The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting 9 May 2024

Agenda item	078/24			
Report Title	How We Learn from Deaths and Medical Examiner / Bereavement Service Quarter 3 2023-24 Board Summary Assurance Report			
Executive Lead	Dr John Jones, Executive Medical Director			
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CQC Domain:	**Link to Strategic Goal:**			**Link to BAF / risk:**
Safe		Our patients and community		
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register ID:**
Responsive		Our governance	√	ID 435
Well Led	√	Our partners		
Consultation Communication	Trust Learning from Deaths Group, 1st February 2024 Quality Operational Committee, 19th March 2024 Quality & Safety Assurance Committee, 26th March 2024			
Executive summary:	• There have been 542 deaths managed by the Medical Examiner Service during quarter 3 (Q3) 2023-24, a decrease of 90 deaths overall to the comparable quarter in 2022-23. • The Trust Summary Hospital-level Mortality Indicator (SHMI) for July 2023, the latest available data, is 98.90. • The year-to-date Structured Judgement Review (SJR) completion rate is 19%. Learning opportunities through SJR completion are currently not maximised due to the lack of regular multi-disciplinary team reviewers, especially senior nurses. • Internal audit undertaken by Mersey Internal Audit Agency (MIAA), has returned a 'substantial assurance opinion'. • During Q3 2023/24, ten deaths have been deemed more likely than not to be due to problems in healthcare. • Performance of issuing Medical Certificate of Cause of Death (MCCD) within 3 calendar days remains consistent with Q2. The sustained delivery of this KPI is challenged due to the availability of the treating doctor. • The expansion of the ME service across the ICS is progressing. The date for the system becoming statutory is to be confirmed, with a timetable expected in early March.			
Recommendations for the Board:	The Board is asked to note the report.			
Supplementary Information Pack Appendices	Appendix A: Supplementary Information. Appendix B: Overview of Learning from Deaths Dashboard. Appendix C: ME and Bereavement Service Full Report. Appendix D: Audit Report			

1.0 Introduction

1.1 Part A of this paper summarises the key issues pertinent to the Learning from Deaths programme of work during Q3 2023-24 with supplementary information, including Statistical Process Charts (SPC) provided at Appendix A. An overview of the Learning from Deaths Dashboard is provided at Appendix B.

1.2 Part B of this paper provides a key issue update from the Medical Examiner and Bereavement Service for Q3 2023-24 with a full report available at Appendix C.

PART A: LEARNING FROM DEATHS KEY ISSUES UPDATE

2.0 Summary of Hospital Deaths

2.1 There have been a total of 542 deaths managed by the Medical Examiner Service within the Trust during quarter 3 (Q3) 2023-24. Of these, 438 occurred as an inpatient and 104 occurred within the emergency department (ED). This figure compares to 632 in the comparative quarter during 2022-23, representing an overall decrease of 90 deaths.

Following a spike in total deaths across the Trust at the end of Q3 into Q4 2022-23, in particular those occurring within the ED, the figures have decreased overall and now demonstrate common cause variation. SPC charts 1 to 6 are provided at section 1.1 of Appendix A. The slight increase in deaths that has occurred within the ED at the end of Q3 2023-24 is in line with seasonal variance. The extraordinary review undertaken to identify potential reasons for the spike in deaths within the ED during Q3 2022-23, was presented the Board of Directors in December 2023.

2.2 Of the 542 deaths in Q3 2023-24, 212 were observed at the Princess Royal Hospital (PRH) and 330 at the Royal Shrewsbury Hospital (RSH). A breakdown of mortality data across both hospital sites by month is provided at charts 7 and 8 in section 1.2 of Appendix A. Common cause variation is currently demonstrated after the overall increase in deaths seen across the Trust at the end of Q3 into Q4 2022-23.

2.3 Divisional mortality data remains consistent across the Trust with approximately 80% of deaths observed within the Medicine and Emergency Care (MEC) Division, and 20 % observed within the Surgery and Cancer care Division, with less than 1% observed within the Women and Children (W&C) Division. Common cause variation is demonstrated within the SPC charts 9 to 11 available at section 1.3 of Appendix A.

2.4 The crude mortality trend for the Shrewsbury and Telford Hospital NHS Trust (SaTH) compared to the CHKS Peer Group, is low. This is due to the higher proportion of elective activity at SaTH. Non-elective crude mortality is comparable to the peer and low for the latest two months. Crude mortality charts are available at section 1.4 of Appendix A. The CHKS Peer Group comprises of acute hospital trusts which have been identified as the most similar to SaTH.

