

Medical Examiner is one of the DH (e-Learning for Healthcare) projects. The project supports government reforms to services and systems of death certification and Coroners' practice that are being introduced from 2012. These reforms concern every doctor in England and Wales.

In 2007, in response to the recommendations of the Shipman Inquiry, the Department of Health called for reform of the current death certification process. Based upon the Inquiry's findings, the DH proposed that a new role of Medical Examiner be established within healthcare environments. The position will be introduced in England and Wales from 2012, and it is estimated that up to 1000 Medical Examiners, most of whom will be part-time appointments, may be required.

Medical Examiners will be appropriately trained senior doctors who will verify clinical information on Medical Certificates of Cause of Death (MCCDs), to ensure appropriate referrals to the Coroner and accuracy and consistency of MCCD content. The documentation and circumstances surrounding the majority of deaths in England and Wales will be scrutinised.

The curriculum to support the role of Medical Examiner has been defined by a working collegiate of representative organisations, hosted by the Royal College of Pathologists.

The Medical Examiner project will provide approximately 30 hours of e-learning content to support the delivery of the curriculum. Together with some face-to-face training, the learning will encompass all aspects of the new role. Doctors will be able to enrol for Medical Examiner training in early 2011 to enable them to undertake the Medical Examiner role on its introduction.

Medical Examiner encompasses training in:

- Completion of the MCCD and Death Registration
- The Law and the Coroner
- The Examination and Disposal of the Body of the Deceased
- Interaction with the Bereaved
- Example case scenarios

For more information visit www.e-lfh.org.uk/medical_examiner

Medical Examiner project e-Learning Curriculum v15 26th October 2010				Resource	
No.	Session No.	Session Title	Learning Objectives	ME Allocated	CA Allocated
1	MEX_00_01	The Role of a Medical Examiner	<ul style="list-style-type: none"> Describe the origins of the medical examiner system and how it is constructed Describe the context in which medical examiners will work and their key relationships Discuss the importance of independence 	Alan Fletcher	Alan Fletcher
	MEX_01	Death Certification			
2	MEX_01_01	The Medical Certificate of Cause of Death	<ul style="list-style-type: none"> Describe the purpose of the medical certificate of the cause of death Identify pertinent ethical issues Recall relevant statute and case law examples to ensure proper completion of the medical certificate of cause of death 	Emyr Benbow/ George Fernie	George Fernie
3	MEX_01_02	Completion of the Medical Certificate of Cause of Death Part 1: Formal Section	<ul style="list-style-type: none"> Outline the purpose of the medical certificate of cause of death Identify what and how information needs to be entered to complete the formal part of the medical certificate of cause of death correctly Complete the formal part of the medical certificate of cause of death 	Emyr Benbow/ George Fernie	David McLay
4	MEX_01_03	Completion of the Medical Certificate of Cause of Death Part 2: Rest of Certificate	<ul style="list-style-type: none"> Identify the information needed to complete the remaining parts of the MCCD Enter the necessary information to complete the MCCD 	Emyr Benbow/ George Fernie	David McLay

5	MEX_01_04	Completion of the Medical Certificate of Cause of Death Part 3: Scenarios	<ul style="list-style-type: none"> • Employ an understanding on how to complete a medical certificate of cause of death • Demonstrate a greater awareness of common mistakes in the process • Improve your ability in identifying the underlying cause of death • Demonstrate the necessary confidence to complete the document accurately in order that the public have confidence in the system 	Emyr Benbow/ George Fernie	David McLay
6	MEX_01_05	International and National Regulations on Death Certification Part 1: Purpose	<ul style="list-style-type: none"> • Describe the international obligations on death certification and mortality statistics • Describe how the Medical Certificate of Causes of Death (MCCD) in England and Wales is derived from ICD-10 • Explain the definition and importance of the underlying cause of death and its use for mortality statistics and public health 	George Fernie	Cleo Rooney
7	MEX_01_06	International and National Regulations on Death Certification Part 2: Certification	tbc	George Fernie	Cleo Rooney
8	MEX_01_07	New Processes and Legislation Part 1: The End-to-end Process	<ul style="list-style-type: none"> • Explain the aims of the end-to-end process for death certification in England and Wales • Identify the key steps in the process for death certification in England and Wales • Describe the key aspects of each step in the process 	Alan Fletcher/Chris Dorries	Paul Ader
9	MEX_01_08	New Processes and Legislation Part 2: Operational Activities and Responsibilities of the Medical Examiner	<ul style="list-style-type: none"> • Summarise the operational activities for which the medical examiner is directly responsible • Explain the management responsibilities of the medical examiner • Describe the limitations of the medical examiner's role 	Alan Fletcher/Chris Dorries	Paul Ader

