Please see the below data for the FOI request.

Questions:

2) Please provide me with a brief overview of the FIRST FIVE incidents in 2021/22 identified in question 3 (i.e. cases of deaths that were more likely than not caused by problems in care), withholding any identifying information that would run into a Section 40 exemption.

3) Finally, can you please summarise what the Trust learnt and what actions have been taken as a result of the aforementioned cases/investigations.

All deaths have a Medical Examiner review

Medicine division: April 2021- March 30th2022

Month	Total number of deaths	ME requested SJR's	Total number discussed at M&M
April 2021	51	7	15
May 2021	52	5	12
June 2021	56	3	5
July 2021	56	5	11
August 2021	65	5	6
September 2021	79	9	11
October 2021	98	6	7
November 2021	102	6	2
December 2021	111	8	3
January 2021	92	4	6
February 2021	80	7	2
March 2021	101	9	6
	Grand Total= 1033		Grand Total = 74

Grand Total = 86

From the number discussed at a M&M meeting **three** were classified as 3,2,1. Due to personnel changes and reporting system changes it is unclear what the learning was from these three cases.

Surgical division: April 2021 – March 30th2022

Total number of deaths: 62
All 62 deaths had a case record review (SJR).

- 61 had an SJR and 1 (ENT) was discussed in Clinical Improvement Group meeting.
- 23 cases progressed to Mortality and Morbidity (M&M) discussion as set out in SJR process.

NONE of the cases were given classification scores of 3 (probably avoidable), 2 (strong evidence of avoidability) or 1 (definitely avoidable) therefore I cannot contribute to the case examples.