Appendix A

Learning from Deaths
Quarter 2, 2021/22

1. Introduction

The purpose of this report is to provide the Board of Directors with a summary of the all inpatient death Medical Examiner reviews between 1st July and 30th September 2021.

2. The Trust's process for reviewing inpatient deaths

The Trust has a process for escalating reviews of inpatient deaths and outcomes of Medical Examiner and Morbidity and Mortality (M&M) reviews.

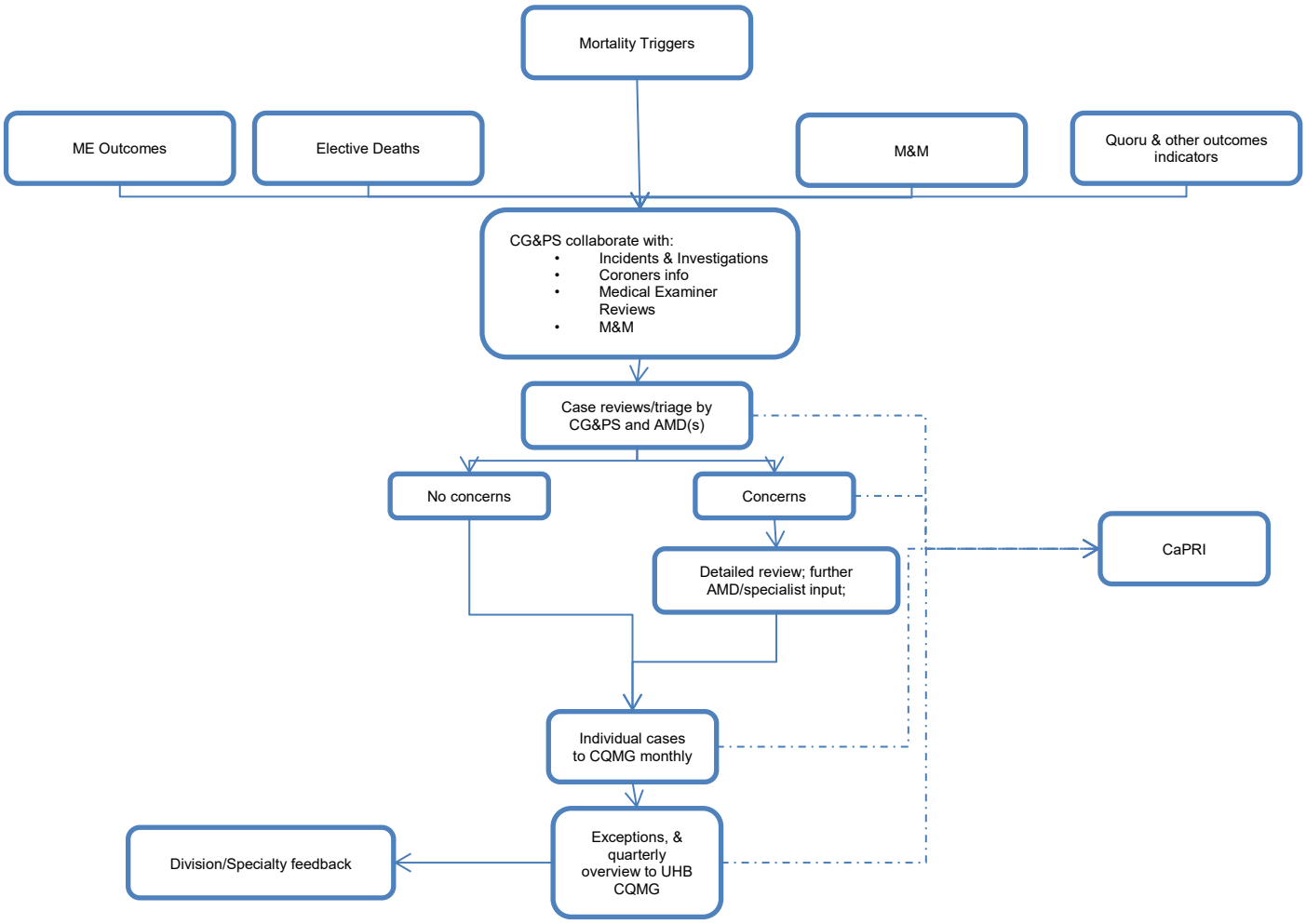


Figure 1: Trust Mortality Review Process

3. External Measures

In accordance with the National Quality Board's Learning from Deaths guidance, the Trust is required to include the following information in a public board paper on a quarterly basis:

- The total number of inpatient deaths in the Trust
- The total number of deaths receiving a front line review
- The number identified to be more likely than not due to problems in care

University Hospitals Birmingham's (UHB) definition of more likely than not due to problems in care is based on the Royal College of Physician's (RCP) Avoidability of Death scoring system. Any case that scores a 3 or less is considered to be possibly due to problems in care and therefore a possibly avoidable death.