10	MEX_01_09	New Processes and Legislation Part 3: Information Flows and Forms	<ul style="list-style-type: none"> • Identify the scope of medical records that are likely to be required by medical examiners • Outline the purpose, contents and use of the statutory forms within the process • Identify existing technologies that may be used to minimise form filling and maximise the availability of management information within the process 	Alan Fletcher/Chris Dorries	Paul Ader
11	MEX_01_10	New Processes and Legislation Part 4: Appointment, Performance and Accountability of the Medical Examiner	<ul style="list-style-type: none"> • List the requirements for the appointment of medical examiners • List the minimum standards and expected levels of performance for the Medical Examiner's Service • Describe the accountability of the Medical Examiner's Service to its primary care trust/local health board (PCT/LHB) • Describe the professional accountability of medical examiners to the National Medical Examiner 	Alan Fletcher/Chris Dorries	Paul Ader
12	MEX_01_11	New Processes and Legislation Part 5: Ethical Framework	<ul style="list-style-type: none"> • Identify key ethical issues that may arise in relation to the work carried out by the Medical Examiner's Service • Analyse appropriate responses for addressing ethical issues that may arise in relation to the work carried out by the Medical Examiner's Service 	Alan Fletcher/Chris Dorries	Paul Ader
13	MEX_01_12	Medical Examiner's Officers Part 1: The Role of the Medical Examiner's Officer	<ul style="list-style-type: none"> • Explain how the medical examiner's officer assists in the medical examiner process • Identify who the medical examiner's officer works with to obtain and prepare information for scrutiny and to complete the medical examiner process after scrutiny • Identify the key types of information the medical examiner's officer needs to obtain/prepare for scrutiny and explain the importance of each type of information • Describe the process used by the medical examiner's officer to collect and prepare information for scrutiny and to complete the process after scrutiny 	Alan Fletcher	Daisy Shale

14	MEX_01_13	Medical Examiner's Officers Part 2: MEO's Contact with the Relatives of the Deceased	<ul style="list-style-type: none"> Identify the problems associated with discussing the cause of death with the recently bereaved Explain how these problems can be overcome Describe the limitations of the medical examiner's officer's role 	Alan Fletcher	Daisy Shale
15	MEX_01_14	New Processes and Legislation Part 6:	tbc	Alan Fletcher/Chris Dorries	Paul Ader
	MEX_02	Death Registration			
16	MEX_02_01	The Death Register	<ul style="list-style-type: none"> Define the process for death registration in England and Wales Describe which documentation is normally required to register a death in England and Wales List the documents that are issued following death registration in England and Wales 	George Fernie	John Lee
	MEX_03	Clinical Governance			
17	MEX_03_01	Confidential Enquiries	<ul style="list-style-type: none"> Describe what is meant by and the achievements of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). Describe the Centre for Maternal and Child Enquiries (CMACE) and its aims. Discuss the function of the National Confidential Inquiry into suicide and homicide by people with mental illness (NCISH) and what it hopes to achieve. 	George Fernie	George Fernie
18	MEX_03_02	Investigating and Reporting Poor Performance Part 1: Recognition	<ul style="list-style-type: none"> List the qualities and standards expected of good doctors Identify what constitutes poor medical practice and poor performance Recognise poor performance State the causes of poor performance State the importance of recognising and dealing with poor performance 	Alan Fletcher/ George Fernie	Anthea Martin

19	MEX_03_03	Investigating and Reporting Poor Performance Part 2: Management	<ul style="list-style-type: none"> • Explain who can report poor performance and how • Describe the role of NHS organisations in investigating doctors suspected of poor performance • Explain the role of National Clinical Assessment Service (NCAS) in cases where there are concerns over a doctor's performance • Describe the role and powers of the GMC • Identify sources of support and advice given to doctors under investigation 	Alan Fletcher/ George Fernie	Anthea Martin
20	MEX_03_04	Major Incidents and the Medical Examiner	<ul style="list-style-type: none"> • Outline the normal functions of a coroner • Describe the coroner's key interactions with other members of the emergency response team • List the main responsibilities of the coroner following a major incident • State the different methods used to identify the deceased victims of major incidents 	Alan Fletcher/ George Fernie	Peter Vanezis
21	MEX_03_05	Pandemic Influenza and the Medical Examiner	<ul style="list-style-type: none"> • Outline the possible effects of an influenza pandemic • Describe the special arrangements for the disposal of bodies in a pandemic • Identify the role of the medical examiner in a pandemic 	Alan Fletcher/ George Fernie	Charles Saunders
22	MEX_03_06	Revalidation of Medical Examiners	<ul style="list-style-type: none"> • To review how you will prepare for revalidation. • To describe what is meant by revalidation. 	George Fernie	Ian Wall
	MEX_04	Interacting with the Bereaved			
23	MEX_04_01	The Bereavement Office	<ul style="list-style-type: none"> • Identify the different types of bereavement service most commonly found in a hospital setting • Outline the core functions of a hospital bereavement office • Identify the key information and documents that the bereavement office may be required to provide to the medical examiner service • Outline how bereavement staff can contribute to facilitating greater transparency for relatives/next of kin • List the potential pressure points for bereavement officers and examine how they can be addressed 	Alan Fletcher	Kathryn Griffin

