NHS
The Shrewsbury and Telford Hospital
NHS Trust

Board of Directors' Meeting
13 March 2025

Agenda item	047/25
Report Title	Medical Examiner & Bereavement Service Report Quarter 3 October 2024 – December 2024
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	√	
Well Led	√	Our partners	√	

Consultation Communication	Trust Learning from Deaths Group, 6 February 2025 Quality Operational Committee, 18 February 2025 Quality & Safety Assurance Committee, 25 February 2025
Executive summary:	• 522 deaths occurred across both hospital sites during quarter three which was an increase of 76 deaths reported in quarter two. • The Medical Examiner (ME) service scrutinised 520 cases and authorised the release of the medical certificate of cause of death in 475 hospital deaths during quarter three. • 100% of bereaved relatives received a phone call from the ME service to discuss the care, treatment, and cause of death. • Across the ST&W health system the ME service has received and undertaken scrutiny of 1,313 deaths during quarter three, which is an increase of 555 cases from the previous quarter. • The ME recommended Structured Judgment Reviews (SJRs) in 45 cases from hospital deaths reviewed and potential learning in 98 deaths. • 81 referrals were made to the coroner for adult deaths during this period with no further action being taken in 37 of these cases and 44 cases proceeding to investigation (Postmortem (PM) or inquest).
Recommendations for the Board:	The Board is asked to note the report.
Appendices:	None

1.0 Introduction

As the host site of the Medical Examiner service for SaTH & ST&W, this report provides a summarised overview of the first full quarter of the statutory service. This report has been 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 reported to the Medical Examiner Service

2.1 There were 519 adult deaths across both hospital sites during quarter three and 3 Paediatric deaths recorded by the Medical Examiner (ME) & Bereavement service, which is an increase of 76 deaths reported in quarter two, however, is a reduction of 20 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 99% of the hospital deaths received ME review during this period. The cases that did not receive ME review were direct referrals to the coroner. Of the 520 reviews, 100% of bereaved relatives received a phone call from the Medical Examiner service to discuss the care, treatment, and cause of death.

3.2 Across the ST&W health system the ME service received 793 referrals in addition to the hospital deaths and so therefore undertook scrutiny in a total of 1,313 deaths during quarter three, which is an increase of 555 cases from the previous quarter. The source of referrals from ICS care providers can be seen in the graph below.

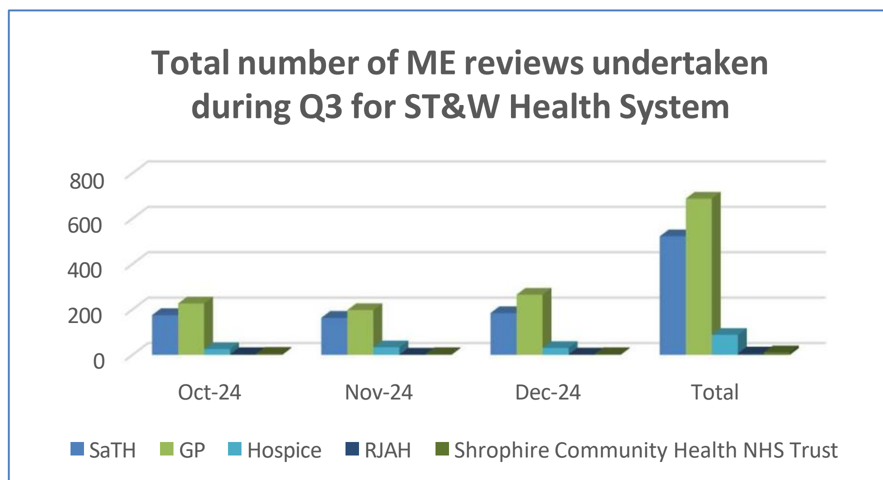

Figure 1 – Total number of ME reviews undertaken during Q3 for ST&W Health System

4.0 Medical Certificates of Cause of Death (MCCD)

4.1 475 MCCDs from hospital deaths were approved by the Medical Examiner following their review and released for registration.

4.2 148 non-coronial cases did not have an MCCD issued within three calendar days during quarter three, which is a significant increase from what was seen in quarter two. This is related to the commencement of the statutory system, whereby the timeframe to review cases has been extended as the service receives increased demand.

