



The Royal College of Pathologists

Pathology: the science behind the cure

National Medical Examiner's Good Practice Series No. 13

Major incidents

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About the National Medical Examiner's Good Practice Series

Medical examiners – senior doctors providing independent scrutiny of non-coronial deaths in England and Wales – are a relatively recent development.

While there is extensive guidance available on a wide range of topics for NHS and public sector staff, the National Medical Examiner's Good Practice Series highlights how medical examiners and medical examiner officers can better meet the needs of local communities and work more effectively with colleagues and partners.

The [Good Practice Series](#) is a topical collection of focused summary documents, designed to be easily read and digested by busy front-line staff, with links to further reading, guidance and support.



Introduction

A major incident is defined by the [Joint Emergency Service Interoperability Programme](#) (JESIP) as an event or situation with a range of serious consequences that requires special arrangements to be implemented by one or more emergency responder agency.

A mass casualty incident is a major incident (or series of incidents) that causes casualties on a scale beyond the normal resources of the emergency and healthcare services' ability to manage. Several smaller incidents may combine so as to require a coordinated response to manage the number of casualties.

A mass fatality incident is a major incident that causes a large number of fatalities where it may not be practical or appropriate to follow normal arrangements due to the circumstances or demands on the emergency responder agencies. In these situations, it may be proportionate and necessary to invoke the UK Disaster Victim Identification (DVI) process.

Major incidents and mass casualty incidents associated with multiple fatalities are thankfully uncommon in the UK but present a number of unique challenges to the role of medical examiners and medical examiner officers.



Recommendations for medical examiners – major incidents

If there are excess deaths in the aftermath of a major incident which apparently are of natural causes, medical examiners should conduct independent scrutiny with heightened awareness that the major incident may have affected circumstances contributing to a death.

While conducting such scrutiny, medical examiners should consider whether there has been some longer-term impact following involvement in a major incident, and will need to notify the coroner if this has contributed to a death. Maintaining excellent communications with the coroner will be important to ensure that the coroner's expectations are understood.

Provide appropriate support and understanding in the aftermath of a major incident, as bereaved people may face additional pressures and difficulties even if they are not directly affected by the incident.

As part of reporting trends, medical examiners and officers should consider whether excess deaths need to be highlighted to healthcare providers, partners and the system, in line with the National Medical Examiner's [Good Practice Paper on escalating thematic issues](#).

In the event of a major incident, lead medical examiners could make themselves available to the coroner, for example providing helpful context, and offering to support local gold command if appropriate.

Lead medical examiners should be aware of local resilience plans, contributing to their formulation and liaising with the local resilience forum where appropriate. They should provide information to NHS representatives at such fora so that they are aware of the role of medical examiners and constraints within which the office operates. When major incidents occur, the response of the medical examiner office will vary according to its configuration and the nature of the incident, and discussions with local gold command.



Context and background

Multi-agency response

The response to a mass fatality incident is coordinated centrally between the Home Office Emergency Preparedness Fatalities Team and the Cabinet Office Civil Contingencies Secretariat. The decision to declare a mass fatality incident lies jointly with His Majesty's Coroner or Procurator Fiscal and the Gold Commander responsible for the scene. The decision to declare a mass fatality incident and the response that follows is influenced by a number of factors that may not be immediately obvious to the public or those providing care to the survivors and bereaved people; for example, the presence of fragmented human remains, actual or potential hazards at the scene, or whether the incident is believed to be the result of criminal or terrorist activity can all influence the scale of the response and the disruption to normal activities. In some circumstances, the need for suitable and sustainable mortuary capacity can have an impact on healthcare services and bereavement support at locations distant to the scene itself.

The Welsh Government facilitates the Wales Resilience Forum, chaired by the First Minister. This provides a forum for discussion on strategic emergency preparedness issues in Wales and may, through the possible creation of a Wales Civil Contingencies Committee, have a part to play in the event of a mass fatality incident. The Wales National Emergency Co-ordination Arrangements provide the overarching framework for inter-agency co-ordination of a pan-Wales crisis.

Major incidents, especially mass fatality incidents, trigger the involvement of multiple stakeholders. Each agency or organisation will have a different level of involvement determined by the scale and nature of the incident. The multi-agency response will follow the principles set out by [JESIP](#).

The Home Office will provide a framework for any multi-agency response, which may also consider a mass fatality response occurring overseas where survivors have been repatriated back to the UK for ongoing care. Agencies involved may include: the Home Office, Local Resilience Forum (LRF), local authorities, the National Police Coordination Centre (NPoCC), the Fire and Rescue Service, the Department of Health and Social Care, the Ministry of Defence, the Foreign Commonwealth and Development Office (FCDO), the Health and Safety Executive (HSE), the Air Accident Investigation Branch (AAIB), the



Marine Accident Investigation Branch (MAIB), the Rail Accident Investigation Branch (RAIB), and INTERPOL.

Further information can be found in [Guidance on dealing with fatalities in emergencies](#)

The coroner's role

Following a major incident, the legal control and care of the deceased passes to the local coroner service to allow them to conduct their statutory investigation. Once formal identification and post-mortem examinations have been completed, the deceased will be released to their next of kin or those entitled to receive them as usual. This process may take considerably longer than usual depending on the nature of the incident and number of fatalities.