24	MEX_04_03	Psychology of Bereavement and Loss and the Medical Examiner's Role	<ul style="list-style-type: none"> • Identify what bereavement is • Recognise how it affects us all • Describe its relationship to grief and mourning • List the symptoms and signs in the early, middle and late stages of bereavement 	Alan Fletcher	David Lord
25	MEX_04_04	Supporting the Bereaved Part 1: Cultural Considerations in Bereavement	<ul style="list-style-type: none"> • List the beliefs of the major religions • Describe why there may be some difficulties surrounding deaths reported to the coroner in some groups • List the different cultural groups that may object to delays for burial or cremations 	Alan Fletcher	David Lord
26	MEX_04_05	Supporting the Bereaved Part 2: Difficult Bereavements and Sources of Help	<ul style="list-style-type: none"> • Identify difficulties specific to those suffering the death of a child • Identify difficulties specific to those experiencing a sudden death, the young, the elderly, and those with learning difficulties • Identify the needs of the very young and those with learning difficulties depending on their capacity to understand what has happened; and what they can expect 	Alan Fletcher	David Lord
	MEX_05	Scrutiny of Documents and Circumstances Surrounding a Death			

27	MEX_05_01	Medical Records Part 1: Ethical and Professional	<ul style="list-style-type: none"> List the ethical requirements of medical record keeping, in particular General Medical Council (GMC) guidance Locate National Health Service (NHS) guidance in relation to the confidentiality of medical records and guidance on the retention and destruction of medical records Recognise the role of Caldicott Guardians in the NHS Assess whether disclosure of medical records without consent may be justified in the public interest Summarise the joint Royal College of General Practitioners/General Practitioners Committee/Department of Health (RCGP/GPC/DoH) guidelines on Good Practice Guidelines for General Practice Electronic Patient Records (2005) Recognise the NHS agency Connecting for Health and its functions 	Emyr Benbow	Michael Devlin
28	MEX_05_02	Medical Records Part 2: Legal	<ul style="list-style-type: none"> Identify the application of the Data Protection Act 1998 to medical records Identify situations in which the Access to Health Records Act 1990 applies and its provisions State the circumstances where the disclosure of medical records may be required 	Emyr Benbow	Michael Devlin
29	MEX_05_03	National Protocol for Scrutiny Part 1:	tbc	Alan Fletcher	Emyr Benbow
30	MEX_05_04	National Protocol for Scrutiny Part 2:	tbc	Alan Fletcher	Emyr Benbow
31	MEX_05_05	When Further Information Arrives	<ul style="list-style-type: none"> Identify the action that should be taken when, during the registration, the informant reveals information bearing on the cause of death contained in the medical certificate of the cause of death (MCCD) Apply any action that should be taken when information bearing on the cause of death comes to light after the MCCD has been issued and the death has been registered 	Emyr Benbow	John Lee
32	MEX_05_06	Scenario: Unexpected Death in a Hospital Emergency Department	<ul style="list-style-type: none"> Apply some techniques of scrutiny of the circumstances surrounding a death in the emergency department 	Emyr Benbow	Alan Fletcher

33	MEX_05_07	Scenario: Telephone Advice to a Junior Hospital Doctor	<ul style="list-style-type: none"> Recall a systematic approach to a telephone discussion with a junior doctor regarding a death Discuss ways of supporting a junior doctor in understanding when and how to complete a Medical Certificate Cause of Death (MCCD) 	Emyr Benbow	Alan Fletcher
34	MEX_05_08	Scenario: When is Old Age Acceptable on an MCCD?	<ul style="list-style-type: none"> Describe the circumstances when 'old age' can be appropriately recorded on a medical certificate of the cause of death (MCCD) Advise when the death of a frail, elderly person should be reported to the coroner Describe the evidence required for completion of an MCCD in deaths of the frail elderly 	Alan Fletcher	Simon O'Connor
35	MEX_05_09	Scenario: Expected Deaths Outside Hospital Including Palliated Cases	<ul style="list-style-type: none"> Explain the difference between relieving symptoms and accelerating death in palliative care Describe the circumstances when expected palliated deaths need reporting to the coroner Explain how to proceed if a medical examiner suspects an excess of palliated deaths from a particular practitioner or group of practitioners 	Alan Fletcher	Simon O'Connor
36	MEX_05_10	Scenario: Post-operative Death Following a Blood Transfusion	<ul style="list-style-type: none"> Explain how the circumstances surrounding a death, possibly related to complications of appropriate therapy, may require investigation by the coroner Investigate, in a proportionate manner, a death related to a known complication of appropriate therapy 	Emyr Benbow	Adrian Bateman
37	MEX_05_11	Scenario: Death After Coronary Stenting	<ul style="list-style-type: none"> Recall that various complications of appropriate therapy may lead to death, and state how to investigate them in a proportionate manner Explain that coroners are at liberty to deal with such cases in a variety of ways List the various sources of information that will help you complete your duties as a medical examiner in such cases 	Emyr Benbow	Kim Suvarna