The RCP Avoidability scoring system is defined as follows:

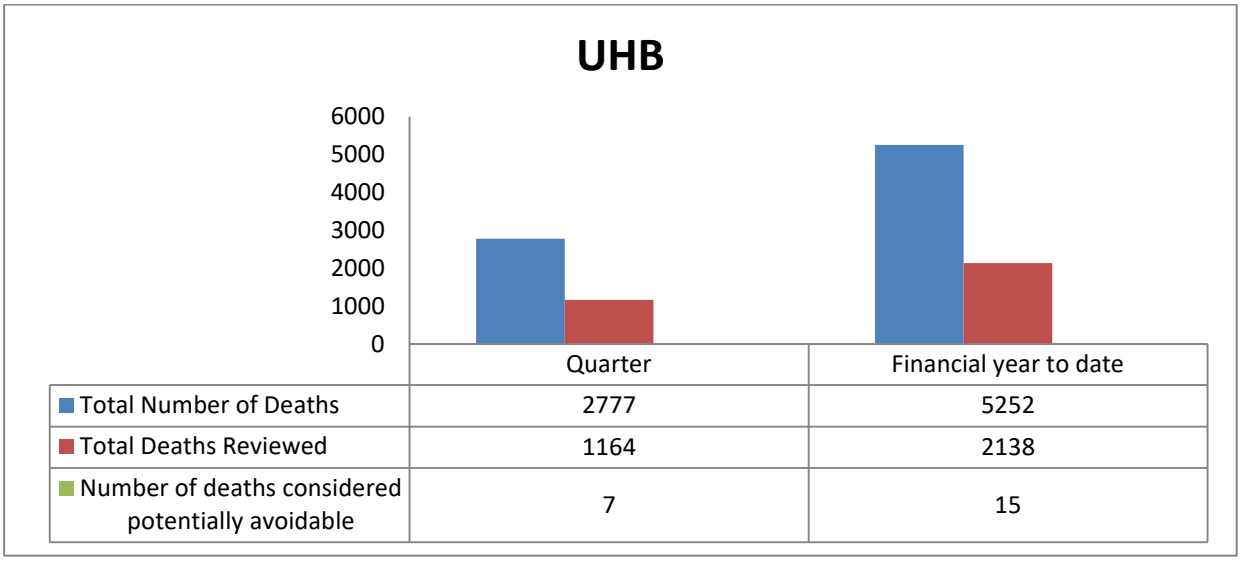
- Score 1: Definitely avoidable
- Score 2: Strong evidence of avoidability
- Score 3: Probably avoidable
- Score 4: Possibly avoidable but not very likely
- Score 5: Slight evidence of avoidability
- Score 6: Definitely not avoidable

Medical Examiners (MEs) will not have had any input into the care of the patient they are reviewing and are not specialists in the clinical specialty of the deceased patient. This is intended to provide an independent opinion into the case. MEs are expected to be overly critical and cautious, to prompt further review into cases where there is the suggestion of shortfalls in care. Any cases which are identified by MEs as having potential shortfalls in care are escalated for further review as per usual Trust processes.

Emergency legislation (Coronavirus Act 2020) includes changes to death certification, registration and cremation paperwork. During the pandemic it was necessary to temporarily suspend scrutiny. However, retrospective scrutiny was subsequently completed for approximately half of these cases, and any meeting the criteria for further follow-up were escalated via usual governance processes. Oversight of coroner referrals and death certification continues during any period of temporary scrutiny suspension.

4. UHB Quarter 2, 2021/22, Summary

The graph overleaf shows the total number of deaths within the Trust during the last quarter, the total number of deaths reviewed by MEs, and the number considered potentially avoidable.



	Quarter	Financial year to date
Total Number of Deaths	2777	5252
Total Deaths Reviewed	1164	2138
Number of deaths considered potentially avoidable	7	15

Figure 2: Number of front line reviews of deaths and those considered avoidable (a score of 3 or less on the RCP Avoidability of Death scoring system) based on front line Medical Examiner reviews.

Seven deaths received a score of three or less, meeting the criteria for being classified as potentially avoidable. Of these, four had already been flagged for higher investigation prior to the ME review. All of the cases have been assessed via a governance review, and are subject to further investigation.

The seven potentially avoidable cases are:

I. An elderly, frail gentleman undergoing surgery for penile cancer at Heartlands Hospital deteriorated and subsequently died despite transfer to a higher level of care. The case is being investigated as an Executive RCA.

II. An elderly patient was admitted for planned surgery to her small bowel. Post operatively she had periods of hypotension, and subsequently an unwitnessed fall and deterioration. A Serious Incident investigation has been completed.

III. A patient presented to a nearby hospital with headaches. Advice was given by UHB Neurosurgery team, and the patient was subsequently discharged. The patient later collapsed in the community with an intracranial bleed and despite treatment did not survive. The case is being investigated as a Serious Incident.

