales will share such information with the National Medical Examiner, and in England with the relevant NHS England regional medical director or in Wales with the relevant health board medical director or the Deputy Chief Medical Officer for Wales, who has responsibility for patient safety."

10. The National Medical Examiner's guidance also notes "*medical examiner officers are well-placed to identify patterns and trends, and to act as a source of expert guidance to all users of the medical examiner system*," as they are the full-time presence in each medical examiner office, whereas medical examiners usually work a small number of sessions and spend most of their time in the clinical specialties.

11. In addition, the Good Practice paper published by the Royal College of Pathologists, *Escalating Thematic Issues* [**INQ0009270**] notes *"it is good practice to make time to reflect on learning, patterns and trends…along with feedback from bereaved people and stakeholders. Such reviews could be general, or focused on thematic areas, such as deaths following surgery or in acute medicine.*

12. *Of course, medical examiner offices should not wait for these periodic reviews to raise issues of concern. As medical examiners and medical examiner officers deliver scrutiny in real time, they should remain vigilant for issues that require immediate escalation. However, a periodic review of the overall work of the office and an*

opportunity to reflect on medical examiner scrutiny may enable staff to identify matters that might otherwise be less obvious." (see paragraph 117 of Professor Fletcher's first statement, which provides additional context [INQ0014570])

13. The Good Practice paper encourages medical examiner offices to share their findings with local healthcare providers including the NHS trust in which they are based, and with the wider healthcare system (ICBs). They identify themes and issues to regional medical examiners, who are employed by NHS England not NHS trusts, and who in turn compile summary reports for the National Medical Examiner.

Are there currently any areas that do not have MEs in place, or do not have a full quota of Mes? If so, please specify which areas are affected, how long they have been operating below the intended staffing level, and what action is being taken to address this.

14. All areas of England and Wales have medical examiner offices, as it is a legal requirement that deaths not investigated by a coroner must be independently reviewed by a medical examiner before they are registered. The Department of Health and Social Care ("**DHSC**") provide an overview of the Death Certification Reforms explaining the policy and contact details for all medical examiner offices are publicly available.

15. The DHSC carried out an impact assessment based on the premise that medical examiners would review 89% of deaths (with the remaining 11% investigated by coroners) and that for every 3,000 deaths, the staffing requirement would be 1 full time equivalent (FTE) medical examiner, and 3 FTE medical examiner officers. When medical examiner offices were being established during the implementation stage, the National Medical Examiner's office used ONS data to model estimated demand and the anticipated staffing requirement for each office. During the implementation phase NHS trusts were encouraged to move as quickly as possible to full staffing of the medical examiner office, even where the medical examiner office had not yet started scrutinising deaths from all healthcare providers in their area. In addition, some adjustments were made to staffing levels in some medical examiner offices, as experience emerged, or if there were changes to the geographical footprint or other healthcare providers linking to a medical examiner office. It should also be acknowledged that the number of deaths is not a static figure, either nationally or in each location served by medical examiner offices.

16. Since the programme started, and particularly since the death certification reforms commenced in September 2024, the activity levels reported by medical examiner offices in England have been kept under review. Once returns for Quarter 2 2025/26 were received and analysed, the National Medical Examiner's office was able to compile a complete calendar year of data and compare this to the modelled activity expectations. No regions in England had experienced more deaths than expected. However, a minority of individual medical examiner offices (30) reported higher activity levels than predicted, with 10 reporting activity more than 10% above that anticipated.

17. In addition, each medical examiner office must report the staffing levels (medical examiners and officers expressed as FTEs) at the end of each quarter, so this can be

compared to expected staffing levels. As the workforce has matured, it is normal for there to be some turnover and a level of vacancies. The National Medical Examiner's report for 2024 notes the estimated requirement for 2024/25 in England was 182.1 FTE medical examiners and 527.8 FTE medical examiner officers in England. At 31 December 2024, medical examiner offices in England reported that 185.5 full-time equivalent (FTE) medical examiners and 508.3 FTE medical examiner officers were in post. In Wales there were 13 FTE medical examiners and 39.5 FTE medical examiner officers.

18. Quarterly returns from medical examiner offices are reviewed by NHS England's regional medical examiners who stay in regular contact with medical examiner offices and provide support where required. In some cases, higher activity has been attributed to local agreements, such as trusts which have asked medical examiners to review deaths even where there is not a requirement to do so, and have provided additional resource to facilitate this. The quarterly returns also provide regional medical examiners with an opportunity to identify any particular challenges, for example if there are vacant posts. In some cases, it has been reported that NHS trusts have not immediately recruited to vacant positions, for example where budgets are under pressure and restrictions have been put on recruitment.