38	MEX_05_12	Scenario: GP Case Cause of Death not Justifiable by Circumstances	<ul style="list-style-type: none"> • Describe the duties of the medical examiner when the cause of death on a medical certificate of cause of death (MCCD) is not justified • Explain that it may not be in the best interest of families to complete MCCDs with inaccurate or incomplete information to avoid referral to the coroner, and recall that this is also an offence • Recall that there is a significant rate of discrepancy between clinical and subsequent autopsy diagnoses 	Emyr Benbow	Mike Harris
39	MEX_05_13	Scenario: Death with MRSA Suspicion	<ul style="list-style-type: none"> • Recognise the issues surrounding health care infections and the importance of the Chief Medical Officer's instruction that they should appear on the MCCD, where appropriate • Appreciate the importance to families of health care infections, and the significance of the difference between carriage and clinically-relevant infection • Understand that it is the Coroner's decision to instigate, or not, any post mortem investigation 	Emyr Benbow	John Duparc
40	MEX_05_14	Scenario: Death Following Minor Fall	<ul style="list-style-type: none"> • Explain that minor falls may precipitate major and potentially fatal sequelae • Explain that falls may be a consequence of collapses caused by natural disease, including fatal natural disease • Recognise when to contact the coroner if in doubt about the significance of a fall preceding death 	Emyr Benbow	Michael Osborn
41	MEX_05_15	Scenario: Natural Death Given as an Either/Or	<ul style="list-style-type: none"> • Recognise the need for precision on a medical certificate of cause of death (MCCD) • Recall the primary ways of including multifactorial causes of death within an MCCD • Understand the relationship between the different components of the statement of the cause of death on an MCCD 	Emyr Benbow	Mike Harris

42	MEX_05_16	Scenario: Death of a Woman with Epilepsy	<ul style="list-style-type: none"> • Explain the concepts of natural and unnatural deaths • Recognise the range of deaths that are regarded as unnatural • Explain that a death remains unnatural, no matter how long the delay between the original 'unnatural' incident and the death 	Emyr Benbow	Michael Osborn
43	MEX_05_17	Scenario: Death of an Elderly Nursing Home Resident	<ul style="list-style-type: none"> • Identify the circumstances where it is appropriate to certify a death as being due to old age • Recognise when it may be valuable to discuss such cases with the coroner before completing your scrutiny of a medical certificate of the cause of death (MCCD) • Describe how to take a proportionate view when scrutinising deaths that are said to be from chronic diseases that may lead to death in old age 	Emyr Benbow	Adrian Bateman
44	MEX_05_18	Scenario: Natural Death Certified with Symptoms Only	<ul style="list-style-type: none"> • List the possible actions open to you when scrutinising an MCCD where there is no acceptable cause of death • Recall some common errors in the formulation of the MCCD cause of death • Explain the importance of the standardised format of the MCCD for coding by the Office of National Statistics 	Emyr Benbow	Mike Harris
45	MEX_05_19	Scenario: Death from Natural Disease Following Refusal of Treatment	<ul style="list-style-type: none"> • Describe, in outline, the issues of consent and capacity in relation to treatment of potentially fatal diseases • Explain the subtle distinction between informed refusal of treatment and self-neglect • State how to proceed when death is related to refusal of treatment 	Emyr Benbow	Kim Suvarna

46	MEX_05_20	Scenario: Death of an Elderly Lady	<ul style="list-style-type: none"> • Explain the concept of death due to a lack of self-care or care by others • Express a proportionate view of situations where a lack of self-care may have contributed to death, when deciding if they should or should not be reported to the coroner • Explain that death due to a natural cause may still require investigation by the coroner when it is caused by neglect 	Emyr Benbow	Michael Osborn
47	MEX_05_21	Scenario: Suspicion of a Work Related Death	<ul style="list-style-type: none"> • Explain the importance of assessing whether death may be due to industrial disease • Identify the major industrial causes of potentially fatal disease • Describe how deaths attributed to industrial disease should be considered • Explain the importance of the coroner's investigation in such cases 	Emyr Benbow	John Duparc
48	MEX_05_22	Scenario: Death Following Palliative Care	<ul style="list-style-type: none"> • List the criteria for completing a medical certificate of the cause of death (MCCD) when the patient has not been seen by the general practitioner (GP) in the last 14 days of life • Explain the options open to the ME when the patient's GP has not seen the patient during a well-defined terminal illness 	Emyr Benbow	John Duparc
49	MEX_05_23	Scenario: Death in Patient on Warfarin Modest Elevation of INR	<ul style="list-style-type: none"> • Explain how to provide proportionate scrutiny and investigation when patients die from the complications of appropriate medical therapy • Recall the importance of close liaison with the local coroner when dealing with such cases, and recognise that different coroners have different approaches • Describe the various sources of information that will help you complete your duties as a medical examiner in such cases 	Emyr Benbow	Kim Suvarna