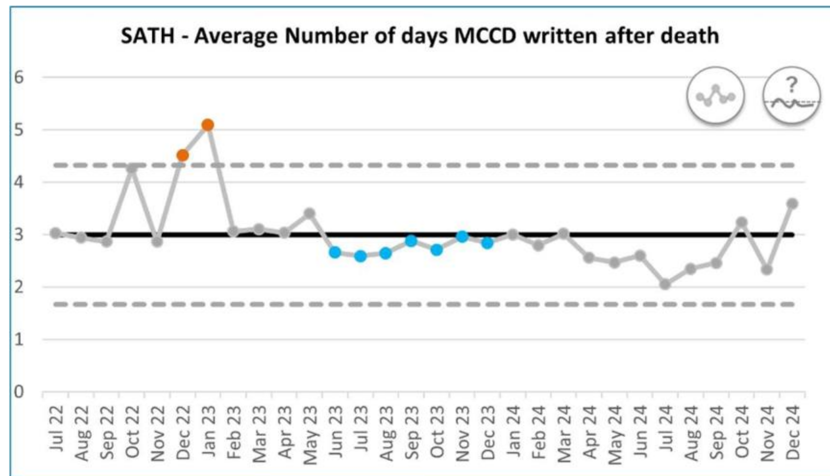

Figure 2 – SaTH Average Number of days MCCD written after death.

The above SPC chart demonstrates that the service took longer than 3 days to release MCCDs in October, which is a correlation with the beginning of the statutory system and again in December when the referral rate increased further, which pushed out the time it took to review the hospital deaths. The average timeframe to release MCCDs was between 3-4 days. The performance of issuing MCCDs will remain under close review whilst the service continues to balance the demand between hospital and community deaths. The timeframe for registering a death is now 5 days from the date the MCCD is approved by the ME, not from the date of death.

4.3 MCCDs for community deaths
MCCDs for 781 of the 793 community cases were processed in addition to the 475 hospital cases giving a total of 1,256 MCCDs approved by the ME service during this quarter. The mean number of calendar days from receipt of community referral to sending the MCCD to the registrar is 6 and this has been reported to NHSE as part of the quarterly data submission.

5.0 Structured Judgement Review (SJR) & Potential Learning

5.1 The Medical Examiner recommended SJRs in 45 of the hospital deaths reviewed in quarter three. Using the predetermined categories for reasons for SJR, 14 cases were recommended due to the bereaved having concerns with care, 16 were recommended because the ME had concerns with the care and felt potential learning will inform providers planned improvement work. The remaining 15 cases were a combination of being mandated SJR and due to the deaths being unexpected, such as following an elective procedure, and so it is good practice to review these cases as part of established robust mortality procedures. This information is also submitted to NHSE as part of the quarterly return.

5.2 Medical Examiners raised potential learning in 98 hospital deaths during quarter three. These were referred to the relevant divisions and specialties for review through their governance processes to ensure learning can be shared.

5.3 The Medical Examiner service advised the next of kin in 12 cases to contact PALS to raise the concerns that were discussed during the ME interaction which is an increase of 10 cases in comparison to quarter two.

6.0 Coroner Referrals

6.1 Across both hospital sites the Medical Examiner facilitated 81 referrals of which the coroner took no further action in 37 cases and took 44 cases to investigation by authorising either a post-mortem or inquest.

7.0 Urgent body release/faith requests

7.1 There was one request for urgent body release for faith purposes in quarter three and this case was fast tracked through the bereavement and ME services to facilitate urgent release. No requests for urgent release have been made to the ME service out of hours during this quarter and so the standard operating procedure for out of hours ME remains untested.

8.0 Service Highlights

8.1 With the Medical Examiner system now being a statutory service, quarter three has seen the impact of increased demand and ensuring a balance between managing hospital cases with those that are referred in by community clinicians has remained the focus of the service.

8.2 Robust processes for escalating concerns and identifying learning in community cases is in place with the Integrated Care Board and has been disseminated across the service. A refined process is being developed to ensure learning for SaTH, which has been identified from reviewing community cases is actioned in the most appropriate way, to ensure any learning that is found is managed in the appropriate forum.

8.3 Commencement of newly recruited Medical Examiners has been seen during this quarter, which has helped to support the team at a time when significant increase in demand has been felt. The vacancies appointed to, were not additional posts, but replacement posts. The ME to case ratio set by NHSE is 1.8 Medical Examiners for 5,000 deaths per year. The ME service currently has 17 Medical Examiners providing 18 sessions (1.8 equivalent) and therefore can be considered fully staffed. However, the increased demand has created administrative volume for the service, and it is hoped that a funding review of the financial envelope is considered for 2025/26.

8.4 Despite the extensive preparations for the statutory system, the increase in demand to the ME service was heavily felt and the quality of ME referral and MCCDs being received by community clinicians created significant administrative burden on the service. This has been addressed with individual providers and wider through meetings with GP Board. Ensuring a balance between managing community referrals along with hospital deaths has continued to be a priority to ensure the impact to mortuary capacity is limited and delays to the bereaved kept to a minimum where possible and is kept under constant review.

8.5 The current process for reviewing hospital deaths is not aligned with the way a community death is referred into the service, and so a pathway review into the referral process has commenced to achieve a streamlined and efficient referral system. This is likely to require a referral management system and primary steps in developing the operational and funding requirements has commenced during this quarter.