East Kent Hospitals University
NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust

Learning from Deaths

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We care

Version Control Schedule

Version	Date	Author	Status	Comment
1.0	Sept-17	Paul Stevens, Medical Director	Final	
2.0	Feb-19	Stefa Buras-Rees	Final	Reformatting of whole document and addition of points

Consultation and Ratification Schedule

Name and Title of Individual	Date Consulted
Dr Sally Smith – Chief Nurse and Director of Quality	September 2017
Dr Jonathan Purday – Deputy Medical Director	September 2017
Dr Michelle Webb – Associate Medical Director for Patient Safety	September 2017
Helen Goodwin – Deputy Director of Risk, Governance and Patient Safety	September 2017
Dr Paul Stevens – Executive Medical Director	November 2018
Dr Michelle Webb – Associate Medical Director for Patient Safety	November 2018
Helen Goodwin – Deputy Director of Risk, Governance and Patient Safety	November 2018
Mel Brewer – Head of Patient Safety	November 2018

Name of Committee	Date Reviewed
Mortality Information Group	September 2017
Mortality Information Group	January 2019
Patient Safety Committee	February 2019

Associated Documentation

Incident Management Policy

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1. Policy Summary

1.1. East Kent Hospital University Foundation Trust (EKHUFT or the 'Trust') is required to demonstrate how it responds to, and learns from, deaths of people who either die while in our care or whose subsequent death may be attributable to our care. Our aim is to support our staff to review and learn from deaths and then take effective action to embed improvements. Our aim is also to enable families and carers to raise and have answered questions or concerns about the care of patients who have died. We will work collaboratively with the Kent Surrey Sussex Community of Mortality Practice to develop the system wide capacity to work together with system partners to share learning.

1.2. This policy describes our approach to learning from deaths, see summary and flowchart (Appendix 1 and 2), and should be followed in conjunction with the Incident Management Policy (including Duty of Candour).

1.3. The policy applies to all staff whether they are employed by the Trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the Trust's behalf.

2. Introduction

2.1. Learning from deaths of people under our care can help us improve the quality of the care we provide to patients and their families, and identify where we could do more.

2.2. A Care Quality Commission (CQC) review in December 2016, 'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England' found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care[i]. Following on from this in March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care[ii]. That report required Trusts to undertake a number of actions to ensure a systematic approach to identifying those deaths requiring review and a systematic, standardised approach to the performance, reporting and learning from those reviews, working with commissioners to review and improve local approaches following the death of people receiving care.

2.3. The latest research suggests that preventable deaths due to problems in care make up around 5% of deaths and that the variation seen in the 'Summary Hospital-Level Mortality Indicator' (SHMI) and other indicators is likely to be due to other factors[iii]. However, the burden of preventable deaths nationally is still

substantial and further analysis locally is required to attempt to identify those areas where there may be systematic and correctible shortcomings in care that contribute to preventable deaths. Findings from the recent Francis report show that 'higher than expected' mortality rates were at worse ignored or manipulated and at best the subject of poorly functioning non-systematic mortality review meetings in which failings in the quality of care were not confronted or corrected[iv]. Essentially, there are three levels of scrutiny that a provider can apply to the care provided to someone who dies; death certification; case record review; and investigation. They do not need to be initiated sequentially and an investigation may be initiated at any point, this already happens within the Trust through the incident reporting system (Datix) and identification of StEIS reportable incidents involving mortality.

3. Definitions

3.1. Death certification: The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

3.2. Case record review: A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

3.3. Mortality review: A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

3.4. Serious Incident: Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

3.5. Investigation: The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred (see Incident Management Policy 2018).

3.6. Structured Judgement Review (SJR): The SJR is a tool used by trained reviewers to review the medical record in a critical manner commenting on specific phases of clinical care. The process provides both quantitative and qualitative information on care that goes well, or not so well and examines both interventions and holistic care – which means that the whole record is reviewed, including nursing notes. SJR is usually based on one reviewer's judgement, with a second-stage review where there is cause for concern at first review.

3.7. Service review: consists of a Structured Judgement Review of 30–40 cases (or the maximum number available at the time of review if less than 30 cases) to enable the production of breadth and depth of information regarding a service, area of care or management of a medical condition. After an initial review it will be decided by the clinician leading the review if a repeat review is required the following year other than high risk groups which will be reviewed yearly.