50	MEX_05_24	Scenario: Death in a Child Known to Suffer from Cerebral Palsy	<ul style="list-style-type: none"> Recall the circumstances where it is appropriate certifying death as being due to cerebral palsy Understand the value of discussing such cases with the coroner before completing your scrutiny of an MCCD Recognise the chronic diseases that may lead to death in cerebral palsy, and realise how to take a proportionate view when scrutinising deaths that are said to be related to such diseases 	Emyr Benbow	Gauri Batra
51	MEX_05_25	Scenario: Death of a Preterm Infant Delivered Alive Following Termination	<ul style="list-style-type: none"> Medical termination of pregnancy (especially in mid trimester for congenital abnormalities diagnosed at 20 week anomaly scan or even later due to maternal conditions) may result in a live birth. Live birth can occur at any gestation when any sign of life is seen Any sign of life constitutes a 'live birth' and that this can occur at any gestation period In such cases the infant is to be registered as a live birth and thus needs birth certificate and hence a death certificate Such live births are to be reported to the coroner and some of these cases may need a post mortem examination It is important to discuss such cases with the coroner before completing your scrutiny of a medical certificate of the cause of death (MCCD). 	Emyr Benbow	Gauri Batra
52	MEX_05_26	Scenario: Death of a Child with Cancer	<ul style="list-style-type: none"> Explain that the principles of scrutiny apply equally to children cases and few expected deaths will require referral to the coroner Explain that clinical governance systems are in place to investigate public health concerns and that it is not usually the remit of the medical examiner to investigate such concerns State that the Child Death Overview Panel will also review cases at a later point 	Emyr Benbow	Alan Fletcher

53	MEX_05_27	Scenario: Death Following Police Contact	<ul style="list-style-type: none"> • Explain what constitutes a 'death in police care or custody' • Identify the key information required to assist in determining whether 'death in police care or custody' has taken place • Identify where to seek other relevant information to assist in determining the causes of death • State which other bodies may have interest in or influence on how a death in police custody is investigated 	Emyr Benbow	Jason Payne-James
54	MEX_05_28	Scenario: Death Following Arrest and Hospital Attendance	<ul style="list-style-type: none"> • Describe the relationship between medical care in police custody and medical care in the hospital emergency department • Identify the critical factors affecting the delivery of appropriate and effective medical care • Explain the rationale for clear inter-agency transfer of medically-relevant information • Explain why the enduring nature of care is particularly important in people with long-term medical conditions 	Emyr Benbow	Jason Payne-James
55	MEX_05_29	Scenario: Death of a patient in hospital under supervision in the community	<ul style="list-style-type: none"> • Describe the relevance of safeguarding adult procedures to practice as the ME. • Explain the options open to the ME when a patient under an adult safeguarding process dies and neglect may have been contributory. • Understand the value of triangulating multiple sources of information, when the initial information received is contradictory or controversial. • Describe the importance of ensuring that families understand the nature and limitations of the ME's scrutiny, and of any investigation by the coroner 	Emyr Benbow	Susan Benbow
	MEX_06	The Body of the Deceased			

56	MEX_06_01	Human Tissue Act 2004 Part 1: Overview	<ul style="list-style-type: none"> • Explain what the Human Tissue Act 2004 (HT Act) regulates and what new offences it created. • List the nine areas that are covered in the acts code of practice. • Understand what is considered as “relevant material” by the HTA. • Define when consent is required for the storage and use of human tissue and who can give consent. • List the activities that must be licenced under the HT Act. 	Emyr Benbow	James Ironside
57	MEX_06_02	Human Tissue Act 2004 Part 2: Regulations for Post Mortems and Human Tissue	<ul style="list-style-type: none"> • Explain how the Human Tissue Act 2004 (HT Act) creates a framework to regulate the removal, storage and retention of human tissue during post mortem examinations • Define the HTA Codes of Practice that apply to hospital and coroner’s post mortem examinations under the HT Act • List the methods for disposal of human tissue from the deceased given in the HTA Code of Practice on Disposal • Explain how the HT Act regulates the disposal of human tissue from the living and following pregnancy loss • Define the circumstances under which the HT Act allows the use of human tissue for research 	Emyr Benbow	James Ironside
58	MEX_06_03	Tissue Donation and Organ Transplant Part 1: Introduction	<ul style="list-style-type: none"> • Explain the basic selection criteria, retrieval and referral systems for potential organ and tissue donors. • Describe various research options, NHS and commercial and the criteria for suitability. • Demonstrate awareness of current legislation and consent and the relevance to HTA requirements. • Explain the main influencing factors in donation decisions from both the family and HCP. 	Emyr Benbow	Emma Winstanley