3.0 Learning from Deaths Dashboard

3.1 A high level visual overview of the dashboard is provided at Appendix B highlighting key metrics relating to:

- Context around learning from deaths including SHMI

- Medical Examiner Scrutiny to SJR, including mortality screening
- High level details relating to care.

Further analysis of these metrics are provided in sections 3.2 to 3.8.

3.2 Summary Hospital-level Mortality Indicator (SHMI):

The Trust's SHMI and the trend for observed versus expected deaths is monitored through the Learning from Deaths Dashboard as a monthly standing agenda item. The Trust SHMI for July 2023, the latest available data, is 98.90. This is within the expected range and is favourable to the CHKS Peer Group. The 12-month SHMI rolling month trend, is again favourable to the CHKS Peer Group and decreasing.

SHMI observed deaths are largely comparable to expected deaths for the current time period.

The Trust SHMI and SHMI observed versus expected deaths charts are available at sections 1.6 and 1.7 of Appendix A.

The latest available SHMI data from CHKS, shows the primary diagnosis condition with the highest number of “excess” deaths (more deaths than expected by the SHMI model) across the Trust to be:

- Fluid and electrolyte disorders - a preliminary review will be undertaken to identify if a more detailed investigation of clinical care is required.
- Acute and unspecified renal failure - quality improvement work has been progressing within the Trust which was detailed in the Q4 2022-23 report.
- Aspiration pneumonitis - a preliminary review will be undertaken to identify if a more detailed investigation of clinical care is required.

The indices for these conditions were higher than the peer average and have increased from the previous period.

Within the SHMI model, septicaemia has been identified as one of the top three primary diagnosis condition groups with the highest number of excess deaths at PRH. Septicaemia is also identified as the condition with the highest number of excess deaths across the Trust within the Hospital Standardised Mortality ratio (HSMR) index, where the cumulative sum (CUSUM) chart demonstrates an increasing trend. Whilst the Trust primarily focuses on the SHMI model, an initial review of this condition will be undertaken in collaboration with the Deteriorating Patient Team to identify any further actions that may be required.

Acute cerebrovascular disease remains the primary diagnosis condition with the highest number of excess deaths at the Royal Shrewsbury Hospital (PRH). The Q2 2023-24 report provided details of the assurance review that was undertaken in collaboration with the Stroke Consultants for 25 patients who died at RSH with a relevant cause of death. At the time of the Q2 report, one patient safety datix investigation remained open for one of the patients. This investigation has now been closed. There was no evidence found that opportunities were missed and care was deemed to have been appropriate. The assurance review therefore has concluded that the care was appropriate for all 25 patients who died at RSH and no clinical pathway problems were identified.

Internal monitoring of stroke related deaths at RSH continues through the weekly Mortality Triangulation Group (MTG) and all deaths with a stroke related cause of death who die at RSH are referred to the Stroke Consultants for further review.

Additional assurance reviews are currently being undertaken for deaths where the primary diagnosis codes are myocardial infarction, hematologic conditions and those in low mortality condition groups.

3.3 Wider metrics relevant to mortality across the Trust include hospital occupancy and length of stay. These are displayed on the overview of the Learning from Deaths Dashboard as seen at Appendix B.

3.4 Medical Examiner Scrutiny:

A summary of Medical Examiner Service activity is detailed in Part B and Appendix C of this report.

3.5 Mortality Screening:

Clinical colleagues are provided with the opportunity to complete online mortality screening for cases which have not been flagged for SJR. During Q3, 242 online mortality screenings were received of which 118 were completed for deaths within the quarter. 35% of screenings were completed less than 4 weeks after the death of the patient. Of the 242 screenings, 25 were classed as 'positive', which means that learning was identified. All positive screening cases are subsequently discussed at the weekly MTG meeting where the most appropriate method to review or share the identified learning is confirmed. This may result in an SJR being raised, learning being shared with the appropriate clinical teams, or it may be identified that there is another review already underway for the same issues, for example a Formal Complaint or Datix investigation.