3.8. Learning: The process of identifying what goes well in order to improve, or what may need to change in order to reduce the risk, in service provision or of future occurrence of similar events. Learning also ensures that any identified information derived from these processes is shared through robust governance processes, and acted upon.

3.9. Preventable death: A death due to a problem in care is a death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

3.10. Timely: Cases reviewed as close to death as possible, in view of potential duty of candour needs. Ideally, within six weeks of death or in cases selected as a result of cluster review selection within six weeks of selection.

4. Purpose and Scope

4.1. The Trust is required to demonstrate how it responds to, and learns from, deaths of people who either die while in our care or whose subsequent death may be attributable to our care. This policy outlines the minimum number and the categories of deaths that should be reviewed:

4.1.1. All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;

4.1.2. All deaths of those with learning disabilities and with severe mental illness;

4.1.3. All deaths which are subject to a coroners review;

4.1.4. All deaths in areas where people are not expected to die, for example in relevant elective procedures;

4.1.5. All cardiac arrests >24hrs after admission to hospital;

4.1.6. Through the Mortality Information Group, all deaths where the senior coders have concerns during their process of coding the cause of death;

4.1.7. A service review of deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator, or where death has occurred linked to a Regulation 28 from the coroner (Report to Prevent Future Deaths);

4.1.8. A service review of deaths classified as High Risk Groups (HRGs), for example stroke, acute kidney injury, pneumonia, COPD, MI, fractured neck of femur, emergency laparotomy pathway;

4.1.9. A service review of deaths, where learning will inform our existing or planned improvement work, for example improving sepsis care. In order to maximise learning, such deaths will be reviewed thematically;

4.1.10. A further sample of other deaths that do not fit the identified categories so that the Trust can take an overview of where learning and improvement is needed most. The aim is that this will be every third adult death that is recorded from within the Trust as identified by the Trust’s analyst team.

4.2. Pending introduction of the Medical Examiner role all doctors completing cremation forms are required to also refer deaths for review where possible concerns regarding care are identified.

4.3. This policy will ensure that:

4.3.1. There will be consistency in the quality of patient mortality reviews within the Trust;

4.3.2. The outcome of such reviews will be clearly documented and archived;

4.3.3. Clear reporting mechanisms will be in place, to escalate any areas of concern identified by mortality reviews, so that the organisation is aware and can ensure appropriate action is taken;

4.3.4. Mortality monitoring data is analysed and acted upon as appropriate;

4.3.5. Learning is shared through the Mortality Community of Practice and any other relevant route (http://www.kssahsn.net/what-we-do/better-quality-and-safer-care/leadership-culture-capability/communities-of-practice/Pages/Mortality.aspx).

5. Duties

5.1. Board of Directors have overall responsibility for monitoring and learning from deaths across the Trust.

5.2. A non-executive director will be responsible for the oversight of the programme and to ensure that progress is made against the national recommendations.

5.3. The Medical Director is responsible for ensuring the Trust complies fully with all national requirements for the programme.

5.4. The Mortality Information Group, under the chairmanship of the Medical Director, will be responsible for the review and monitoring of Trust learning from avoidable deaths.

5.4.1. This committee has the required multi-disciplinary and multi-professional membership and will continue to meet monthly to oversee the process.

5.5. Consultants and clinicians nominated as clinical leads for the learning from deaths programme are responsible for training their colleagues in the process and ensuring the programme is delivered and functioning in line with national recommendations.

5.6. Senior medical staff (ST4 and above) and senior members of other professional groups will be trained and participate in the process of case note review to support a thorough review process.

5.7. The role of Medical Examiners

5.7.1. The introduction of the Medical Examiner role is expected to provide further clarity about which deaths should be reviewed by actively identifying and allocating appropriate cases as per Trust policy.

5.7.2. A national network of medical examiners was recommended by the Shipman, Mid-Staffordshire and Morecambe Bay public inquiries and in March 2016 the Secretary of State announced a consultation for their introduction from April 2019.

5.7.3. The proposed role of the Medical Examiner will be to:

5.7.3.1. Scrutinise every death not requiring a coroner investigation, provide expert advice and confirm the doctor's Medical Certification of Cause of Death ensuring the cause of death is accurate;

5.7.3.2. Discuss the cause of death with the family and address any concerns they may raise;

5.7.3.3. Identify patterns of causes of death; where indicated refer the death of any patient for review by the most appropriate provider organisation(s).

5.7.4. The exact role of the medical examiner will be clarified by research commissioned by NHS Improvement and the Department of Health.