59	MEX_06_04	Tissue Donation and Organ Transplant Part 2: The Donation Process and Coronial Law	<ul style="list-style-type: none"> • Describe the interaction between transplant professionals and the HM coroner. • Explain the importance of lack of objection, jurisdiction and the role of the pathologist and APT and the donation process. • Demonstrate awareness of current legislation with regards to consent hierarchy and HTA requirements. • Describe and discuss complex cases, family dynamics and the law. Explain the relevance of competency and the EU Directive. • Describe HTA licensing in relation to the donation process. 	Emyr Benbow	Emma Winstanley
60	MEX_06_17	Tissue Donation and Organ Transplant Part 3: The Role of the Pathologist	<ul style="list-style-type: none"> • Describe a practical approach to examining the body of the deceased • Explain how this differs from examining the body of the living and state the limitations inherent in examining the dead externally • Explain why surface marks and injuries need to be considered in the context of the other available evidence • Outline the circumstances which should prompt further investigation and/or referral to the coroner 	Emyr Benbow	Paul Johnson
61	MEX_06_05	External Examination of the Body	<ul style="list-style-type: none"> • Identify the infective diseases that require notification, and know how to notify them, and to whom • Recognise the public health implications of serious infective diseases • Understand when it may be appropriate to contact the coroner about a death related to infectious disease 	Emyr Benbow	Sebastian Lucas
62	MEX_06_06	Implications of Serious Infective Disease	<ul style="list-style-type: none"> • Describe the post mortem process, particularly the differences between a coroner's post mortem and a hospital post mortem • Define the important elements of the Human Tissue Act (HT Act) in its regulation of the post mortem process • Describe the procedure for gaining consent • Determine who may give consent, particularly in cases where there are conflicting family wishes 	Emyr Benbow	Angus McGregor

63	MEX_06_07a	Post Mortem Examination Part 1: Consent	<ul style="list-style-type: none"> • Explain the basic procedure of the post mortem examination • Identify factors that indicate whether a post mortem examination is likely to establish the cause of death • Identify investigations that are unlikely to produce useful information, so that they can be minimised 	Emyr Benbow	Angus McGregor
64	MEX_06_07b	Post Mortem Examination Part 2: Autopsy Practice	<ul style="list-style-type: none"> • Explain to relatives what samples may be removed at post mortem examination • Describe the information that may be derived from those samples, and its potential value in refining the conclusions drawn from the examination 	Emyr Benbow	Emyr Benbow
65	MEX_06_08	Post Mortem Examination Part 3: Investigations After the Autopsy	<ul style="list-style-type: none"> • Explain to relatives what is meant by non-invasive and minimally-invasive post mortem examinations • Explain that, in a coroner's case, the choice of type of autopsy is entirely at the discretion of the coroner • Describe the information that may be derived from those investigations • Recognise the advantages, disadvantages and availability of non-invasive and minimally-invasive post mortem examinations • Summarise the current evidence derived from studies into adult and fetal/perinatal autopsy using non-invasive and minimally-invasive post mortem examinations 	Emyr Benbow	Ian Roberts/E Benbow
66	MEX_06_09	Non-invasive and Minimally-invasive Post Mortems	<ul style="list-style-type: none"> • Explain to relatives the various methods of disposal available to them • Explain the restrictions associated with some forms of disposal 	Emyr Benbow	Terry Johnson
67	MEX_06_10	Disposal of the Body Part 1: Legal Disposal Methods	<ul style="list-style-type: none"> • Explain the statutory and procedural requirements associated with disposal • Describe how you can assist the bereaved in satisfying these statutory requirements 	Emyr Benbow	Terry Johnson

67	MEX_06_11	Disposal of the Body Part 2: Statutes, Procedures and Limitations	<ul style="list-style-type: none"> • Describe the procedures for donating bodies for anatomical examination • Distinguish between the regulations for those donations consented before and after the Human Tissue Act was implemented • Identify the legal and medical reasons that prevent bodies from being accepted for donation • Identify the importance of timely action upon the death of a potential donor 	Emyr Benbow	Louise Evans
69	MEX_06_12	Donating Bodies for Anatomical Examination	<ul style="list-style-type: none"> • Explain critically the fundamental underlying beliefs and values of the Abrahamic faith. • Differentiate the held principles of the different religions within the Abrahamic faith namely Judaism, Christianity, Islam, the Baha'i Community and Rastafarianism. • Discuss their diverse attitudes toward death. • Appreciate the religious diversity in caring for the deceased, including funeral and body disposal preferences. • Examine the religious variations in stance towards organ donation and the autopsy. • Critically reflect on the relevance of religious holy days and festivals in caring for the deceased and their family. 	Emyr Benbow	Jane Ruddy