IV. Patient with cancer of the cervical spine underwent complex decompression surgery. Post-operatively the patient was stable and had multiple assessments regarding his airway. The patient suffered a sudden respiratory arrest and could not be resuscitated. The case is under review as a Divisional RCA.

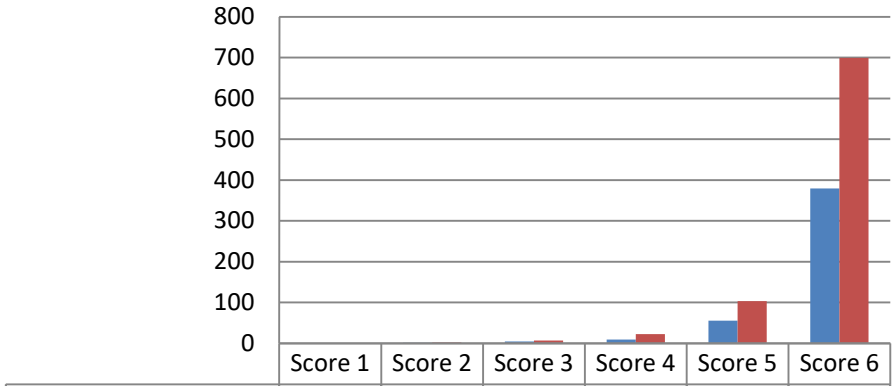
V. An elderly patient was admitted with diverticulitis. During the admission they had a stroke. The patient acquired Covid-19 from which they deteriorated and died. The case is under investigation as a Level 1 Serious Incident.

VI. A middle-aged patient was admitted for treatment of an urosepsis, had a sudden deterioration on the ward and despite treatment on ITU died of organ failure and septicaemia. The case has been referred to Mortality and Morbidity meeting for further investigation.

VII. An elderly patient was admitted post a fall in the community. There were some delays in management of the fracture and treatment of the lower respiratory tract infection the patient developed. The case has been referred to Mortality and Morbidity meeting for further investigation.

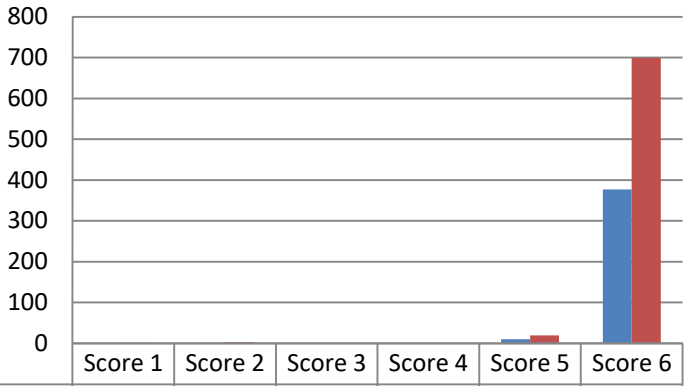
The graphs below show the breakdown of scoring against the avoidability measures across the four hospital sites.

Figure 3 - QEH



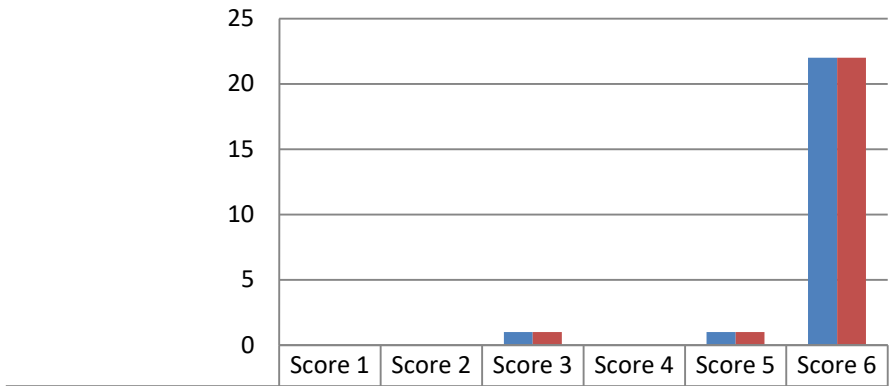
	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	1	4	9	55	379
Financial Year to Date	0	2	7	22	103	699

Figure 4 - BHH



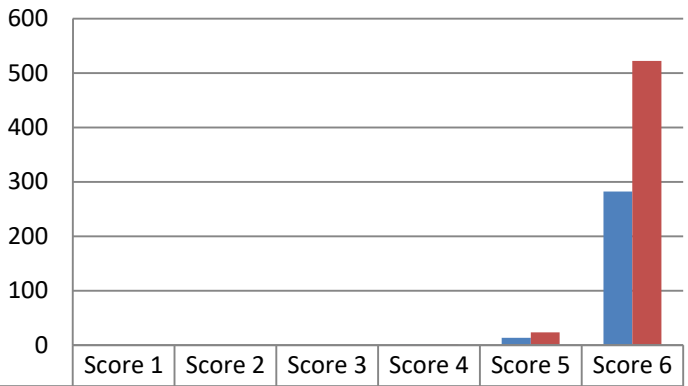
	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	1	0	0	10	377
Financial Year to Date	1	3	0	0	19	699

