Policy on responding to deaths (including engagement with bereaved families and carers)

Scope	**Trust Wide**
Owner	**Mortality Surveillance Committee**
Contact	**Jane Wells, Director of Nursing**
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Search summary:

National Guidance on learning from deaths was published in March 2017 by the National Quality Board and provides a framework for Trusts for identifying, reporting, investigating and learning from deaths. It includes requirements for policy, investigation and regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information in Quality Accounts from June 2018. Explicit within this is the requirement to compassionately and meaningfully engage with bereaved families and carers.

VERSION CONTROL

Document Location

Oxleas NHS Foundation Trust Intranet	*See under* Policy and Document Library

Change History

Vrsn	Owner	Changed by	Change summary	Date
1.0	Mortality Group	N/A	First issue of policy	17.05.17
1.1	Mortality Group	L French	Updated CYP section (appendix 5)	Aug 2017

Responsibility for distribution of this document

Mortality Surveillance Committee

CONTENTS

1 Introduction

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

In December 2016, the Care Quality Commission (CQC) published its review Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

The Secretary of State for Health accepted the report's recommendations and in a Parliamentary statement made a range of commitments to improve how Trusts learn from reviewing the care provided to patients who die. A National Guidance on learning from deaths was published in March 2017 by the National Quality Board and provides a framework for Trusts on identifying, reporting, investigating and learning from deaths. This includes regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information in Quality Accounts from June 2018.

The National Guidance on Learning from Deaths should be read alongside the Serious Incident Framework. The National Guidance makes explicit that Trust boards are accountable for ensuring compliance with both these frameworks and states:

> "*Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under its management and care….Boards should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This will allow them to identify any areas of failure of clinical care and ensure the delivery of safe care. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership, regular mortality reporting to the Board at the public section of the meeting with data suitably anonymised, and outputs of the mortality governance process including investigations of deaths being communicated to frontline clinical staff" (NQB March 2017 page 8).*

2 Aims

The policy aims to set out how we:

- determine which patients are considered to be under our care and included for case record review if they die (and also state which patients are specifically excluded);
- report the death within the organisation and to other organisations who may have an interest (including the deceased person's GP), including how we determine which other organisations should be informed;

- respond to the death of an individual with a learning disability or mental health needs, an infant or child death review the care provided to patients who we do not consider to have been under our care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past;
- review the care provided to patients whose death may have been expected, for example those receiving end of life care;
- record the outcome of our decision whether or not to review or investigate the death, which should have been informed by the views of bereaved families and carers;
- engage meaningfully and compassionately with bereaved families and carers including informing the family/carers if we intend to review or investigate the care provided to the patient. In the case of an investigation, this will include details of how families/carers will be involved to the extent that they wish to be involved.

3 Definitions of terms used

Case record review

The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians or similar methodology.

Investigation

The act or processes of investigating using root cause analysis methodology; 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. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

Death due to a problem in care

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.

4 Roles and responsibilities

The board will ensure that our organisation:

- has an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress;
- pays particular attention to the care of patients with a learning disability or mental health needs;
- has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;
- adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in

care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
- ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
- ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting of deaths is discussed at the public section of the board level with data suitably anonymised;
- ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts;
- shares relevant learning across the organisation and with other services where the insight gained could be useful;
- ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths;
- offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death;
- acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved;
- works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services.

Chief Executive
The Chief Executive is ultimately accountable for the process of managing learning from deaths.

Executive Director of Nursing
The Executive Director of Nursing has the responsibility for the learning from deaths agenda.

Non-Executive Director
The Non-Executive Director has the responsibility for oversight of mortality surveillance.

Public Governor
The public Governor has the responsibility for providing assurance of the execution of the executive and non-executive roles to the Council of Governors.

All Trust directors, executive and non-executive
All directors have a responsibility to constructively challenge the decisions of the board and have a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:
- the processes in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support;
- quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change;
- the information published is a fair and accurate reflection of its achievements and challenges.

Mortality Surveillance Committee

The Mortality Surveillance Committee is chaired by the Executive Director of Nursing (lead for Patient Safety) and reviews all death data learning from deaths.