70	MEX_06_13	Faith Considerations Part 1: Abrahamic Faiths	<ul style="list-style-type: none"> • Explain critically the fundamental underlying beliefs and values of the Dharmic faith • Differentiate analytically the held principles of the different religions within the Dharmic faith: Hinduism, Buddhism, Jainism and Sikhism. • Discuss the diverse attitudes toward death within the various religious groups • Appreciate the religious diversity in caring for the deceased after death, including funeral and body disposal preferences • Examine the religious variations in stance towards organ donation and the autopsy • Critically reflect on the relevance of the religious calendar in caring for the deceased and their family 	Emyr Benbow	Jane Ruddy
71	MEX_06_14	Faith Considerations Part 2: Dharmic Faiths	<ul style="list-style-type: none"> • Explain critically the fundamental underlying beliefs and values of the Far Eastern traditions; • Differentiate analytically the held principles of the differing religions within the Far Eastern namely Taoism, Shinto and Confucianism. • Discuss the diverse attitudes toward death within the various religious groups; • Appreciate the religious diversity in caring for the deceased after death including funeral and body disposal preferences; • Examine the religious variations in stance towards organ donation and the autopsy; • Critically reflect on the relevance of the religious calendar in caring for the deceased and their family. 	Emyr Benbow	Jane Ruddy

72	MEX_06_15	Faith Considerations Part 3: Far Eastern Faiths	<ul style="list-style-type: none"> • Explain critically the fundamental underlying beliefs and values of the Other faith traditions • Differentiate analytically the held principles of the differing religions within the Other faith traditions namely Atheism, New Age Spirituality and Zoroastrianism. • Discuss the diverse attitudes toward death within the various religious groups; • Appreciate the religious diversity in caring for the deceased after death including funeral and body disposal preferences; • Examine the religious variations in stance towards organ donation and the autopsy; • Critically reflect on the relevance of the religious calendar in caring for the deceased and their family 	Emyr Benbow	Jane Rutty
73	MEX_06_16	Faith Considerations Part 4: Other Traditions	<ul style="list-style-type: none"> • Discuss the impact of the Human Tissue Act 2004 on the practice of gaining consent for tissue and organ donation • Recall the statistics that reflect the current attitudes towards donation amongst the general public • List the main issues relating to donation from a family perspective • List the main issues relating to donation from a Health Care Professional perspective 	Emyr Benbow	Jane Rutty
	MEX_07	Death of Children			
74	MEX_07_01	The Law and Death of Children Part 1: Definitions	<ul style="list-style-type: none"> • Interpret and apply the law in the relevant circumstances relating to the deaths of children • Identify and distinguish between Sudden Unexpected Death in Infancy (SUDI), Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Death in Childhood (SUDEC) • List the issues of consent relating to SUDI, SIDS and SUDEC • Describe how to minimise distress to bereaved parents while maintaining compliance with the law 	Emyr Benbow	Marta Cohen

75	MEX_07_02	The Law and Death of Children Part 2: Stillbirth Intrapartum and Neonatal Death	<ul style="list-style-type: none"> • Apply the law regarding the investigation of early neonatal death • Describe how to guide bereaved parents through the investigations in a sensitive manner • Describe and distinguish between the concepts of different modalities of intrapartum deaths (intrapartum asphyxia vs. intrapartum trauma) • Identify the importance of common risk factors in all types of intrapartum death • Describe the problems involved in concealed pregnancy • Describe the problems involved in precipitous delivery • Identify the issues of consent relevant in these cases 	Emyr Benbow	Marta Cohen
76	MEX_07_03	The Law and Death of Children Part 3: Unnatural and Suspicious Circumstances	<ul style="list-style-type: none"> • Identify general aspects of neglect and child abuse • List the modes of death in child abuse • Distinguish between the range of likely accidental and likely non-accidental injuries in children • Describe the differences in protocol when the death being investigated becomes suspicious 	Emyr Benbow	Marta Cohen
77	MEX_07_04	The Law and Death of Children Part 4: The LSCB and the Role of the Medical Examiner	<ul style="list-style-type: none"> • Identify the role of the Local Safeguarding Children's Board • Describe the processes followed when a child dies and the coroner is involved and cases where there is no coroner involvement • Identify the appropriate procedure for a variety of scenarios involving the death of a child 	Emyr Benbow	Marta Cohen
	MEX_08	The Law and the Coroner			
78	MEX_08_01	HM Coroner's Office Part 1: Office Structure and Remit	<ul style="list-style-type: none"> • Contrast the roles of the coroner, coroner's officers and coroner's clerks • Describe the typical office structure and functions, noting the frequent variation in role between officers and clerks in different areas • Explain the relationship between the coroner and his/her deputies and also the coroner's relationship with local and central government • Identify appropriate methods of interaction with the coroner and other members of the coroner's team 	Christopher Dorries	Tony Williams