6. Case Note Record Review Methodology

6.1. The Trust will adopt a modified version of the Structured Judgement Review proposed by national guidance (see Appendix 3 and 4).

6.2. This methodology is robust and evidence-based and will generate the information the Trust is now being required to publish.

6.3. Trust health professional staff will be trained and given sufficient time and resources to undertake case record reviews and act on what they learn.

6.4. To ensure objectivity case record reviews will be conducted by clinicians other than those directly involved in the care of the deceased.

6.5. The judgement of whether a problem may have contributed to a death requires careful review of the care that was provided against the care that would have been expected at the time of death. Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems none of which would be likely to have caused the death in isolation but which in combination can contribute to the death of a patient iii, v.

6.6. All patient deaths of those with learning disabilities and with severe mental illness will be reviewed using the Learning Disabilities Mortality Review (LeDeR) Programme methodology (see LeDeR Process Flowchart at Appendix 5).

6.7. All child deaths will be reviewed using the Trust Child Death Review Process (Appendix 6).

7. Interactions with Bereaved Families and Carers

7.1. The Trust will engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death.

7.2. Bereaved families and carers will:

7.2.1. Be treated as equal partners following bereavement;

7.2.2. Receive a clear, honest, compassionate and sensitive response in a sympathetic environment;

7.2.3. Receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support.

7.2.4. Be informed of their right to raise concerns about the quality of care provided;

7.2.5. Receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.

7.3. Bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed.

7.4. Bereaved families and carers should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations.

7.5. Bereaved families and carers who have experienced the investigation process will be supported to work in partnership with the Trust in delivering training for staff in supporting family and carer involvement where they want to.

8. Reporting and governance arrangements

8.1. In addition to the mortality reports already received by the Trust Board in the Integrated Performance Report in the future these reports will also include two additional areas:

8.1.1. The total number of deaths reviewed monthly by the structured judgement review methodology and the total number of deaths considered to have more than a 50% chance of having been avoidable.

8.1.2. The total number of adult inpatient deaths for patients with identified learning disabilities reviewed using the LeDeR methodology and the total number of deaths considered to have been potentially avoidable.

8.2. The same reports will be made available to the CCG Performance and Quality monitoring meetings.

8.3. The learning from avoidable death in individual patients will also be made available to the patient's GP.

8.4. Learning will be shared through the Mortality Community of Practice.

9. Key Stakeholders, Consultation, Approval and Ratification Process

9.1. This policy will be approved by the Patient Safety Committee after appropriate consultation with the Mortality Information Group.

9.2. This policy will be ratified by the Policy Compliance Group.

10. Review and Revision Arrangements

10.1. This policy will be reviewed after a three year period, or earlier where necessary due to changes in national guidance or organisational updates.

11. Dissemination and Implementation

11.1. The policy will be available on the Trust policy management system.

12. Document Control including Archiving Arrangements

12.1. This policy conforms to the policy for the Development and Management of Procedural Documents.

12.2. Archiving of this policy will conform to the EKHUFT Information Lifecycle policy, which sets out EKHUFT's policy on the management of its information.

12.3. The policy, in its previous form and future version formats, will be maintained in Trust's policy management system.

12.4. This policy will be uploaded to the Trust's policy management system.

13. Monitoring Compliance

13.1. The Mortality Information Group, under the chairmanship of the Medical Director, will be responsible for the review and monitoring of this policy.

13.2. The Patient Safety Board will receive reports concerning structured case note reviews from each Care Group as part of the regular Care Group Governance reports to Patient Safety Board.

14. References

i. Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. CQC December 2016. https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

ii. National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. National Quality Board March 2017. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

iii. Horgan H, Healey F, Neale G, et al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. BMJ Quality and Safety (2012). Doi:10.1136/bmjqs-2012-001159.

iv. Healthcare Commission, Investigation Into Mid Staffordshire NHS Foundation Trust, March 2009

v. Hogan et al. Avoidability of hospital deaths and association with hospital-wide mortality ratios: a retrospective case record BMJ 2015; 351:h3239

15. Appendices

Appendix 1 – Summary of Adult Structured Judgement Review process

Ten things you should know about the Adult Structured Judgement Review process at EKHUFT

1. **The Structured Judgement Review (SJR) is a process to enable our organisation to learn from deaths of people who die while in our care or whose subsequent death may be attributed to our care**

2. **There are three categories of patient deaths that require review. See the tables below:**

2.1.