3.6 Structured Judgement Reviews:

During the period of intensive support provided by NHS England, the 'Better Tomorrow' Leads recommended that 15% of all adult deaths across the Trust should be receive an SJR to ensure sufficient information is available to identify themes and trends for learning. Whilst this is not a nationally mandated target, this percentage has been adopted within SaTH as 'best practice'. Consequently, a local target of completing 30 SJRs per month was introduced. This target has been achieved and sustained since May 2023 as is shown at section 1.8 of Appendix A. As a result of increased SJR completion per month, the Trust has demonstrated compliancy with the 15% target since June 2023. This is demonstrated within the Learning from Deaths Dashboard Overview at Appendix B where the latest available data is for October 2023. The overall percentage of SJR completion for deaths within the year to date to October 2023 is 19%.

When reporting on performance relating to the percentage of deaths within a given month that have had an SJR completed, there is a delay between the latest available months' data and reporting via the Learning from Deaths Dashboard. This reflects the 8-week period for SJR completion from the date the patient died in line with the Trust Learning from Deaths Policy, and the subsequent timeframe required for construction of the Learning from Deaths Dashboard in collaboration with the Performance Team.

Compliancy with both the number of SJRs completed each month and the percentage of deaths within each month that have received an SJR is monitored as a standing agenda

item on the monthly Learning from Deaths Group and is additionally incorporated into the monthly Trust Integrated Performance Report (IPR).

Senior nursing support for SJR completion is currently only available on an ad hoc basis. The high SJR completion rates seen in July and August 2023 reflect the additional senior nurse temporary staffing support for SJRs that was available in that period in addition to the corporate and divisional medical support for SJRs. This temporary staffing availability has now significantly reduced which means that the Trust is no longer able to reliably provide a multi-disciplinary team approach to SJR completion on a regular basis. To maximise learning opportunities a strategy to ensure sustained support from the wider clinical teams needs to be developed or there is a risk that the learning opportunities arising from SJRs may be less impactful.

3.7 Care:

In line with the Q2 2023-24 report, 54% of SJRs completed during Q3 2023-24 identified an overall assessment of care rating as good. Learning from excellence is celebrated and promoted through the wider Learning from Deaths agenda including the Trust Learning from Deaths group and Divisional Morbidity and Mortality or Governance meetings. Positive feedback is sent to individual clinicians and clinical teams. An overall assessment rating of poor was identified in just over 10% of cases, with the remainder being rated as adequate. An SJR datix is required for any case where a rating of poor or very poor is given. This ensures that the care provided is reviewed by divisional teams in addition to the SJR reviewer and is then discussed at the Trust Incident Response Oversight Group - IROG (formerly known as the Trust Rapid Review Group) to determine level of harm and any actions required to address learning identified.

Of the 115 SJRs completed during Q3 2023-24, 40 met the criteria for submission of an SJR datix based on identification of an unexpected death, poor / very poor care, Hogan score of preventability greater than 50:50 or above, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading less than satisfactory, any problem in care where potential harm was identified or any case where the reviewer did not feel able to grade the care. An SJR datix is not a patient safety incident datix, although may be converted to this and be reportable to the National Reporting and Learning System (NRLS) once the case has progressed through the Trust IROG forum where level of harm is agreed. At the time of writing this report only 52% of the SJR datix have been submitted for completed SJRs which met the threshold, risking a failure to appropriately identify potential patient safety incidents for investigation that have not been flagged through any other source. Work is in progress with the SJR reviewers and the Divisional Quality Governance Teams to address this and ensure that outstanding SJR datix are submitted. Weekly monitoring of this process is being established through the Learning from Deaths team.

The top 3 problems in care identified in SJRs completed in Q3 2023-24 were:

- Problems in treatment plan – 18 cases.
- Problems of any other type – 18 cases. These cases include, documentation issues, cancellation of procedures, delays in ED, capacity issues, falls in ED, and verification of death issues.
- Problems in relatives communication – 15 cases

3.8 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) ratings:

An NCEPOD rating of 'Good' was given in 62 out of the 115 of the SJRs completed in Q3 2023-24, with 30 SJRs identifying 'Room for Improvement in Clinical care', 8 identifying 'Room for improvement in clinical and organisational care' and 5 SJRs identifying an NCEPOD rating of 'Less than satisfactory'.