19. Higher than expected activity levels and vacancies do not always cause significant difficulties, but where they do regional medical examiners have taken a range of actions, including: re-aligning non-acute healthcare providers including GPs to distribute activity between medical examiner offices more evenly and in line with expectations; engagement including regional forums and visits to teams to review processes, peer review, service refinement to improve efficiency and effectiveness; supporting medical examiner offices which experienced significant staff vacancies including unblocking local recruitment freezes; supporting discussions with NHS trusts, Integrated Care Boards (ICBs) and NHS England regional teams regarding additional resources where workload was higher than anticipated (e.g., activity higher than anticipated, or case mix is causing additional work); and additional resource agreed by NHS trusts (e.g., admin staff) to clear backlogs.

What is the annual budget for the Medical Examiner service, and what proportion of the overall NHS England budget this represents? By way of context, publicly available information suggests the NHS England budget for 2024/25 was approximately £187 billion (The King's Fund).

20. There is no national, ring-fenced budget for medical examiners. While it is not within my direct remit, I have checked with colleagues within NHS England and I can confirm that the overall budget the Inquiry has attributed to NHS England for the financial year 2024/25 of approximately £187 billion is correct. As the Inquiry will be aware, this budget is determined by the DHSC.

21. The National Medical Examiner's guidance notes "*NHS bodies that host medical examiner offices and those that may fund them, such as integrated care boards (ICBs) in England, must ensure that resources allocated for medical examiner offices are fully available. The Coroners and Justice Act 2009 s18A requires the Secretary of State to ensure NHS bodies in England appoint sufficient medical examiners and that the funds and other resources made available to medical examiners are adequate to*

enable them to discharge their functions. The Secretary of State has the power to direct NHS bodies regarding resources and the appointment of medical examiners."

22. NHS England does not have a national budget for medical examiners as funding is distributed as part of ICBs' Service Development Fund (SDF). Financial arrangements have changed over the years since implementation commenced, medical examiner offices in England are now dependent on their NHS trust (and ICB) to release funding and prioritise recruitment to maintain establishment.

23. When implementation started in 2019/20, each NHS trust setting up a medical examiner office was provided a financial envelope based on notional staffing costs, the envelope figure being the maximum that would be reimbursed by NHS England. If actual staffing costs were lower, the lower amount was reimbursed. The DHSC in turn provided reimbursement to NHS England for the costs incurred. During the pandemic, wider NHS financial arrangements changed to reflect the national emergency, and specific invoicing for medical examiner offices was suspended. After the pandemic arrangements came to an end, NHS England and the DHSC agreed that funding for medical examiners would be included in the overall mandate payment from DHSC to NHS England.

24. NHS England started to move financial arrangements for medical examiners to an arrangement that was more regularised. From 2024/25, funding for medical examiner offices was distributed in ICBs' SDF allocations, and no invoicing was required. DHSC's April 2024 impact assessment for medical examiners and death certification reform notes NHS England's estimated costs "*are £56.5 million for 2024 to 2025 (in 2024 prices)*".

25. Distribution of funds to ICBs through SDF allocations continued in 2025/26, but NHS England had taken wider decisions to de-ringfence many funding streams, including but not specific to SDF/medical examiners. From this time, there was therefore no national budget or allocation specific to medical examiners.

26. NHS England's "Service Development Fund allocations technical guidance for 2025/26" (issued 30 January 2025, a copy of which is **enclosed**) notes at page 6 that "*ICBs and NHS trusts (unless the NHS trust has agreed otherwise with the National Medical Examiner) are required to provide resources for an appropriately staffed and resourced medical examiner office, as required within the standard NHS contract*." The standard NHS contract reference is to clause 3.7, page 8 of the NHS Standard Contract Service Conditions, available here 03-full-length-service-conditions-2526-cancer-amend-med-opt-mc.pdf

27. I was recently informed that NHS England's finance FAQs document ("Medium Term Planning Framework – delivering change together 2026/27 to 2028/29", a copy of which is **enclosed**) states the following:

"*6.2.9 Q: How are providers funded for medical examiner offices?*

A: Following the introduction of the statutory medical examiner system, NHS organisations are required to arrange medical examiner services for all non-coronial deaths in healthcare settings and in the community. The NHS standard contract includes a requirement for NHS trusts and FTs to operate a medical examiner office, unless agreed otherwise with the national medical examiner. Funding is included in

ICB allocations for these costs. The funding for medical examiner offices transferred from SDF into ICB core programme allocations in 2025/26, where it continues to be funded in 2026/27."

28. It should be noted that Welsh Government and the NHS in Wales have separate arrangements for funding the medical examiner service.

What information is available to the National Medical Examiner regarding how ME systems are operating at trust and regional level, including any routine reporting, oversight or monitoring arrangements?