Category 1:
all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision; (Pending introduction of the Medical Examiner role this includes, all doctors completing cremation forms are required to also refer deaths for review where possible concerns regarding care are identified)
all deaths of those with learning disabilities and with severe mental illness;
all deaths in areas where people are not expected to die, for example in relevant elective procedures, cardiac arrests >24 hours stay
all deaths where the senior coders have concerns during their process of coding the cause of death

2.2.

Category 2:
deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised through whatever means
deaths where learning will inform our existing or planned improvement work
deaths from High Risk Groups (HRGs)

2.3.

Category 3:
a further sample of other deaths that do not fit the identified categories so that the Trust can take an overview of where learning and improvement is needed most

3. **Column 2 on the tables below, describe how these deaths are reported and/or identified for a SJR**

3.1.

Category 1:	**Column 2 (How deaths are reported/identified for SJR)**
all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision; (Pending introduction of the Medical Examiner role this includes, all doctors completing cremation forms are required to also refer deaths for review where possible concerns regarding care are identified)	Datix Incident reporting system, Complaints process, SOS, Freedom To Speak Up Guardians
all deaths of those with learning disabilities and with severe mental illness;	LeDeR process
all deaths in areas where people are not expected to die, for example in relevant elective procedures, cardiac arrest >24 hours stay	M&Ms, Errors and Complications meetings
all deaths where the senior coders have concerns during their process of coding the cause of death	Mortality Information Group
all deaths that have been referred to the coroner	via the Relatives Support Officer

3.2.

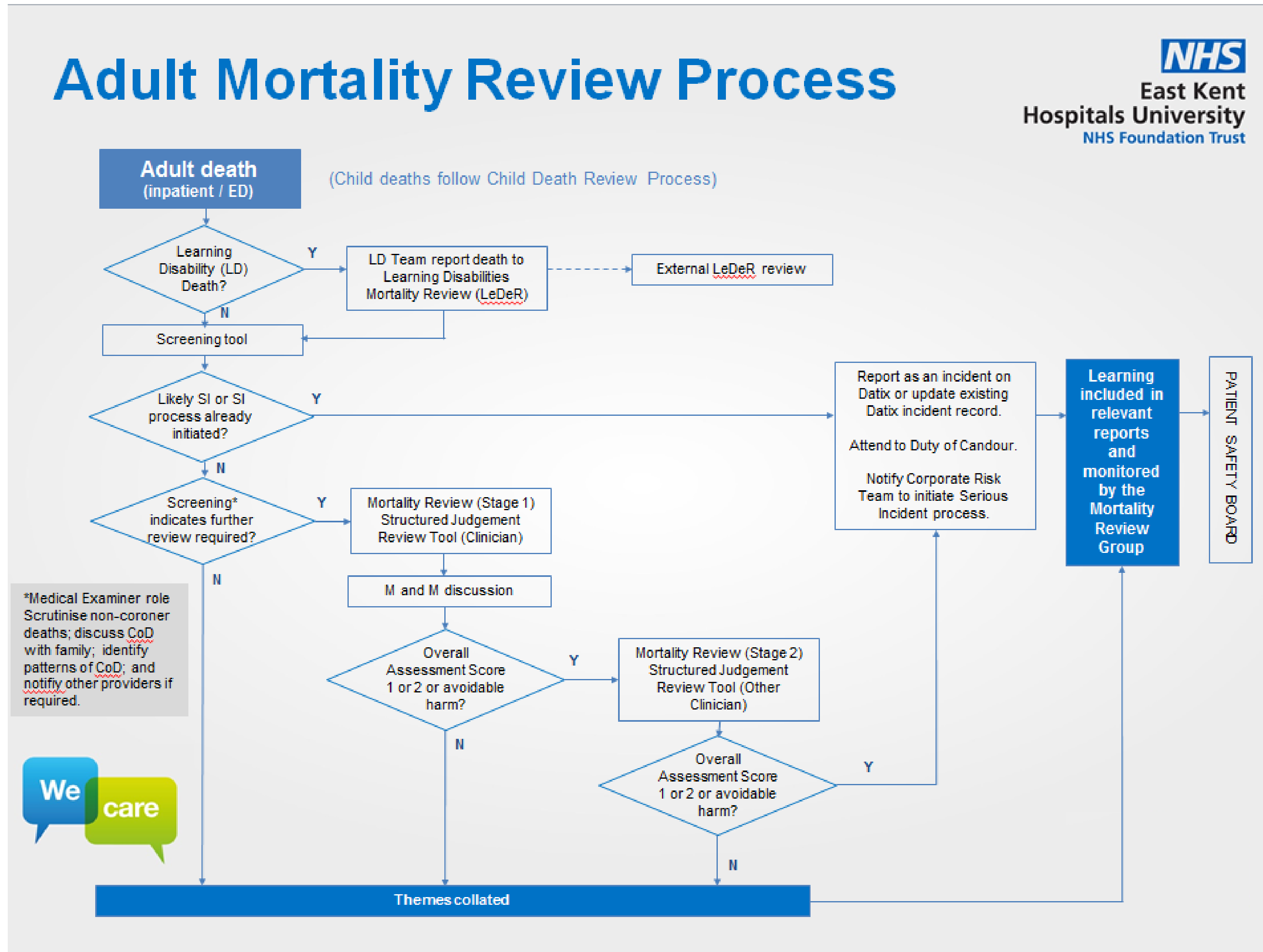
Category 2:	**Column 2**
deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised through whatever means	Examples are via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator, or where death has occurred linked to a Regulation 28 from the coroner (Report to Prevent Future Deaths)
deaths where learning will inform our existing or planned improvement work	For example improving sepsis care. In order to maximise learning, such deaths will be reviewed thematically
deaths from High Risk Groups (HRGs)	Random selection of deaths

