The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 16 January 2025

Agenda item	019/25				
Report Title	Medical Examiner / Bereavement Service Quarter 2 2024-2025 Board Assurance Report				
Executive Lead	Dr John Jones, Executive Medical Director				
Report Authors	Dr Suresh Ramadoss, Trust Lead Medical Examiner Lindsay Barker, Head of Medical Examiner & Bereavement Services				
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	√		
Well Led	√	Our partners			
Consultation Communication	Trust Learning from Deaths Group, 5th December 2024 Quality Operational Committee, 13th December 2024 Quality & Safety Assurance Committee 31st December 2024				
Executive summary:	• There were 445 adult deaths across both hospital sites and one paediatric death during quarter two which was a reduction of 78 deaths reported in quarter one, however an increase of 11 deaths from the same period in 2023. • The statutory role of the Medical Examiner Service came into effect on the 9th September with SaTH being the host service for ST&W. • 405 MCCDs for hospital deaths and 306 MCCDs for community deaths were approved by the ME during this quarter allowing death registration to take place, a total of 711 certificates. • The coroner issued one CN1B to the ME service during Q2 requiring an ME MCCD which is a new process because of the death certification reforms/statutory ME. • The Registration service rejected 4 MCCDs during this quarter, however, this was prior to the statutory commencement and will not feature in future reports due to the changes in death certification. • The Medical Examiner recommended SJRs in 35 cases from hospital deaths reviewed and potential learning in 87 deaths. • 77 referrals were made to the coroner for adult deaths during this period with no further action being taken in 40 of these cases and 37 cases proceeding to investigation (PM or inquest).				
Recommendations for the Board:	The Board is asked to note the report.				
Appendices:	None				

1.0 Introduction

This is a summarised report specifically prepared for Board recognising that more detailed reports are presented to and scrutinised by the Quality Operational Committee (QOC) and the Quality and Safety Assurance Committee (QSAC).

2.0 Summary of Hospital Deaths report to the Medical Examiner Service.

2.1 There were 445 adult deaths across both hospital sites during Q2 and one paediatric death recorded by the Medical Examiner (ME) & Bereavement service, which was a reduction of 78 deaths reported in Q1, and an increase of 11 deaths from the same period in 2023. The ME service has reported this data to NHSE as part of the ME quarterly data return.

3.0 Medical Examiner Scrutiny

3.1 98% of the overall deaths received ME review during this period. Eleven cases not reviewed by the ME during quarter two were conducted in early October, these reviews therefore fall into work undertaken in Q3. 99% of bereaved relatives received a phone call from the Medical Examiner service to discuss the care, treatment, and cause of death. One case had no contact with the ME due to calls not returned.

3.2 The ME service can receive an average of 130-230 hospital deaths a month across both sites. In addition to this and during quarter two the ME service undertook reviews of 323 cases from community providers across ST&W, an increase of 124 cases from the previous quarter with numbers steadily rising as the statutory system approached.

4.0 Medical Certificates of Cause of Death (MCCD)

4.1 46 non-coronial cases did not have an MCCD completed within the target of 3 days, an improvement from what was reported in Q1, attributed to the overall reduction in deaths during this period and due to the improved working process between the ME & Bereavement offices to support this time sensitive work.

4.2 MCCDs for 306 of the 323 community cases were processed in addition to 405 hospital cases giving a total of 711 causes of death approved by the medical side of the death certification system.

4.3 A small number (4) of MCCD certificates were rejected by Registration Services. These were in cases that were reviewed before the commencement of the statutory system. The ME is now required to sign the MCCD to demonstrate proportionate review has taken place, and that they approve the cause of death. The Registrar is therefore not permitted to “reject” an MCCD and any queries that they may have with an MCCD, are raised directly with the ME.

5.0 Structured Judgement Review (SJR) & Potential Learning

5.1 There were 35 deaths in Q2 where the ME recommended an SJR which is an increase from the previous quarter where 30 SJRs were recommended. Using the predetermined categories for reason for SJR, 12 cases were recommended due to the bereaved having concerns with care, and 12 cases were recommended because the ME felt there was an opportunity to inform the providers planned improvement work. To ensure continued governance of the learning the ME identifies, these cases are discussed at the weekly SaTH triangulation meeting, which is attended by the ME service.

5.2 The Medical Examiner service raised potential learning in 87 cases. These were referred to the relevant divisions and specialties for review through their governance processes.

5.3 During conversations between the next of kin and the ME, 2 families were advised to contact PALS to raise concerns, which is a reduction from the previous quarter.

6.0 Coroner Referrals

6.1 Across both hospital sites the Medical Examiner facilitated 77 referrals of which the coroner took no further action in 40 of the cases and took 37 cases to investigation by authorising either a post-mortem or inquest.

During this quarter there was one request by the coroner for a CN1B, which for clarity, is only requested in circumstances where there is no attending practitioner available to write an MCCD, and the death does not require investigation by the coroner due to a nature cause of death being identified, therefore the coroner will request an ME MCCD by issuing a CN1B to the service.

7.0 Urgent body release/faith requests

7.1 There were four requests for urgent body release for faith purposes in quarter two and all cases were fast tracked through the ME service to facilitate urgent release. None of these cases came as a request out of hours and were all facilitated during core working hours.

8.0 Service Highlights

8.1 The Medical Examiner system became a statutory service on the 9th of September 2024. The service for Shropshire, Telford, and Wrekin, which is hosted by SaTH, was prepared for full implementation from this date and is now responsible for reviewing all deaths across the system that do not fall under the remit of the coronial system. Deaths cannot be registered without approval by either a Medical Examiner or the coroner.

8.2 Quarter 2 figures do not reflect the full impact of the statutory system but gives an indication of the rate of referral with the final 3 weeks of the quarter receiving half of the overall community deaths for that quarter.

8.3 Robust processes for escalating concerns and identifying learning in community cases is in place with the Integrated Care Service and has been disseminated across the service.

8.4 The Standard Operating Procedure (SOP) for the out of hours ME service has been approved and is now available to ensure clarity is in place for cases that require urgent release for faith purposes and ensure a proposed cause of death in organ donation cases is approved by an independent medical examiner.

8.5 The commencement of the statutory system and implementation of death certification reforms has been successful, however continuous review of our systems and processes will take place to ensure we are working efficiently so not to impact the bereaved and SaTH mortuary capacity.