Clinical reviewers

Clinical directors and senior clinicians in each directorate are appointed to conduct clinical case reviews and are responsible for undertaking these using the RCP Structured Judgment Review or similar methodology and reporting the findings to the Mortality Surveillance Committee monthly.

Line managers

It is the responsibility of all Trust managers to support employees to comply with this policy.

Employee responsibility

All employees must comply with their professional codes in respect of this policy.

5 Skills and Training

The skills and training to support mortality surveillance will be regularly reviewed to ensure that staff reporting deaths have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard.

All clinical reviewers receive training in root cause analysis serious incident investigation methodology in order to form a judgment about the predictability and preventability of the deaths.

Training will be undertaken in LeDeR review process for clinical reviewers undertaking reviews of deaths of people with learning disabilities.

All new and existing employees will be made aware of the Policy for Responding to Deaths as part of their induction programme.

6 Support and advice for staff

It is very rare for healthcare staff to go to work with the intention of causing harm or failing to do the right thing. While we do all we can to minimise risk, it will never be possible to eliminate it fully and human factors can increase risks. The culture and focus will always be on learning and prevention and not individual blame. Support will be provided to staff from line managers initially, senior managers and professional leads and through the Trust's Employee Assistance Programme.

7 Policy for engagement with bereaved families and carers

We will engage with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one and follow the key principles:

Key principles:

- bereaved families and carers should be treated as equal partners following a bereavement;
- bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;
- bereaved families and carers should 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;
- bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one;
- bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed;
- bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;
- 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; bereaved families and carers who have experienced the investigation process should be supported to work in partnership in delivering training for staff in supporting family and carer involvement where they want to.

When a patient dies, bereaved families and carers should be informed immediately after the death. People who are bereaved need others to recognise and acknowledge their loss. Recognition by professionals, appropriately expressed, may be particularly valued. Communication at the time of a death, and afterwards, should be clear, sensitive and honest. Bereaved families and carers should be given as much information as possible in line with the Duty of Candour for providers. Every effort should be made to hold these discussions in a private, sympathetic environment, without interruptions. Providers should ensure that their staff, including family liaison officers where available, has the necessary skills, expertise and knowledge to engage with bereaved families and carers. This includes recognising and dealing with common issues such as family members feeling guilty about their loss.

When reviewing or investigating possible problems with care, involvement of bereaved families and carers begins with a genuine apology. Saying sorry is not an admission of liability and is the right thing to do. The appropriate staff member should be identified for each case, including to explain what went wrong promptly, fully and compassionately. This may include clinicians involved in the case but this may not always be appropriate and should be considered on a case by case basis.

Depending on the nature of the death, it may be necessary for several organisations to make contact with those affected. This should be discussed with the bereaved families and carers and a co-ordinated approach should be agreed with them and the organisations involved. If other patients and service users are involved or affected by the death they should be offered the appropriate level of support and involvement.

The responsible clinician should check that the deceased person's General Practitioner is informed of the death and provided with details of the death as stated in the medical certificate at the same time as the family or carers. The GP should be informed of the outcome of any investigation.

Bereavement Support

We offer information about bereavement support and guidance for families and carers of people who die under our care (including offering or directing people to suicide bereavement support). This includes assigning the role of a named contact from within the Patient Safety Team to help families and carers through the practical aspects following the death of a loved one such as a death referred to the coroner; emotional support and information. When a patient dies in one of our inpatient services, the ward manager will ensure the sensitive collection of belongings and documentation.

The following should be taken into consideration

- timely access to an advocate (independent of the Trust) with necessary skills for working with bereaved and traumatised individuals;
- support with transport, disability, and language needs;
- support during and following an investigation, such as, counselling or signposting to suitable organisations that can provide bereavement or post-traumatic stress counselling, with attention paid to the needs of young family members, especially siblings; further meetings with the organisations involved or support in liaising with other agencies such as the police.

Resources available include: Public Health England - Support after a suicide: A guide to providing local services
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf
http://supportaftersuicide.org.uk/support-guides/help-is-at-hand/

If family or carers have raised a concern following the death of a relative, we will review and / or investigate. If following a case review of a death we consider instigating an investigation, we will involve wherever possible inform families and carers of this decisions in line with our key principles for engaging with bereaved families and carers. We will share with family and carers the findings of a review if any problems with care are identified and any lessons the review has contributed for the future investigation.