3.3.

Category 3:	**Column 2**
a further sample of other deaths that do not fit the identified categories so that the Trust can take an overview of where learning and improvement is needed most	Every third death selected using Patient Tracker lists at corporate level

4. **Formal SJRs must be carried out by a senior doctor (Consultant or ST4 and above). This is one person's view that is then escalated to M&M or other wider review processes as applicable, for example coroner, Serious Incident (SI)**
5. **Anyone carrying out a SJR must have attended a training programme delivered by a Royal College of Physicians (RCP) SJR trainer**
6. **Doctors should not review a patient who was within their own case load**
7. **Documentation of a formal SJR is via an electronic form found on the Trust Intranet portal. Follow link: http://10.136.235.150/MeticulousFormsTEST/Form/EKBI/mortality_case_record_review A review not entered onto the electronic database cannot be used as part of the Trust's learning profile**
8. **A SJR is not required if the death is already subject to a RCA (SI) investigation**
9. **The completed SJR and associated M&M review record may be requested by the coroner**
10. **To find out more detail about SJR, read the policy "Learning from Deaths" which can be found by following the link: https://insight4grc.ekhuft.nhs.uk/Assets/394/policy?inline=true**

Appendix 2 - Adult Mortality Review Process



Appendix 3 - EKHUFT Structured Case Note Review Screening Tool

Adult Structured Judgement Review Screening Tool

Part 1 *Completed by Doctor completing Part I of death certificate* ***(for all deaths)***

Patient ID	NHS number	Hospital Number
Patient Name		
Date of Birth		
Date of Death		
Ward of Death		
Cause of Death (if available)	1:	
	1a:	
	2:	
Was this death reported to the Coroner?	☐ Yes ☐ No	
Consultant at Time of Death		

Checklist for submitting to case record review		**Yes**	**No**
1	Have family members or carers raised a significant concern about the quality of care provision?	☐	☐
2	Have any staff members raised a significant concern about the quality of care provision?	☐	☐
3	Was this an unexpected death, for example following an elective procedure?	☐	☐
4	Did the patient have a learning disability?	☐	☐
5	Did the patient have a severe mental illness?	☐	☐
6	Do you have any other cause to think that this death would benefit from a mortality review? *(Please indicate your reasons below)*	☐	☐

Completed by: **Date completed:**

Job Title: *RSO to scan and send to s.buras-rees@nhs.net Keep original in patient notes*

Part 2 *Completed by Corporate Patient Safety team*

Criteria for Case Record Review		Yes	No
1	Has an alert been raised on CHKS or through SHMI indicators?	☐	☐
2	Has a concern or red flag been raised in relation to an area which is already under investigation or subject to review, for example sepsis or cardiac arrest?	☐	☐
3	Is there an incident recorded on Datix which directly relates to the death?	☐	☐
4	Is there a complaint/PALS concern relating to this case?	☐	☐
5	Is there a safeguarding concern relating to this case?	☐	☐
6	Has a CQC or other regulatory organisation raised a concern regarding this case?	☐	☐

Serious Incident Investigations	Yes	No
Is this case already being investigated under the SI process?	☐	☐

Completed by: **Date completed:** Click here to enter a date.