29. Medical examiner offices in England provide a quarterly submission including activity and outcomes data they have collected, along with narrative including regarding themes and issues detected. In an **Annex** to this letter, the current detail required in quarterly submissions from medical examiner offices in England is set out.

30. The National Medical Examiner's office collates the data and provides each of NHS England's regional medical examiner with a dataset for the offices in their region. Regional medical examiners review the data and follow up queries and matters of concern this individual medical examiner offices. The enclosed Regional Medical Examiner job description illustrates expectations around this. Regional Medical Examiners then provide a summary report which is used in two ways. First, it is shared with the National Medical Examiner Oversight Group (see paragraph 126 of INQ0014570 and INQ0012398), chaired by the National Medical Examiner and meeting each quarter. Second, Regional Medical Examiners share their summary report with NHS England's Regional Medical Director (reflecting the expectation, as per the Regional Medical Examiner job description, that information and reports on mortality related issues are provided to the NHS England Regional Medical Director and their team and that the Regional Medical Examiner participates in regional mortality governance arrangements).

What systems or processes are in place to ensure that Medical Examiners hold discussions with relevant medical practitioners where a death is unusual or complex, or, in the case of neonates, where there may be limited medical records due to the child's age?

31. A core part of the role of Medical Examiners is discussion, as part of carrying out their independent scrutiny role. This is reflected in the statutory framework, specifically Regulation 8 of the Medical Certificate of Cause of Death Regulations 2024. This also includes listening and discussing cases with bereaved families, as set out in paragraphs 110-115 of Professor Alan Fletcher's First Witness Statement [INQ0014570].

32. The Medical Certificate Cause of Death Regulations 2024 (section 8) include the following requirement:

    a. *8. (1) The appropriate medical examiner, or someone acting on behalf of the examiner, must, as soon as practicable—*

        i. *take reasonable steps to discuss the cause of death with a person who is qualified to give information concerning the death under*

sections 16(2) or 17(2) of the 1953 Act or any other person whom the examiner considers appropriate;

ii. *offer a person mentioned in sub-paragraph (a) an opportunity to raise any matter which might cause the relevant senior coroner to think that there is a duty to investigate the death under section 1 of the Act; and*

iii. *make a summary record of any discussion under sub-paragraphs (a) or (b) and its outcome.*

b. *(2) Paragraph (1) does not apply where, in the case of a death for which a revised attending practitioner's certificate has been completed under regulation 13(2)(a), the appropriate medical examiner or someone acting on their behalf has previously complied with the requirements of paragraph (1) in relation to the death.*

33. The requirement applies in all cases, and that the discussion is carried out by a medical examiner or someone acting on the medical examiner's behalf. If not the medical examiner, this will normally be a medical examiner officer. Ultimately, individual medical examiners are responsible in each death for ensuring they fulfil their statutory duties set out in the Medical Certificate Cause of Death Regulations 2024, including the requirement for a discussion between the medical examiner or someone acting on their behalf and a person who is qualified to give information concerning the death.

34. The National Medical Examiner's guidance notes that the medical examiner role "complements the established statutory child death review process and gives bereaved families an opportunity to raise concerns about care provided with someone not involved in providing healthcare for the deceased."

35. The principle of an opportunity for a discussion with someone not involved in providing care is fundamental to the medical examiner system. Every bereaved family, especially those who have lost a baby or child, should be offered the opportunity to speak with a medical examiner (or medical examiner officer) because they will not have been involved in providing care and thereby offer an independent person who families can ask questions of and raise concerns with.

36. The previous National Medical Examiner published advice on this in The Good Practice paper addressing deaths of children and neonates (published by the Royal College of Pathologists), which includes the recommendation that:

"After the death of a child or neonate, medical examiners (or medical examiner officers on their behalf) 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; families who are bereaved after the death of an infant or child will have equal opportunity to discuss any concerns with an independent person. As in adult deaths, the medical examiner will help the clinical team navigate the legal requirements of referral to the coroner where there is uncertainty or concern."

As part of quarterly submissions (set out in the Annex) to the National Medical Examiner, medical examiner offices in England must report the proportion of all deaths for which the bereaved take up the offer of a discussion. The data submission collects the numbers of those who do not take-up the offer of a discussion in the aggregate. It does not allow us to distinguish between deaths of children and adults. As a reminder, the offer of such a discussion has been a requirement of the Medical Certificate Cause of Death Regulations 2024 since the Death Certification Reforms were implemented in September 2024. In the four quarters for which data is available, medical examiner offices in England reported the proportion of deaths for which this occurred has ranged between 96% and 98%. In the remaining cases, some bereaved families do not respond or decline the offer of a discussion, and some deceased patients do not have identified next of kin. If I can assist the Inquiry further, please do not hesitate to be in touch.

Yours sincerely

PD

Dr Huw Twamley

National Medical Examiner

NHS England

nme@ I&S

https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/