3.9 Deaths where a significant concern about the quality of care provided is raised by bereaved families or carers:

Bereaved families and carers have the opportunity to discuss the care provided to their loved ones during Medical Examiner Scrutiny of each case. Responding to feedback given is a vital part of the learning from deaths within the Trust. During Q3 2023/24, significant concerns were raised by the bereaved during Medical Examiner Scrutiny in 13 cases where the patient died. At the time of writing this report, formal complaints have been raised in 4 of these cases and Structured Judgement Reviews (SJRs) completed for 8 of these cases, with 1 SJR outstanding. No Serious Incidents or Patient Safety Incident Investigations (PSII) have been commissioned although 2 Divisional Investigations are currently in progress. Themes identified through this route include delays in the ED / offload delays, communication including around ReSPECT, general care issues and concern around possible failed discharges.

4.0 Learning to Improvement

4.1 Positive learning themes identified through the completion of SJRs during Q3 2023-24 relate to:

- Evidence of good team working and proactive involvement of appropriate specialist teams including Dementia team, Oncology and Palliative care.
- Positive learning relating to End-of-Life care.
- Communication with the family.
- Provision of patient centred holistic care, best interest of the patient prioritised.
- Excellent documentation of Treatment Escalation Plan (TEP), clear evidence of both escalation and de-escalation.
- Provision of excellent nursing care.
- Clear senior leadership positively impacting patient management by junior clinicians.

Feedback from one reviewer is quoted below:

"Although her death is tragic, I believe the timely, comprehensive and compassionate care this patient received was faultless, and an excellent example of the outstanding multidisciplinary care offered by the NHS."

4.2 Key themes of learning for improvement identified through the completion of SJRs as well as the wider learning from deaths processes including the weekly MTG group during Q3 2023-24 relate to:

- Delays within the ED including offload delays and long waits for admission to a ward.
- Management of fluid balance and electrolyte imbalance including completion of fluid balance charts and maintenance fluids not given in line with Trust policy. Learning identified is referred to the Trust Fluid Balance Specialist Nurse to support the ongoing programme of improvement that is underway.

- Medication issues including midazolam prescription, delay in second dose antibiotics, poor opiate prescribing, delay in prescription of regular medications and venous thromboembolism prophylaxis, use of nephrotoxic drugs, use of reversal agents for example opioid toxicity. The Learning from Deaths team work closely with the Medicines Safety Officer (MSO) to share learning and contribute to quality improvement initiatives consequently being developed.
- EoL care including communication, delayed recognition of active dying including failure to stop active management pathway, continuation of inappropriate observations, documentation, pain control, use of ReSPECT including within the community to prevent unnecessary admission to hospital, referrals to Palliative Care and End-of-Life team for symptom control, fast track discharge issues. The Learning from Deaths team collaborate closely with the PEoLC team and submit identified learning to them on a regular basis. This is subsequently fed into the system wide steering group and used to inform quality improvement initiatives both within the Trust and the ICS.
- Issues around completion of Mental Capacity Act (MCA) and Best Interests (BI) forms
- Lack of clinical reviews over a weekend or post-take ward rounds
- Delayed referrals to specialties or other healthcare professionals
- Documentation issues including legibility, completion of nursing charts for example, nutrition and stool charts, incorrect name on scan form resulting in unnecessary non-invasive test, documentation around prognosis, completion of Local Safety Standards for Invasive Procedures (LOCSSIP) forms on ITU, lack of documentation to evidence consultant review in last week of life
- Lack of comprehensive management plans
- Need for clarity regarding access to 24-hour tapes and ECGs on the Clinical Portal. Identification of this learning has resulted in the issue of trust-wide communication to staff to highlight how to access investigations on the clinical portal and an update to the relevant intranet webpage. Information will also be included in the junior doctors induction in the future.
- Verification of death issues – this is a consistent theme during 2023-24 and work continues between the Medical Examiner Service and the PEoLC team to develop a handover document to support staff to ensure all required tasks including verification of death have been completed before the patient leaves the ward. A sticker is also being developed.
- Readmission and discharge issues including cases where the patient was deemed medically fit for discharge but then deteriorated and died and fast-track discharge issues.

The Learning from Deaths team work closely with healthcare professionals across the organisation and across the Integrated Care System to appropriately share identified learning to positively influence quality improvement initiatives.

5.0 Maternal Mortality

5.1 There have been no direct, indirect or coincidental maternal deaths reported by the Trust within Q3 2023-24.

6.0 Perinatal Mortality

6.1 The invited external expert review in relation to the ‘above average’ mortality within SaTH highlighted in the latest ‘Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries’ (MBBRACE-UK) report for 2021 and which was detailed in the Q2

2023-24 report, has been completed. It is anticipated that the recommendations identified from the review will be presented within the Q4 2023-24 iteration of this paper.