Job Title:

Outcome *Completed by Corporate Patient Safety team*

Is further review required?	☐ Yes ☐ No
If 'Yes', which review process?	☐ Structured Case Note Review ☐ Serious Incident
Date review requested	
Request sent to	
Request sent by	

Appendix 4 - EKHUFT Structured Case Note Review Form

Structured Case Note Review Form

Name of reviewer	
Reviewing specialty *(e.g. cardiology)*	
Patient NHS Number	
Patient Hospital Number	
Patient name	
Patient date of birth	
Age at death *(years)*	
Sex	☐ Male ☐ Female
First 3 / 4 digits of postcode	
Date of last admission	
Time of last admission	
Date of death	
Time of death	
Place of death *(ward)*	
Specialty at time of death	☐ Surgical ☐ Medical
Specialty team at time of death *(e.g. cardiology)*	
Consultant at time of death	
Type of admission	☐ Emergency ☐ Elective ☐ Day Case
Recorded cause of death *(part 1a, 1b, 1c and 2 on medical certificate of cause of death)*	

Phase of Care Scores

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during each phase. Please circle only one score for each.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Phase of care	Score and explicit judgements
Admission and initial management *(approximately the first 24 hours)*	 Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Ongoing care	 Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Phase of Care Scores Continued

1 = very poor care   2 = poor care   3 = adequate care   4 = good care   5 = excellent care

Phase of care	Score and explicit judgements
Care during a procedure *(excluding IV cannulation)*	 Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Perioperative care	 Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
End of life *(or discharge care in the event that this form is used for a morbidity review)*	 Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Overall Care Score

Overall assessment *(explicit judgements about quality of care the patient received overall)*	 Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Quality of patient record *(patient notes)*	 Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Assessment of Problems in Healthcare

Were there any problems with the care of the patient?

☐ **No** *(please stop here)* ☐ **Yes** *(please continue below)*

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please circle all problems which relate to this case.

Problem Type	**Yes?** *(tick as appropriate)*	**Did the problem lead to harm?** *(include comments as necessary and tick as appropriate)*
Problem in assessment, investigation or diagnosis *(including assessment of pressure ulcer risk, VTE risk, history of falls)*	☐	 ☐ No ☐ Probably ☐ Yes

Problem with medication / IV fluids / electrolytes / oxygen *(other than anaesthetic)*	☐	 ☐ No ☐ Probably ☐ Yes
Problem related to treatment and management plan *(including prevention of pressure ulcers, falls, VTE)*	☐	 ☐ No ☐ Probably ☐ Yes
Problem with infection control	☐	 ☐ No ☐ Probably ☐ Yes
Problem related to operation / invasive procedure *(other than infection control)*	☐	 ☐ No ☐ Probably ☐ Yes
Problem in clinical monitoring *(including failure to plan, to undertake, or to recognise and respond to changes)*	☐	 ☐ No ☐ Probably ☐ Yes
Problem in resuscitation following a cardiac or respiratory arrest *(including cardiopulmonary resuscitation - CPR)*	☐	 ☐ No ☐ Probably ☐ Yes
Problem of any other type not fitting the categories above	☐	 ☐ No ☐ Probably ☐ Yes

Avoidability of Death Judgement Score

We are interested in your view on the avoidability of death in this case.

Please choose from the following scale (tick one score).

☐ **Definitely avoidable**

☐ **Strong evidence of avoidability**

☐ **Probably avoidable (more than 50:50)**

☐ **Possibly avoidable but not very likely (less than 50:50)**

☐ **Slight evidence of avoidability**

☐ **Definitely not avoidable**

This section is for your any notes you want to make in support of your judgement

Mortality reviews must be completed promptly and on the electronic form to facilitate early learning and prevent delays.

Appendix 5 - LeDeR Process Flow Chart

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP), on behalf of NHS England.

LeDeR Process Flowchart

Notifications
LeDeR Team receive notification. Identify those meeting criteria for review.

↓

Inform and assign cases for review
LeDeR Team informs Local Area Contact of a new case.
LAC identifies suitable reviewers and informs LeDeR.
LeDeR Team informs reviewer of the case allocation.

↓

Local reviewer: pre-initial review information gathering
Is this individual subject to any other existing review process.