Bereaved families and carers will:

- be made aware, in person and in writing, as soon as possible of the purpose, rationale and process of the investigation to be held;
- be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed, in a way that they have agreed, of the process of the investigation;
- have the opportunity to express any further concerns and questions and be offered a response where possible, with information about when further responses will be provided;
- have a single point of contact to provide timely updates, including any delays, the findings of the investigation and factual interim findings;
- have an opportunity to be involved in setting any terms of reference for the investigation which describe what will be included in the process and be given expectations about the timescales for the investigation including the likely completion date;
- be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case;
- be offered an opportunity to respond on the findings and recommendations outlined in any final report; and, be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future.

8 Reviewing deaths

The following minimum requirements are required to complement current approaches in relation to reporting and reviewing deaths - **Death certification, case record review and investigation**

There are three levels of scrutiny that we can apply to the care provided to someone who dies; **(i) death certification; (ii) case record review; and (iii) investigation**. They do not need to be initiated sequentially and an investigation may be initiated at any point, whether or not a case record review has been undertaken (though a case record review will inform the information gathering phase of an investigation together with interviews, observations and evidence from other sources). For example, the apparent suicide of an in-patient would lead to a Serious Incident Investigation being immediately instigated in advance of death certification or any case record review. The three processes are summarised below:

Death Certification

In the existing system of death certification in England, deaths by natural causes are certified by the attending doctor. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. Reforms to death certification, when implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

Case Record Review

Some deaths should be subject to further review by the provider, looking at the care provided to the deceased as recorded in their case records in order to identify any learning. At a minimum, we will reviews:

- all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
- all in-patient, out-patient and community patient deaths of those with learning disabilities (the Learning Disabilities Mortality Review Programme (LeDeR) review process)and with severe mental illness and deaths in custody;
- all deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means (quality alert, concerns raised by audit work, concerns raised by the CQC or another regulator);
- all deaths in areas where people are not expected to die, for example in relevant elective procedures;
- deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed to and maximise learning, such deaths could be reviewed thematically;
- *As all deaths are considered for review and / or investigation we do not require a further sample of other deaths that do not fit the identified categories as all categories are included.*

The above minimum requirements are additional to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths, such as deaths of patients detained under the Mental Health Act 1983.

Clinical directors should review a case record review following any linked inquest (which has not been subject of a serious incident review) and issue of a "Regulation 28 Report on Action to Prevent Future Deaths" in order to examine the effectiveness of their own review process. If an inquest identifies problems in healthcare, consideration must be given to the need to undertake additional investigation and improvement action, regardless of the coroner's verdict.

Investigation

Where it is decided that a death warrants an investigation this should be guided by the circumstances for investigation in the Serious Incident Framework.

Some deaths will be investigated by other agents, notably the coroner. Indeed, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. While care should be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication will be maintained by the Patient Safety Team.

Decisions to conduct a case record review and / or investigate will be in line with the flow chart in appendix 1 and processes specific to Learning Disabilities (appendix 2), Mental Health (appendix 3), Prison Healthcare (appendix 4), Children and Young People (appendix 5) and Community Health Services (appendix 6).

Consistency and Judgement in Case Record Review

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. There is no validated Structured Judgement Review tool currently validated for mental health and community services. The RCP (2016) "acute hospital" Structured Judgement Tool does not add further information produced by a mental health or community health Serious Incident Investigation which includes root cause analysis and a judgement about avoidability.

Until a validated tool is available for mental health and community services a structured judgement will be conducted through root cause analysis in Serious Incident Investigation with a view about predictability and preventability. LeDeR will be used for learning disability services.