Figure 5 - SH



	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	0	1	0	1	22
Financial Year to Date	0	0	1	0	1	22

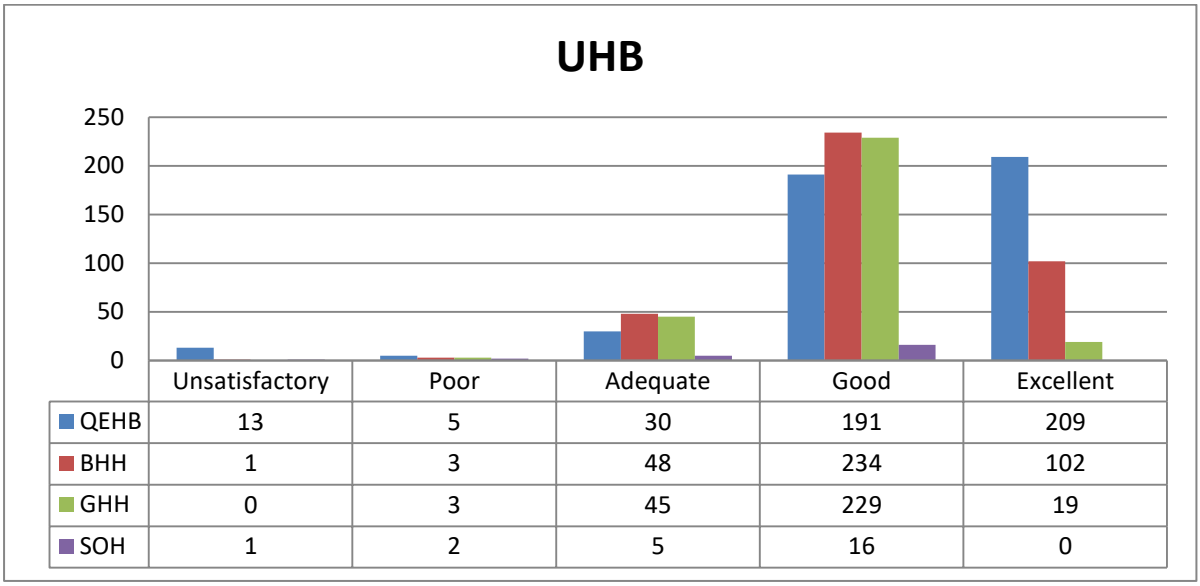
Figure 6 - GHH



	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Most recent quarter	0	0	0	1	13	282
Financial Year to Date	0	0	0	1	23	522

5. Medical Examiner Scoring of Care

This section summarises Medical Examiners overall scoring of care, which is based on the RCP Summary Category of Care scoring system. This scoring system is only monitored and reported internally. Internal scoring of care focuses mainly on the quality of care provided, regardless of the effect on the patient's outcome, whereas the external avoidability measure is focused on outcomes.



	Unsatisfactory	Poor	Adequate	Good	Excellent
QEHB	13	5	30	191	209
BHH	1	3	48	234	102
GHH	0	3	45	229	19
SOH	1	2	5	16	0

Figure 7: UHB Scoring of Care by Hospital Site for the quarter

The RCP Summary Category of Care scoring system is defined as follows:

- Excellent care: This was excellent care with no areas of concern.
- Good care: This was good care with only one or two minor areas of concern and no potential for harm to the patient.
- Adequate care: This was satisfactory care with two or more minor areas of concern, but no potential for harm to the patient.
- Poor Care: Care was suboptimal with one or more significant areas of concern, but there was no potential for harm to the patient.
- Unsatisfactory care: Care was suboptimal in one or more significant areas resulting in the potential for, or actual, adverse impact on the patient.

Fifteen cases were found to have unacceptable care. Four of the cases marked as unsatisfactory care this quarter were the same cases found to have been potentially preventable as described above. The cases highlight the following themes which are being followed up at a case level via M&M and Root Cause Analysis (RCA) Investigation:

- In-hospital falls prevention and management
- Medication management including diabetes medications and palliative medications
- Hospital onset Covid-19
- Respiratory and oxygen management

6. Deaths in Patients with Learning Disabilities

There were fourteen deaths in patients with Learning Disabilities reviewed by the Medical Examiners within Quarter 2, 2021/22, at UHB.

All of cases were found to be not avoidable, with ten definitely not avoidable, three with a slight evidence of avoidability, and one probably not avoidable.