6.2 During Q3 2023-24, there were 2 stillbirths, 1 late fetal loss and 1 neonatal death reported to MBRRACE-UK which met the criteria for review using the Perinatal Mortality Review Tool (PMRT).

6.3 At the time of writing this report, PMRT had been completed for 1 stillbirth and the care was graded A, which means no issues were identified. PMRT has been completed for the late fetal loss reported, and the care was graded B, which means that some learning was identified but this did not impact on the outcome. External Obstetric Consultants were present for these reviews.

6.4 Following initial presentation of this Q3 2023-24 report through the Trust Learning from Deaths Group in February and the Quality Operational Committee in March, the MBRRACE-UK Perinatal Mortality Report: 2022 Births within the Shrewsbury and Telford Hospital NHS Trust, has been received. This continues to show higher than average neonatal mortality compared to similar Trusts and Health Boards. This is being reviewed by the Maternity Governance team in the first instance. A more detailed response will be included in future iterations of this report.

7.0 Paediatric Mortality

7.1 During Q3 2022-23, 2 paediatric deaths have been managed by the Medical Examiner Service. 1 of these occurred in the ED and 1 occurred as an inpatient on the paediatric ward with an advanced care plan in place. Both of these deaths will be reviewed through the Child Death Overview Panel (CDOP) process to identify learning. No serious incidents, or PSIRF Learning Responses have been commissioned within the Trust for either of these cases. Paediatric mortality data is available at chart 14 in section 1.5 of Appendix A.

8.0 Deaths deemed more likely than not due to problems in healthcare

8.1 A potentially avoidable death is defined within the National Quality Board (2017) guidance as any death that has been clinically assessed using a recognised methodology of case record review and determined more likely than not to have resulted from problems in healthcare. The methodology used to investigate potentially avoidable deaths in the Trust was, to the end of November 2023, the Serious Incident Framework (SIF). From December 2023, this has been replaced with the Patient Safety Incident Response Framework and deaths that are considered at the outset to have been potentially due to problems in healthcare, will be investigated as a Patient Safety Incident Investigation (PSII).

8.2 On completion of an investigation, SIs or PSIIs are presented to the Trust Review Actions and Learning from Incidents Group (RALIG), chaired by the Executive Medical Director. Following serious incident investigation, deaths judged more likely than not to have been due to problems in healthcare and therefore potentially avoidable are reported to the Board of Directors.

8.3 During Q3 2023-24, there have been 5 deaths investigated through the SIF and presented to RALIG within this period where the death was deemed more likely than not due to problems in healthcare. There have been a further 5 deaths deemed more likely than not due to problems in healthcare, where the investigation was presented to RALIG prior to

Q3 23/24 but where the final outcome regarding avoidability was determined at a later date. These cases are therefore included within this report. A theme of delay in treatment and diagnosis has been identified for these deaths.

8.4 A detailed summary of learning identified within these Patient Safety Investigations is provided in the monthly Incident Overview Report presented to the Quality and Safety Assurance Committee (QSAC) and the Quarterly Learning from Incidents Report presented to the Quality Operational Committee (QOC) and as such, are not further detailed within this report.

9.0 Deaths of patients with a confirmed Learning Disability, Autism or a Serious Mental Illness

9.1 Research has shown that people with a learning disability and autism die earlier in their lives and do not receive the same quality of care as people who do not have a learning disability or autism. As such, all patients with a confirmed learning disability or autism who die are referred to the service improvement programme for people with a learning disability and autistic people (LeDeR). An external review is then undertaken to identify learning by reviewing key episodes of health and social care the person received that may have been relevant to their overall health outcomes.

9.2 To support the external LeDeR review, an internal SJR is mandated for all patients with a learning disability who die whilst receiving care as an inpatient in the Trust or within the ED. On completion, this is then forwarded to Shropshire, Telford, and Wrekin Integrated Care System (STW ICS) for inclusion in the external LeDeR review.

9.3 In Q3 2023-24 there were 2 patients with confirmed learning disabilities or autism reported to LeDeR, who died in the Trust, either as an inpatient or in the emergency department. The SJR has been completed for both of these cases.

9.4 Learning for improvement identified relates to documentation of observations, issues around AIRVO administration in ED, and fluid balance monitoring. Positive learning was identified relating to the use of advanced care plans, nutrition, involvement of specialist teams and review following deterioration.