Each death reviewed will then be subjectively scored using the Structured Judgement Review criteria:

Score 1: Definitely avoidableScore 2: Strong evidence of avoidability

Score 3: Probably Avoidable (>50:50)

Score 4: Possible avoidable but not very likely (<50:50)

Score 5: Slight evidence of avoidability

Score 6: Definitely not avoidable

Classification of Deaths

Deaths will be categorised using the Mazars (2015) descriptions natural / unnatural and expected / unexpected matrix:

Type	Example Description
Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame. E.g. people with terminal illness or perhaps in palliative care services. These deaths may not be investigated but could be included in a mortality review of early deaths amongst service users. These deaths are unlikely to be preventable.
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer or liver cirrhosis but who dies earlier than anticipated. These deaths should be reviewed and in some cases would benefit from further investigation. Some may be preventable.
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people who misuse drugs, are dependent on alcohol or with an eating disorder. These deaths should be investigated. Some may have been preventable.
Unexpected Natural (UN1)	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke. These deaths should be reviewed and some may need an investigation. Some of these deaths may have been preventable.
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns. These deaths should all be reviewed and a proportion will need to be investigated. Likely to be preventable.
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect. These deaths are likely to need investigating. Likely to be preventable.

The descriptions are not definitive but serve to demonstrate that there are natural cause deaths that would benefit from a review or investigation.

Objectivity in Case Record Review

To ensure objectivity, case record reviews should wherever possible be conducted by clinicians *other than those directly involved in the care* of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased, the review process should still involve clinicians who were not involved in order to provide peer challenge. Objectivity of reviews should be a component of clinical governance processes and will be monitored at the Mortality Surveillance Committee.

Investigations

This National Guidance on Learning from Deaths and the Serious Incident Framework are complementary. This guidance sets out what deaths should be subject to case record review, which is inevitably a wider definition than deaths that constitute Serious Incidents. Equally, when a death meets Serious Incident criteria there is no need to delay the onset of investigation until case record review has been undertaken. A review of records will inevitably be undertaken as part of an investigation process. However, immediate action to secure additional information and evidence to support full investigation should not be lost due an inappropriate requirement for all deaths (regardless of nature) to first undergo a case record review.

Inquiries by the coroner and investigations by providers are conducted to understand the cause of death and contributing factors. However provider investigations are not conducted to hold any individual or organisation to account. Other processes exist for that purpose including criminal or civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, including the General Medical Council and the Care Quality Commission. In circumstances where the actions of other agencies are required then those agencies must be appropriately informed and relevant protocols must be followed.

Medical Examiners

The introduction of the Medical Examiner role will provide further clarity about which deaths should be reviewed. Medical Examiners will be able to refer the death of any patient for review by the most appropriate provider organisation(s) and this new mechanism should ensure a systematic approach to selecting deaths for review, regardless of the setting or type of care provided in the period before a patient's death. NHS Improvement and the Department of Health are commissioning research to explore whether Medical Examiners are best placed to select which deaths need further review and ensure they do not inadvertently miss or over-refer certain types of cases. Prior to the implementation of the Medical Examiner system, Trusts are advised to allow for any doctors undertaking the certification of death to refer cases for case record review to the most relevant organisation.

9 Data collecting and reporting

The Trust Board will receive a **monthly** report collating the deaths reported at the Mortality Surveillance Committee (Appendix 7). The data will include:

- Number of deaths by directorate / care group (children and young people, forensic and prison, adult learning disability, mental health including older people by borough and adult community by borough). These include cases of people who had been an in-patient but had died within 30 days of leaving hospital.
- Number of case reviews undertaken
- Number of mortality investigations undertaken
- Numbers of level 4 and 5 serious incident investigations undertaken
- Number requiring LeDer review process
- Number requiring Child Death Overview Panel process
- For investigations completed, the numbers more than likely to be due to problems in care

The Mortality Surveillance Committee will receive a quarterly update from directorates / care groups which will include:

- The themes identified and changes made following reviews and investigations
- Outcomes of investigations where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
- Outcomes of investigations where an '**alarm' has been raised** with the provider through whatever means (for example quality alert, concerns raised by audit work, concerns raised by the CQC or another regulator)
- Thematic reviews e.g. deaths in custody, falls, suicides, sepsis

10 Learning

Regardless of whether the care provided to a patient who dies is examined using case record review or an investigation, the findings will be part of, and feed into the Mortality Surveillance Committee for governance. Learning from the mortality surveillance reviews will be considered alongside other information and data including complaints, clinical audit information, mortality data, patient safety incident reports and data and outcomes measures to inform wider strategic plans and safety priorities.

Where case record review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this should be reported via local risk management systems to the National Reporting and Learning System (NRLS).