Eleven cases were either good or excellent care. Three were deemed adequate care. Two of these related to potential delays in diagnosis that were not significant enough to have affected the outcome, and one related to management of palliative care medications.

No other concerns have been highlighted for this patient group. Learning Disability cases are subject to LeDeR reviews.

Appendix B

Child Death Review Process
Quarter 1, April to June 2021

1. Introduction

The purpose of this report is to provide the Board of Directors with a summary of the child death reviews for the period 1st April 2021 to 30th June 2021.

The aim of the Child Death Review Process is to identify learning to prevent future child deaths. These reviews are in addition to other existing governance processes as appropriate such as: Sudden and Unexpected Deaths in Children (SUDIC) multi agency reviews; safeguarding; and learning disabilities.

It should be noted that the data presented in this report represent babies, children and young people who have died; and each and every death is a devastating loss to the families, friends and others who knew the child.

2. Update on the National picture

Published on 10th June 2021, the National Child Mortality Database (NCMD) published its second annual report. The report is based on data for children who died from 1 April 2019 to 31 March 2020 in England, providing analysis of the 3,347 children who died in that period; this equates to approximately 28 child deaths for every 100,000 children living in England. The report offers insights based on the characteristics of the deaths analysed in order to improve outcomes for children in the future.

Key points covered in this report were as follows:

Most deaths occurred before the age of one (63%) and, of these – where gestational age at birth was known – 69% were born preterm (before 37 weeks).

42% of all children who died were under 28 days old, prompting a recommendation to reduce the number of preterm births and improve outcomes after preterm delivery.

The infant mortality rate (children under one year old) in England over this period was 3.4 deaths per 1,000 live births.

A number of other key findings relating to ethnicity, deprivation and location of death (where this data was recorded) are as follows:

78%, of deaths had ethnicity recorded. 62% were from a White ethnic group, 19% were from an Asian or Asian British background, 9% were from a Black or Black British background, and 7% were from a mixed background.

The majority of child deaths (78%) occur in hospitals with 22% occurring in the community.

There were approximately three times as many deaths for children who were resident in the most deprived neighbourhoods compared to the least deprived neighbourhoods.

Modifiable factors

For the first time since the start of the child death review process in 2008, factors that are considered to be modifiable in children's deaths were analysed on a national scale[1]. These factors help to identify key areas for improvement. Across all categories of death, the most frequent modifiable factor identified was smoking by a parent or carer. The next most frequently identified factor was gaps in service delivery, while challenges with access to services and poor communication both also feature in the most frequently identified modifiable factors.

Recommendations

This report states a clear call to action for all professionals involved in planning or providing services to children to play an active part in reducing the number of children who die, encouraging them to use the data in this report to implement changes to address the issues highlighted by the report.

NCMD also recommends further improvements in the completeness and quality of child death data collected to allow for enhanced future analyses. It is further recommended that actions be put in place at local, regional and national levels to address the modifiable factors identified in this report.

> "*As a society it is incumbent upon us to learn from these tragedies and to identify ways in which we can change things to reduce the number of children who die in the future*."
>
> Professor Karen Luyt, NCMD Programme Lead

3. UHB Child Death Review Process

The Child Death Review meeting is chaired by a Deputy Chief Medical Officer and clinicians include the Assistant Medical Director - Clinical Governance, consultants (paediatrics, neonatology and obstetrics) and senior nursing and midwifery leads. Other attendees include clinicians who were directly involved in the care of the child during his or her life, the Clinical Service Lead and any professionals involved in the investigation into the death.

Child Death Review meetings include:

- A review of the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death;
- Ascertaining contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery;
- A review of support provided to the family.

[1] In child mortality review, professionals have moved away from defining 'avoidability' to instead using the language of 'a preventable death' where the latter is defined as a death in which modifiable factors may have contributed to the death.

- Identification of any learning arising from the death and, where appropriate, to identify actions to improve the safety or welfare of children.

On completion of each review, a summary of the panel findings are forwarded by the Trust to the relevant Child Death Overview Panel (CDOP) i.e. to the area where a child who has died was normally resident.

4. UHB Quarter 1, 2021: Summary

There were 15 neonatal deaths and 4 paediatric deaths during quarter 1.