Yes → **Link in with other process**
Establish the nominated contact for the other review process and liaise with them.
Where possible collect core data required for the LeDeR review. Provide learning disabilities expertise to other review process if appropriate and required.

↓

Agree with the other review process
Complete initial review.
Agree comprehensive pen portrait and timeline.
Agree potentially avoidable contributory factors.
Identify lessons learned.
Agree on good practice and any recommendations.

↓ (to Summary and Close)

No → **Initial Review**
Conversation with someone who knew the person well.
Review of relevant case notes.
Complete pen portrait, timeline and action plan.

↓

Decide whether further action is required
Further action is required if:
Additional learning could come from a fuller review;
If it is a Priority Themed Review;
If red flags indicate this.

← **Further Action: Prepare for Multi-agency Review**
Contact other agencies involved.
Contact family members/someone who knew person well.
Request relevant notes and documents.
Arrange and prepare for multi- agency meeting.
Update case documentation.

↓

Multi-agency Meeting
Agree comprehensive pen portrait and timeline.
Agree potentially avoidable contributory factors to death.
Identify lessons learned.
Agree on good practice and any recommendations.
Complete action plan.

↓

→ **No Further Action**
The completed report and action plan is returned to the Local Area Contact for sign off and then sent to the LeDeR Programme

↓ (to Share with Steering Group)

Summary and Close
The completed report and action plan is returned to the Local Area Contact for sign off and then sent to the LeDeR Programme.

→ **Share with Steering Group**
Local Area Contact shares anonymised learning points and actions with their relevant Steering Group to ensure learning is embedded and action plans are taken forward.

V2.2 Jan 2017

Appendix 6 - Trust Child Death Review Process

Child Death Review Process

History - Aide-mémoire

Please ensure these points are covered

1. Identification Data

a. General:

i. Name of child (and preferred name)
ii. Date of birth
iii. Date of death
iv. Gender
v. Ethnicity
vi. Address and postcode

b. Family:

i. Name, address, DOB and current contact numbers for father, mother, partner
ii. Names of siblings and dates of birth

Other relevant information

i. GP name and address
ii. Consultant on call
iii. Designated Doctor
iv. Police officer/senior investigating officer
v. Social worker
vi. Coroner/Coroner's officer
vii. School/ nursery
viii. Other professionals

2. Details of transport of child to hospital

a. Place of death(home address/another location/DGH)

b. Time found

c. Time arrived in A&E

d. Resuscitation details (if carried out)

a) At scene/ambulance/A&E

b) By carers/GP/ambulance crew/hospital staff/others

c) Confirmation of death:

Date, Time, Location, by whom?

c. History details

a. Taken by? In A&E/at home.

b. Obtained from? Relationship

Child Death Review Process

History - Aide-mémoire

Please ensure these points are covered

Events surrounding death:

- Who found the child
- Where/when
- For accidental/traumatic deaths, details of circumstances around death and witnesses
- Appearance of child when found
- Who called emergency services?
- Details of any resuscitation at home, by ambulance crew and in hospital

Detailed narrative account of last 24 – 48 hours:

- All activities and carers during last 24 – 48 hours
- Any alcohol consumed by either child or carers
- For SUDI, details of last sleep (including where/how put down, where/how found and details of feeding and care given/who with
- Details of when last seen by a doctor/other professional
- Further details of previous 2 – 4 weeks (including child's health and any changes to routine)

Family History:

- Details of all family and household members (names; DOB; health – previous or current illness; mental health; medications; occupation, alcohol/drug use, smoker/not)
- Maternal parity and obstetric history
- Parental relationships
- Children (including those by previous partners)
- Household composition
- Any previous childhood deaths in family

Past Medical History:

- Child (pregnancy, delivery, perinatal, feeding, growth and development)
- Health (current/previous illness, hospital admissions, medications)
- Routine checks/immunisations
- Systemic review
- Behavioural and educational history if appropriate

Social History:

- Type and nature of housing, any major life events
- Travel
- Wider family support networks

Any other relevant history:

- May vary according to age of child and nature of death

Information retrieved from records:

- Hospital, GP, Health visitor, Midwife, NHS Direct (inc. family held records eg. request PHCR red book)
- Ambulance crew
- Social services, databases, case records, child protection register
- Police – intelligence, assist, PNC, domestic violence etc.

Child Death Review Process
Physical examination - Aide-mémoire

To be carried out by a senior paediatrician or senior clinician on call for emergency department, ideally together with an officer from the police child protection team. Where necessary, photographs should be taken by a police forensic officer.