11 Cross-system Reviews and Investigations

In many circumstances more than one organisation is involved in the care of any patient who dies. Where early case reviews indicate potential concerns relating to other organisations, the relevant organisation must be informed via their Head of Patient Safety. Where required, multi-agency case reviews or investigations for groups of patients should be considered. The organisation that declares the serious incident is responsible for recognising and alerting other providers, commissioners and partner organisations as required in order initiating discussions about subsequent action. All organisations should work together to undertake one single investigation. Commissioners will be contacted to facilitate this collaborative process.

12 Other relevant policies, procedures and guidelines

- Duty of Candour
- Reporting and investigation incidents
- Raising matters of concern
- Safeguarding adults
- Safeguarding children

13 References

Care Quality Commission (CQC) (December 2016) Learning, Candour and Accountability: A review of the way Trusts review and investigate the deaths of patients in England. https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

National Quality Board (NQB) (March 2017) 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. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

NHSE (March 2015) Serious Incident Framework: Supporting learning to prevent recurrence

https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf

Mazars (December 2015) Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015
https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

Public Health England - Support after a suicide: A guide to providing local services
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf
http://supportaftersuicide.org.uk/support-guides/help-is-at-hand/

Royal College of Physicians (RCP) (2016) Using the structured judgement review method: A guide for reviewers
https://www.rcplondon.ac.uk/file/4678/download?token=UjZTzTMl

Royal College of Physicians (RCP) Using the structured judgement review method: A clinical governance guide to mortality case record reviews
https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20clinical%20governance%20guide_1.pdf?token=AS-qWBcA

The Structured Judgement Review (SJR) is recommended to be used by clinical reviewers in acute hospital settings. The Structured Judgement Review methodology is presented in:
Royal College of Physicians (RCP) (2016) Using the structured judgement review method: A guide for reviewers
https://www.rcplondon.ac.uk/file/4678/download?token=UjZTzTMl

Royal College of Physicians (RCP) Using the structured judgement review method: A clinical governance guide to mortality case record reviews
https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20clinical%20governance%20guide_1.pdf?token=AS-qWBcA