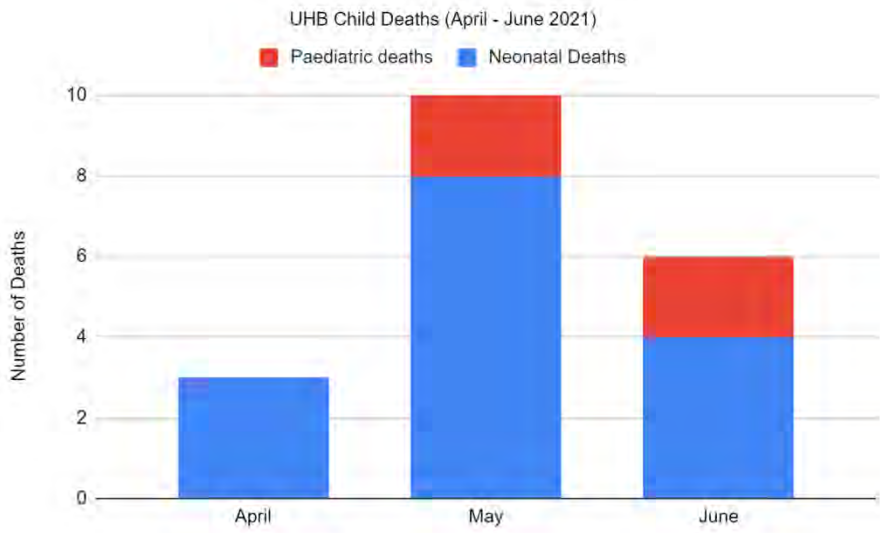


Figure 1: Paediatric and Neonatal Deaths reported by month

Data from the previous quarters for comparison are shown below:

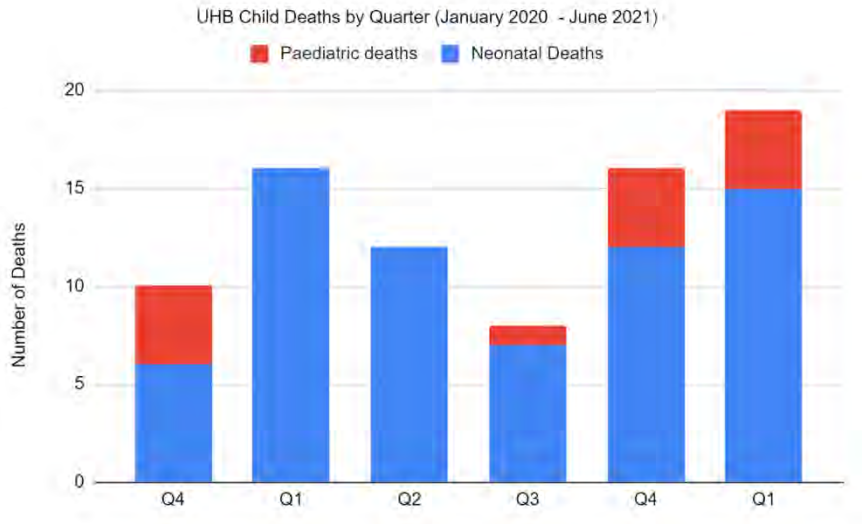


Figure 2: Paediatric and Neonatal Deaths reported by quarter

4.1. Neonatal deaths

Of the 15 neonatal deaths (which included two sets of twins), all of these were early deaths (survived between 22 minutes - 4 days) and, with the exception one baby, all

were all born prematurely; 93% born prematurely compared with the national figure of 69%. Twelve babies died very shortly after birth (less than 5.5 hours).

Gestation period ranged from 15+5 weeks to 41weeks.

All deaths were categorised as perinatal/neonatal events with the exception of one which was a congenital anomaly.

Twenty two weeks and above (six babies)

PMRT[2] reports are produced for all babies born at 22 weeks and over.

PMRT reviews include a grading system to apply a quality of care level to a number of different areas; antenatal care, neonatal care and bereavement care. The grading is as follows:

- A - No issues with care identified;
- B - Care issues identified that would have made no difference to the outcome;
- C - Care issues identified which may have made a difference to the outcome;
- D - Care issues identified which were likely to have made a difference to the outcome.

From the PMRT reports available to the CDRM, there were either no issues identified (A) or some care issues although they were of the opinion that this would sadly not have changed the outcome for the babies (graded as B).

Area for improvement

One mother's baby was identified prenatally as having an anomaly. Following counselling, the parents chose to continue with the pregnancy and a 'comfort care pathway' was put in place. This was clearly documented on the patient's record on Badgernet. The purpose of this pathway is to support professionals to deliver sensitive and timely support at what is a heart breaking time, enabling families to bond and build memories of their baby with as little technologically dependent care as possible.

However, not all staff members were aware of this pathway being in place and on more than one occasion, a CTG[3] was commenced and then discontinued once the comfort care pathway had been identified.

Discussion took place at the CDRM about what systems could be put in place to highlight that certain interventions during pregnancy would not be appropriate for some patients. Further discussions are to take place regarding this with the divisional team.

Below 22 weeks

There were nine babies born below 22 weeks (range 15+5 weeks to 21+1weeks).

[2] **PMRT:** Perinatal Mortality Review Tool. The aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.

[3] **Cardiotocography (CTG**) is used during pregnancy to **monitor** fetal heart rate and uterine contractions. It is most commonly used in the third trimester and its purpose is to monitor fetal well-being and allow early detection of fetal distress.

Modifiable factors identified related to maternal health (smoking and obesity). There were no modifiable factors related to service issues.