The role of the medical examiner office following a major incident

Involvement of the medical examiner office depends on actions taken in the aftermath of a major incident. If the criteria are fulfilled, senior coroners have responsibility for coordinating investigations so medical examiner offices would not be expected to become involved in certification or scrutiny.

It is important to remember that every major incident is a unique event, especially where there are mass fatalities, and the circumstances that follow can be confusing for all stakeholders involved. Medical examiners understand that a death should be referred to a coroner when any event that is not otherwise considered natural has contributed. Fatalities at the scene are inevitably an unnatural death but the causation threshold becomes progressively blurred for those that are admitted to hospital and discharged, or return home but then die subsequently. It is important to remember that a death can be referred to the coroner at any time if an unnatural aspect is believed to have contributed, even if it is many years after the event, in line with [Notification of Deaths guidance](#).

If there are excess deaths but no apparently unnatural circumstances, medical examiners should conduct independent scrutiny but have a raised awareness of how a major incident may have affected the circumstances contributing to a death. This may require greater awareness of the incident itself and more extensive discussions with the clinical team treating the deceased and bereaved people to ensure that the coroner is notified of deaths appropriately. This is needed to ensure medical examiners consider all factors that may indicate the major incident contributed to the death of the deceased person. Ideally, the



responsible senior coroner will provide clear direction on what they expect and, in some circumstances, may arrange meetings to facilitate close collaboration and ensure appropriate referrals are made.

Medical examiners and officers are used to providing caring and compassionate support to bereaved people, who may face additional pressures and difficulties in the aftermath of a major incident even if they are not directly affected by the incident. Medical examiners and officers will need to provide appropriate support and understanding, where this is the case, and assist bereaved people in accessing other support that is available where needed, for example through hospital bereavement services and voluntary organisations.

Learning from the coronavirus pandemic

Emergency measures introduced for 2 years only by the Coronavirus Act 2020 set aside the usual statutory requirement for medical practitioners completing Medical Certificates of Cause of Death (MCCDs) to have attended the deceased. In the early stages of the pandemic, NHS England encouraged healthcare providers to redeploy medical practitioners whose specialty role did not include direct patient care as dedicated certifiers. Medical examiners and others fulfilled this role, enabling patient-facing medical practitioners to focus on care for patients. However, within 4 months, when levels of stress on the NHS became clearer, healthcare providers were encouraged to reinstate medical examiner scrutiny to strengthen insight into potential improvements in care.

It should be noted, however, that redeployment of medical examiners took place while medical examiners did not have statutory duties. When medical examiners are made a requirement of the statutory death certification process, it will only be possible to redeploy them if the government makes provisions to temporarily set aside their statutory duty to provide independent scrutiny of non-coronial deaths.

Medical examiners and medical examiner officers will need to consider business continuity if medical examiners are redeployed to provide frontline care after a major incident. Lead medical examiners may be asked to join multi-agency response discussions and may wish to liaise with NHS England's Regional Medical Examiners who can provide additional support and advice.



Interaction with people bereaved after a major incident

In a major incident, the senior identification manager (SIM – the senior police officer responsible for overseeing the recovery and identification process) may appoint a family liaison coordinator (FLC) and several family liaison officers (FLOs). The role of the FLC is to manage the deployment of FLOs and family liaison advisors (FLAs). They are responsible for providing or arranging support, guidance and development opportunities for the family liaison community. Their key objectives are to assist the investigation by obtaining a full family background, ante-mortem data, exhibits and other details as required by the SIM and the coroner. They will signpost bereaved people to other statutory and voluntary support agencies but do not provide emotional or practical support to bereaved people.

It is not appropriate for medical examiners and officers to initiate contact with people bereaved after a major incident. The responsible senior coroner has oversight to ensure that a consistent approach is provided that does not compromise any ongoing investigation.

Post-mortem examinations and mortuary capacity

Most fatalities at the scene of a major incident will have a post-mortem examination as part of the investigation to establish the cause of death, as well as to inform any concurrent criminal investigation. These decisions are entirely the remit of the coroner. Further information can be found in [Guidance on dealing with fatalities in emergencies](#) and the National Medical Examiner's Good Practice Paper on [post-mortem examinations](#).

A major incident may impact on deaths where a post-mortem examination is required, but which were not part of the major incident. Medical examiners and officers should be alert to the potential for such delays, and working with pathology services, ensure bereaved people are made aware if there is a potential impact.

Deaths of children

While the elements of scrutiny are generic and remain the same for deaths of children (discussion with bereaved people, review of records and interaction with the doctors completing the MCCD), so do the principles around timeliness of care and escalation of concerns. The National Medical Examiner's [Good Practice Paper on deaths of children](#) offers guidance. Deaths of children caused by a major incident will almost certainly be



subject to coronial investigation and therefore outside the remit of medical examiners and medical examiner officers.



Find out more

- Coroners – Notification of Deaths guidance.
- JESIP – Joint Emergency Service Interoperability Programme.
- JESIP – roles and responsibilities.
- NHS England clinical guidelines for major incidents.
- National Medical Examiner’s Good Practice Series – post-mortem examinations, deaths of children and escalating thematic issues and maximising the impact of medical examiner scrutiny.
- UK Government – Guidance on dealing with fatalities in emergencies.
- Wales – emergency preparation, response and recovery.



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