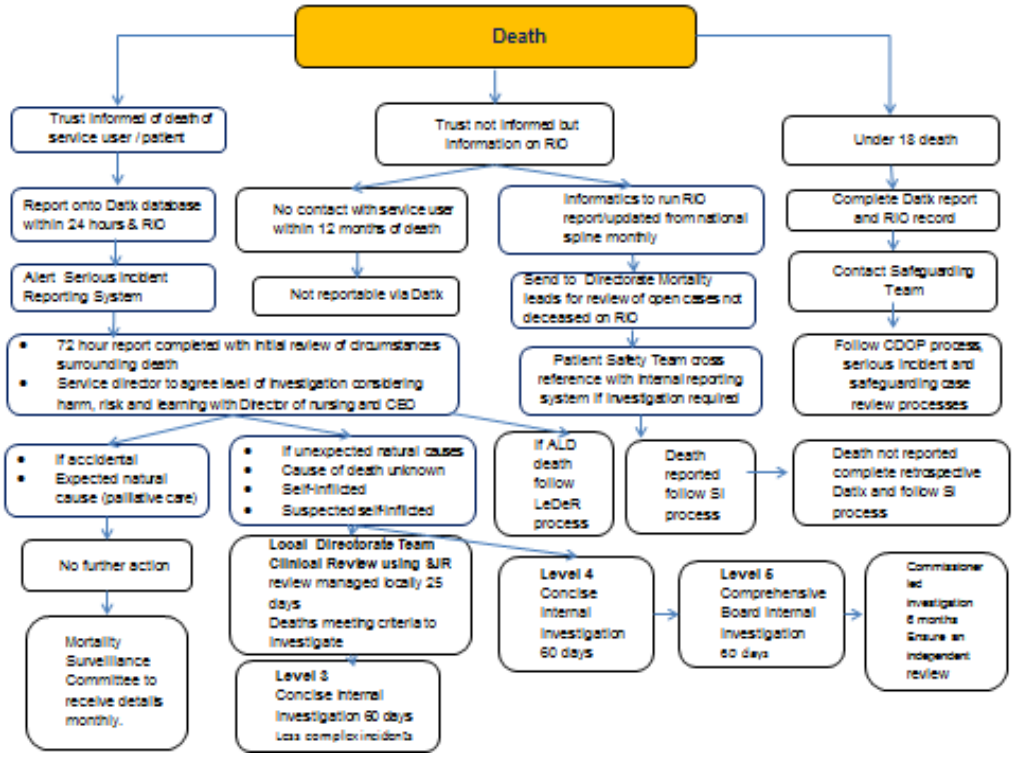
7 Monitoring statement

This may include clinical or non-clinical audit, spot checks or the development of key performance indicators. Where appropriate, consideration should be given to utilising the trust Clinical Audit Programme or Internal Audit Programme. If clinical audit or internal audit is to be used, it is the responsibility of the policy lead to request for the audit to be formally included in the Audit Programme.

Compliance with and monitoring of policies is assessed externally by the NHS Litigation Authority. Policy authors are advised to contact the Risk Manager for advice on any specific monitoring requirements as part of the policy development process.

Key elements to be monitored	How will the monitoring be carried out	Frequency	Responsible person	Reported to	How will shortfalls be addressed and lessons learnt?
Data publication	Mortality Surveillance Committee	Monthly	Director of Nursing	Board	Mortality Surveillance Committee action

Appendix 1 Responding to a death flowchart



Appendix 2 Learning Disabilities

For all deaths of people with learning disabilities the Learning Disabilities Mortality Review programme (LeDeR) process will be applied.

NHS England has commissioned the Healthcare Quality Improvement Partnership (HQIP) and the University of Bristol to undertake the first national programme to review – and ultimately reduce – premature deaths of people with learning disabilities.

Commencing in June 2015 for three years the LeDeR Programme has two key overall aims

- To drive improvement in the quality of health and social care service delivery for people with learning disabilities.
- To help reduce premature mortality and health inequalities in this population support local areas to review the deaths of people with learning disabilities.

To support the delivery of these aims it requires the development of a review process for the deaths of people with learning disabilities and takes forward the lessons learned in the reviews in order to make improvements to service provision.

The LeDeR programme aims to support local areas to review the deaths of people with a learning disability and will be rolling out a standardised review process for the deaths of people with a learning disability across all of England by 2018.