Efforts had been made to maximise the health and well-being in the large majority of cases by offering the opportunity to participate in smoking cessation programmes and promoting a healthy weight.

Brought in deceased from home

Sadly, one neonate with a life-limiting genetic disorder was brought into the A and E department from home without signs of life. Chaplaincy attendance was offered to the family and accepted. The death was expected and CESDI[4] was graded as 1.

5. Paediatric/adolescent deaths

After the first year of life, adolescence is the life stage when children are most likely to die. The factors leading to death in adolescence are different to those in earlier childhood, and differ between males and females. The most common causes of death in this age group are injuries, violence and suicide, followed by cancer, substance misuse disorders and nervous system and developmental disorders (NHS England 2017)[5].

There were four paediatric deaths during this quarter; the age range was 1 year and 3 months to 17 years.

The youngest child had a life limiting condition and was well known to Birmingham Children's Hospital and the community palliative care team. The patient died three days after their admission.

Two adolescents presented to A & E. One child, in cardiac arrest, had a number of known health care issues. This case is being reviewed at a different CDRM. Another child was a victim of an assault in the community. The SUDIC[6] process was initiated and a Police investigation is underway.

One older adolescent deteriorated whilst on an organ transplant waiting list and died on ITU with multi organ failure. The case has been reviewed at M&M and CDRM and as a result, discussions are planned with Birmingham Children's Hospital and Transplant services to discuss the transition process from child to adult care.

[4] **CESDI:** Confidential enquiry into stillbirths and deaths in infancy
[5] National guidance on learning from deaths – NHS England (2017;annex F - children and young people)
[6] SUDIC: Sudden unexpected death in childhood.

Appendix C

Perinatal Mortality Reviews
Quarter 4, 1st January – 31st March 2021

1. Introduction

The purpose of this report is to provide a summary of the Perinatal Mortality Review (PMR) for the period 1st January – 31st March 2021.

2. Background

The Trust has an established PMR process as part of the Trust's approach to identify learning to prevent future deaths.

Output from the Trust's PMR Process is reported internally within the Division and to Clinical Quality Monitoring Group.

The Trust's PMR Process is complementary to other existing governance processes as appropriate such as: Sudden and Unexpected Deaths in Infancy /Childhood (SUDIC) multi-agency reviews; Child Death Review Meeting (CDRM) which reports to Child Death Review Process (CDOP) , Learning from Deaths (adult cases until the statutory Medical Examiner system is introduced); safeguarding; and learning disabilities (LeDeR), etc. Where appropriate 'Perinatal deaths' are also subject to internal incident investigation processes.

3. UHB Perinatal Mortality Review Process

The PMR meeting is a multi-professional meeting chaired by a Consultant Obstetrician and Feto-Maternal Medicine, and includes other obstetrician, senior nursing and midwifery leads and neonatal consultant colleagues. The purpose of the Perinatal Mortality Review Tool (PMRT) which was designed by MBRRACE (UK Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) in 2018, is to facilitate comprehensive, robust and multidisciplinary reviews of all perinatal deaths from 22+0 gestation, to 28 days after birth, including those babies who die after 28 days following neonatal care.

PMR meetings take place on a monthly basis to ensure:

- A comprehensive case review is completed utilising the standard PMRT;
- The identification of any learning and actions to prevent re-occurrence;
- The identification of cases requiring escalation to the Chief Medical Officer for further review and decision to initiate formal / serious incident investigations.

4. PMR Standards

NHSR- Safety Action 1 (Updated March 2021)	Trust Compliance
Standard a i. All perinatal deaths eligible to be notified to MBRRACEUK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July 2021.	**i. Achieved: 100%** **ii. Achieved: 100%** All eligible cases have their review started on PMRT
Standard b i. At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.	**i. Achieved**: **100%** (requirement was 50%) all eligible cases had their review completed and report published.
Standard c i. For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. ii. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. iii. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.	**i. Achieved: 100%** (requirement was 95%) for all eligible cases parental concerns were sought and inputted on the tool **ii. Achieved: 100%** **iii. Achieved: 100%**
Standard d i. Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.	**i. Achieved:** Reporting established.

5. Summary

The outcomes of the Q3 PMRT and associated action plans were reported to the CQMG meeting in March. A summary of the outcomes reported were:

- 3 out of 16 cases (18.75%) outcome would/may have been different
- 12.5% cases had Good care.
- 68.75% cases had care issues or learning identified which would have not changed the outcome
- Safety Action 1 has been met for this quarter.
- National Ambition of 20% reduction in still births by end of 2020, being maintained (4.18 in Q4 2020 to 3.57 in Q1 2021)
- PNMR(MBRRACE) slightly improved during this quarter from 6.97 in previous quarter to 5.1 in this quarter

Perinatal mortality rates are contained within the first section of the Integrated Quality Report.