- General
  - Physical examination carried out by?
  - Other parties present
- Physical exam
  - Date and time
  - Full growth measurements (+ centiles)
    - Length
    - Weight
    - Head circumference
- Findings
  - To include state of nutrition/hygiene; skin markings; distribution of livido; bruises/evidence of injury (document all markings on accompanying body chart); retinal examination; oral examination (check lingual and labial frenulum); genitalia; back; any medical interventions (e.g. venepuncture sites)
  - Any other findings
- Further details, observations and comments
  - Document all medical interventions, all drugs given in resuscitation; if E-T tube inserted, document position prior to removal; any other comments
  - Post mortem samples as per protocol in licensed premises (mortuary) after discussion with coroner, document which specimens were obtained, using checklist
  - It is the admitting clinicians responsibility to check results of any investigations done and act upon
  - Ensure personal telephone call by admitting clinician and offer to meet with the family soon (document in notes)
  - Offer further follow up with family following post-mortem result

Appendix 7 - Equality Analysis (EA)

An Equality Analysis not just about addressing discrimination or adverse impact; the policy should also positively promote equal opportunities, improved access, participation in public life and good relations.

Person completing the Analysis		
Name	Dr Paul Stevens	
Job title	Medical Director	
Division/Directorate	Corporate	
Date completed		
Who will be impacted by this policy	[ ] Staff (EKHUFT) [ ] Staff (Other) [ ] Service Users	[ ] Carers [ ] Patients [ ] Relatives

Assess the impact of the policy on people with different protected characteristics. When assessing impact, make it clear who will be impacted within the protected characteristic category. For example, it may have a positive impact on women but a neutral impact on men.		
Protected characteristic	**Characteristic Group**	**Impact of decision** Positive/Neutral/Negative
e.g. Sex	Women Men	Positive Neutral
Age	Low	Neutral
Disability	Medium	Neutral
Gender reassignment	None	Neutral
Marriage and civil partnership	None	Neutral
Pregnancy and maternity	None	Neutral
Race	None	Neutral
Religion or belief	None	Neutral
Sex	None	Neutral
Sexual orientation	None	Neutral

If there is insufficient evidence to make a decision about the impact of the policy it may be necessary to consult with members of protected characteristic groups to establish how best to meet their needs or to overcome barriers.	
Has there been specific consultation on this policy?	There has been national, regional and local consultation regarding the key principles. The results of the consultation are reflected in the policy and there were no differences identified.
Did the consultation analysis reveal any difference in views across the protected characteristics?	

Mitigating negative impact: Where any negative impact has been identified, outline the measures taken to mitigate against it.	There are several strands to the learning from deaths that focus on both age and disability. Whilst there are different approaches to the assessment of the death, this is to segment the approach rather than to exclude or manage the review in a different way.

Conclusion: Advise on the overall equality implications that should be taken into account by the policy approving committee.	The guidance is one that has a national remit. The findings are based on the national consultation.

Appendix 8 – Plan for Dissemination of Policy

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

<table>
<tr><td>Title of document:</td><td colspan="3">Learning from Deaths Policy</td></tr>
<tr><td>Version Number:</td><td colspan="3">2</td></tr>
<tr><td>Approval Date:</td><td>06 February 2019</td><td rowspan="2">Dissemination lead:</td><td rowspan="2">Paul Stevens</td></tr>
<tr><td>Previous document already being used?</td><td>Yes, version 1</td></tr>
<tr><td>If yes, in what format (paper / electronic) and where (e.g. Directorate / Trust wide)?</td><td colspan="3">Electronic, on Trust policy management system and on Trust website (external facing)</td></tr>
<tr><td>Proposed instructions regarding previous document:</td><td colspan="3">The policy, in its previous form and future version formats, will be maintained in Trust's policy management system.</td></tr>
<tr><td>To be disseminated to:</td><td>How will it be disseminated, who will do it and when?</td><td>Format (i.e. paper or electronic)</td><td>Comments:</td></tr>
<tr><td></td><td>Once ratified, this policy will be distributed to the Clinical Directors and Heads of Nursing of each Care Group from the Medical Directors Office, who will in turn, distribute it the their relevant Clinical Leads, Senior Matrons, Consultant Nurses, Nurse Specialists and Matrons; within one month of it being ratified.</td><td>Electronic</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
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