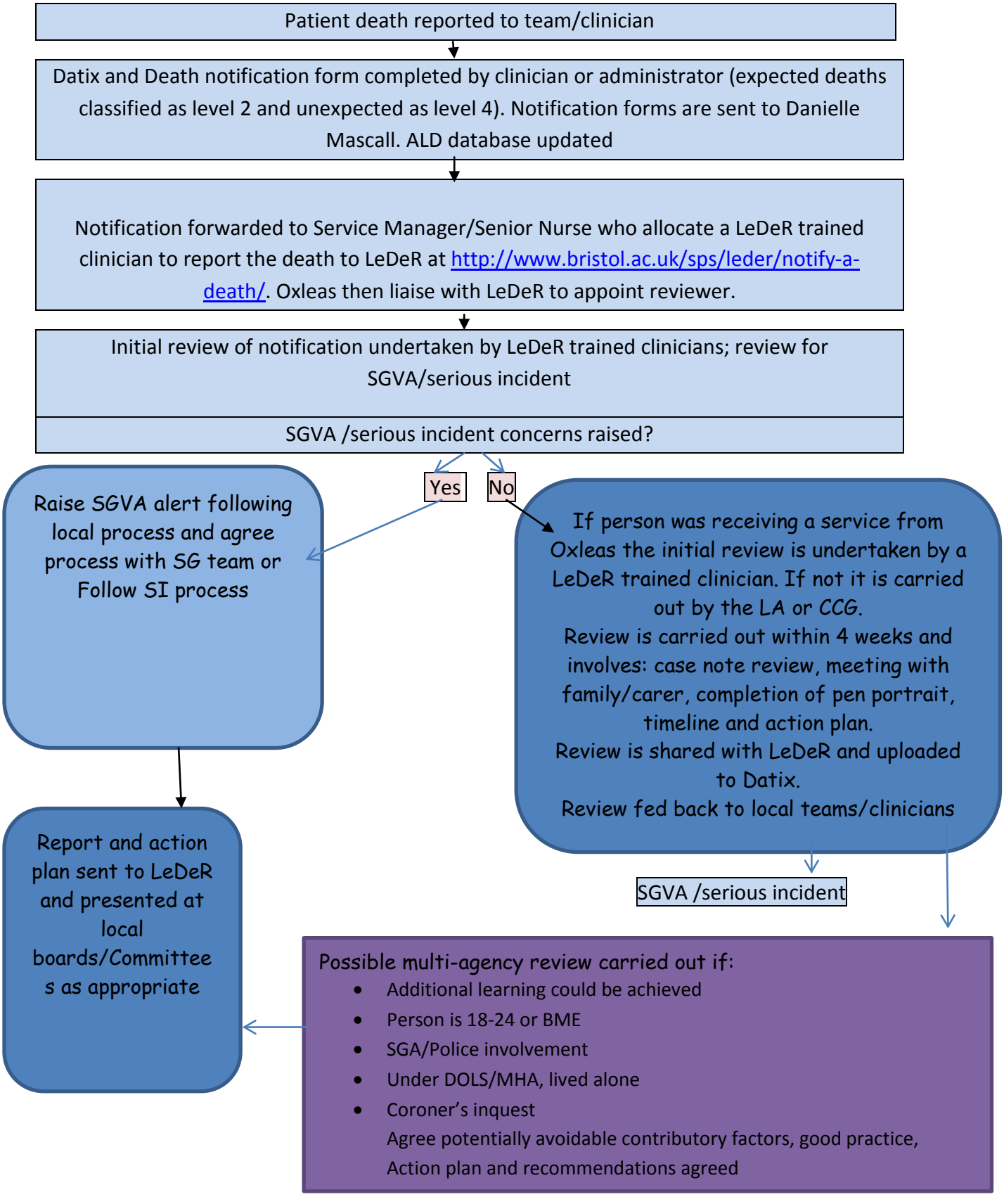
The review process is about identifying how care might have been improved for a person who had died, with a view to enabling local organisations to learn and improve their processes. The review process is expected to be multi-agency in approach and, depending on the circumstances of the person who has died, may involve gathering information from coroners, GP records, social care, community learning disability services and/or community mental health services and from local hospital services.

People with a learning disability and their families have been central to developing and delivering the programme to date. As reviews are implemented, families and the carers of who have died will have the opportunity to feed into the review process, so that the review is personalised to the circumstances of the person who died.

Key points to note are:

- All deaths of people with learning disabilities aged four years to 74 years are subject to review using LeDeR methodology *(deaths under the age of 18 are subject to the child death overview panel)*
- The LeDeR programme is currently being rolled out across England.
- The LeDeR processes will be used for conducting mortality review, it is recommended that it uses the LeDeR initial review process and documentation available at: http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf
- The review must then be submitted as an attachment to the LeDeR notification web-based platform once their internal review is completed;
- Once the LeDeR review has been completed, a copy will be sent to the relevant governance body at the Trust where the death occurred;
- Identify appropriate personnel who will undertake LeDeR training and review processes. Reviewers will be expected to conduct reviews independent of the Trust in which they work.

OXLEAS LEARNING DISABILITY MORTALITY REVIEW PROCESS FOR ADULTS (June 2017)



Appendix 3 Mental health

For deaths of people in mental health care services.

Key points to note are:

Physical and mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people16. In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems.

Reporting and reviewing of any death of a patient with mental health problems should consider these factors i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

Inpatients detained under Mental Health Act
Regulations17 require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay. In 2015, the Care Quality Commission reported concern that providers were failing to make this notification in 45% of cases. The Commission has since updated its notifications protocols to ensure that providers ensure they report in a timely way.

Under the Coroners and Justice Act 2009, coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983).

In circumstances where there is reason to believe the death may have been due, or in part due to, to problems in care - including suspected self-inflicted death - then the death must be reported to the provider's commissioner(s) as a serious incident and investigated appropriately. Consideration should also be given to commissioning an independent investigation as detailed in the Serious Incident Framework.