Next steps:

- Continued focus on Education:
  - Learning from PMRT/PEM-G Stillbirth and Neonatal Death reviews
  - Focussed interventions(Saving babies Lives –2)
  - Robust Action Plans and audit compliance
- Annual PNMR Rolling audits
- Sustain progress and continue improvement
- Reports to new Joint Quality Group commenced from April 2021

6. Learning and Actions:

6a. Immediate Learning:

Themes	Actions: All completed
1)To ensures that maternal observations in labour are carried out commensurate with the level of risk.	1) Midweek message shared and email to band 7 midwives (06.04.21)
2)To ensure management of hypertension is managed appropriately in pregnancy.	2) Midweek message shared by governance team communication within the community midwifery team forum(18.06.21 and 31.08.21). HT GI updated to include guidance for community midwives
3)To ensure the Bereavement team are up-to-date with the indications for chromosomal analysis for the pregnancy loss cases.	3) Team brief by Bereavement lead Midwife .
4)To ensure that Combined screening is facilitated if opted by the women.	4) Shared communication with the individual regarding trisomy screening /timing.(22.03.21) Ensure that women receive letter for their next appointment for USS before they leave clinic (22.03.21)
5) To Ensure that appropriate monitoring continues during the transfer of a Neonate from delivery to the NNU.	5) Neonatal Governance letter (March 2021) Midweek message (03.02.21 and 14.06.21)
6) Ensure the management of neonatal infection in the first 24 hours is appropriately assessed and carried out	6) Golden Hour Audit , informed midweek message (03.02.21) and March Newsletter
7)To ensure that women who present with pregnancy complications that specific birth planning advice is given	7) To highlight at Safety Champions meeting and Q&S regarding a process of changing plans between Consultants for safety netting and support for consultants.

8) To ensure that appropriate escalation is carried out when a patient presents unwell.	8) Midweek message reminding staff of early escalation to senior staff and email to Band 7 midwives (06.04.21)
9) Ensure that additional surveillance is in place if IOL is delayed beyond an agreed date /gestation.	9) Case Vignette with Midweek Message
10) Ensure awareness of administration of Anti D in the first trimester when presenting with recurrent PV bleeding.	10) Midweek message reminding of Anti D guidance
11) Awareness of the importance of commencing MGSO4 when in threatened preterm labour for optimization	11) Mid-week message to remind staff of the MGSO4 guidance. Team Brief (01.03.21)

6b. Systems Learning:

Themes	**Actions: 6x completed 10x in Progress**
1) Re- Audit of Aspirin and PET risk assessment to ensure compliance	1) Re—Audit of Aspirin and PET risk assessment: Presented at Q&S speciality (June 2021.)
2)To ensure that Lead professional is documented on Badger Net for all Bookers	2) Audit completed of a sample of patients from ANC re documentation of lead professional— Ockendon documented on to the Badger Net system. Continuous Audit.
3)Education and Awareness regarding the need of immediate presentation with reduced fetal movements	3) Working Group on RFM, communication via audio in different languages.
4) Review of CTG interpretation and documentation.	4) Dedicated Fetal monitoring study day. b)Audit to check pulse oximetry is available for every CTG machine c)Daily equipment checks to be carried out (March 2021)
5)To ensure contact is made with patients who are COVID + and that follow up management is documented	5) Knock Door Policy introduced , new guideline implemented (12.05.21)
6) To ensure that when women DNA appointments they are followed up according to the local DNA guidance.	6) NEW DNA guideline launched (19.07.21)
7)Embed in existing ANC pathway to ensure appropriate risk assessment for aspirin and VTE	7) The ANC Transformation Pathway -risk assessment for aspirin and VTE for every booker attending hospital at time of their dating scans
8) Review of current interpreting services for use in maternity care	8) On-going review of interpreting services, current guidance, survey monkey completed by labour ward manager, results awaited.
9) Whilst attending hospital, observations to be performed at USS appointments.	9) Exploring existing ANC pathways and establishing feasibility and resources/ Implemented in FM.
10)Ensure that patients are booked at the appropriate AN clinics to meet their risks and needs	10) New triage tool and pathway to be rolled out as part of ANC Transformation (July 2021).
11) To establish appropriate use of IT systems within gynaecology to fall in line with one used in Maternity services	11) To use the EPAU section of badger net for pregnant patients attending GAU.
12) Discuss and explore feasibility of integrated system of working between hospital and out of area community midwives.	12) On-going: Part of SUI Investigation
13) Explore as MDT issues around documentation of neonatal aspects of care on maternal badger net	13) On-going review and QI project within the team to review use of badger net for all aspects of Neonatal care.
14) Monitor capacity of the bereavement suite	14) Ongoing audit for families who cannot access bereavement suite.
15) Ensure that the process for Placenta histological examination to be carried out is clear within guidance.	15) Placenta Guideline currently under review
16) Delay in receiving clotting results from labs	16) On-going: Part of SUI Investigation