79	MEX_08_02	HM Coroner's Office Part 2: Coroner's Right to Enquire	<ul style="list-style-type: none"> • Demonstrate knowledge of selected relevant legislation, case law and practice pertaining to the work of coroner, and in particular: <ul style="list-style-type: none"> - The basis of the coroner's decision to inquire into a particular death - The coroner's right to possession of the body - The necessity to hold an autopsy and the associated principles including – choice of pathologist, who can attend an autopsy and the right to a copy of the report - Legal and practical requirements where tissue is retained at autopsy 	Christopher Dorries	Tony Williams
80	MEX_08_03	HM Coroner's Office Part 3: Coroner's Inquiries	<ul style="list-style-type: none"> • Describe the process by which the Coroner deals with different types of case (Form A, Form B and proceeding to inquest). • Identify the basis for the decision to hold an inquest and legal principles. • Recognise the purpose of the inquest in terms of both legal and practical principles. • Analyse the nature of the Coroner's relationship with families and others affected by the inquiry and in particular the requirements arising from the need for visible independence. • Discuss briefly the affect of the European Convention on Human Rights on the Coroner's work (in particular considering the effect or Articles 2 and 8) • Apply relevant legal principles to specific cases. 	Christopher Dorries	Tony Williams
81	MEX_08_04	The Unnatural Death Part 1: Coroner's Jurisdiction	<ul style="list-style-type: none"> • Describe the concept of a 'sudden death of unknown cause' with relevance to coronial jurisdiction • Describe the concept of an 'unnatural death' with relevance to coronial jurisdiction • Explain the principle of 'reasonable cause to suspect' • Recognise straightforward examples of an unnatural death 	Christopher Dorries	Sheriff Payne

82	MEX_08_05	The Unnatural Death Part 2: Unnatural Originating Events	<ul style="list-style-type: none"> • Question the effects of an unnatural originating event on a seemingly natural death • Define the 'chain of causation' • Identify the importance of immediate discussion with the coroner where an apparently natural death was preceded by a potentially unlawful event • Articulate the need for consistent judgement over which deaths are unnatural • Recognise more complex examples of an unnatural death 	Christopher Dorries	Sheriff Payne
83	MEX_08_06	The Unnatural Death Part 3: Neglect or Medical Care	<ul style="list-style-type: none"> • Describe the general principles of a death contributed to by neglect • Identify the circumstances in which an unnatural death may occur in medical care • Illustrate that a death due to a recognised complication of a procedure or treatment is still likely to be unnatural 	Christopher Dorries	Sheriff Payne
84	MEX_08_07	The Unnatural Death Part 4: Rare Cases	<ul style="list-style-type: none"> • Identify examples of potentially unnaturally contracted and rare diseases that can be difficult to categorise as natural or unnatural • Outline the necessity to follow precedent and national guidance in all decisions on whether a death is unnatural • Recognise the value of seeking advice at an early stage on more complex decisions about whether a death is unnatural • Outline the necessity to resist inappropriate pressure from relatives, clinicians or others in relation to whether or not a death is referred to the coroner 	Christopher Dorries	Sheriff Payne

85	MEX_08_09	Repatriation	<ul style="list-style-type: none"> • Identify procedures to be followed where a body is brought into England and Wales, including differences relating to the registration process and disposal of the body • Identify procedures to be followed where a body is to be removed from England and Wales, including the involvement of the coroner even where the death is from natural causes • Recognise the specific pitfalls involved in repatriation and removal of bodies 	Christopher Dorries	Tony Williams
86	MEX_08_10	Reporting a Death to the Coroner Part 1: Duties of the Medical Examiner	<ul style="list-style-type: none"> • Identify the purpose of reporting a death to the coroner • Describe the importance of full and prompt reporting • Demonstrate the necessity to identify potential homicide in the chain of causation • Describe factors to be taken into consideration when making the decision to refer to the coroner, and those pressures that the medical examiner cannot take account of. 	Alan Fletcher	Christopher Dorries
87	MEX_08_11	Reporting a Death to the Coroner Part 2:	tbc	Alan Fletcher	Christopher Dorries
88	MEX_08_12	Reporting a Death to the Coroner Part 3:	tbc	Alan Fletcher	Christopher Dorries

89	MEX_08_13	Reporting a Death to the Coroner Part 4:	tbc	Alan Fletcher	Christopher Dorries
90	MEX_08_17	The Coroner's Investigation Part 1: The Coroner's Powers	<ul style="list-style-type: none"> • Describe when the coroner is likely to require a post mortem examination • Identify the legal framework that allows a coroner to request a post mortem examination • Differentiate between examinations conducted under sections 19 or 20 of the Coroners Act 1988 • Recognise the coroner's responsibilities to the family of the deceased • Recognise the limits of the coroner's jurisdiction 	Christopher Dorries	Karen Henderson
91	MEX_08_18	The Coroner's Investigation Part 2: The Investigative Process	<ul style="list-style-type: none"> • State the obligations of the pathologist under Part III of the Coroners Rules 1984 • Explain how and why a pathologist is chosen to carry out a post mortem • Identify the essential components of a post mortem report 	Christopher Dorries	Karen Henderson
92	MEX_08_19	Interim session on reportable deaths	<ul style="list-style-type: none"> • Describe the well established principles behind the current arrangements for reporting deaths to a coroner • Explain the likely categories of death in forthcoming Regulations which place a statutory duty to report upon doctors for the first time • Explain the structure of the likely new Regulations and be able to apply this to the current arrangements as an interim measure • Distinguish between the roles of the ME and the coroner with regard to specific types of death 	Alan Fletcher	Christopher Dorries