9.5 The provision of specialist support for SJRs mandated for patients who die in the Trust with a confirmed learning disability or autism remains unresolved. However, it is understood that appropriate resource for a new specialist Learning Disability and Autism Lead role within the Trust is currently under review. It is anticipated that recruitment to this post would potentially facilitate appropriate support for the SJR process for both Learning Disability and Autism, moving forwards. In the meanwhile temporary support from the Mental Health and Safeguarding Nurse Specialist Leads in the Trust has been agreed dependent on their capacity.

9.6 In Q3 2023-24, there were 3 deaths of patients with a serious mental illness (SMI) of which 1 SJR has been completed and 1 case is being investigated as an SI. At the time of writing this report,1 SJR for a patient who died in Q2 2023-24 remains outstanding. This is being supported by the Mental Health Clinical Nurse Specialist in the Trust.

10.0 Mersey Internal Audit Agency Review (MIAA)

10.1 An internal audit to assess the robustness of the Mortality Framework, the effectiveness of frontline to Board governance arrangements for identifying, investigating and reporting

on mortality, and the Trust's commitment to learning from deaths, has been completed. This review was originally planned for 2022 but was deferred at the request of the Trust and the approval of the Audit Committee in light of peer support work that took place during 2021-22 and an external review conducted by NHSE in 2022. At the time of writing this report and presentation to the Trust Learning from Deaths Group in February, the final audit report had not yet been received by the Trust. This was however received in March and the 'substantial assurance opinion' awarded acknowledged within presentation of this Q3 report to the Quality Operational Committee. Only one risk was identified through the audit process relating to recruitment and resourcing within the Learning from Deaths team to ensure sustainability of the service. The full report is available at Appendix D of the Supplementary Information Pack.

11.0 Risk Register

11.1 There is one risk that remains on the Trust Risk Register relating to recruitment within the Corporate Learning from Deaths team. There has been turnover within the team and difficulties experienced recruiting to the specialist roles. The office space limitations reported in Q2 2023-24 have now been resolved and the team has relocated to more appropriate facilities.

PART B: MEDICAL EXAMINER & BEREAVEMENT SERVICE KEY ISSUE UPDATE

12.1 Of the 542 deaths that occurred in Q3, 537 received Medical Examiner scrutiny, 99% of the overall deaths therefore receiving a review. Those cases that did not receive review are cases directly referred to the coroner but not by the ME service. Of these, 97% of bereaved relatives received a phone call from the Medical Examiner service to discuss the care, treatment, and cause of death. The cases where contact was not made was due to a combination of no next of kin available and relatives not returning our calls.

12.2 Of the 479 MCCDs written, 405 of these had no coroner involvement and so the target timeframe for MCCDs with no coroner involvement to be written, is within 3 calendar days. 114 of the MCCDs were not completed within 3 calendar days during Q3. Delays were therefore experienced for bereaved relatives being able to register the death of their relative during this time. Our performance in respect of meeting 3 calendar days is being monitored by the Regional Medical Examiner. The challenges of completing MCCDs is the point of discussion at Death Management Meetings, with external stakeholders and colleagues from local authority. They are aware of the challenges and are supportive of the significant effort that is put in to ensuring MCCDs are issued as promptly as possible and are assured of the processes in place and the regular communication that occurs between our services.

12.3 There were 35 deaths where the Medical Examiner recommended an SJR during Q3. Further analysis of the reasons for why an SJR was recommended in covered in the full report. The Medical Examiner service raised potential learning in 87 cases during this period and advised next of kin in 10 cases to contact PALS to raise their concerns.

12.4 The National Medical Examiner shared the draft regulations in December outlining the legislative changes that will come in once the ME service is statutory. These have been shared with Executive colleagues and colleagues in the ICB to keep them appraised of progress with the statutory position. A date for the statutory commencement is yet to be

confirmed, but a timetable is expected in early March 2024 and early indication of the reforms to death certification will see significant changes in this process.

12.5 The National Medical Examiner is seeking each ME service to submit plans for providing an out of hours service to support cases of urgent body release for faith purposes during weekends and bank holidays. The service requirements for this have altered from being a full 7-day service, to an out of hours service, and so our proposal for an on-call service will support the requirements and the low number of urgent body release requests the service receives. The full proposal for what the ME service can provide will be worked on during Q4.

13.0 Recommendation(s)

13.1 The Board is asked to note the issues highlighted in this report and the progress made within Q3 2023-24.

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