Appendix 4 Prison Healthcare

For all deaths of people in custody:

Key points to note are:

People with Mental Health Disorders in Prisons

Evidence shows that there is a high incidence of mental health problems in prisons:

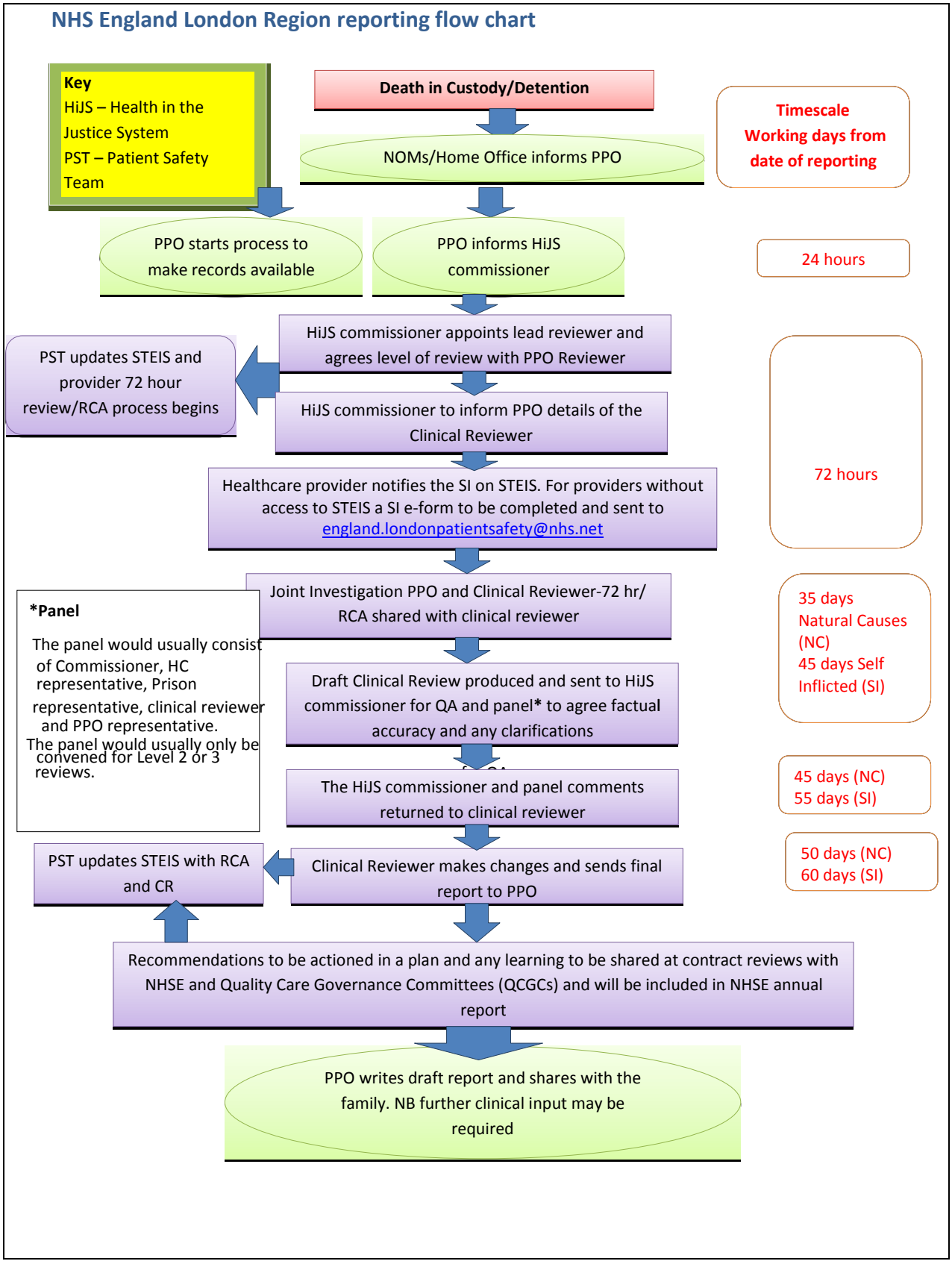
- 72% of adult male and 71% of female prisoners may have 2 or more mental disorders.
- 20% have 4 or more mental disorders
- Five Year Forward View For Mental Health (NHS England, 2016) is available at: https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf

There have been large increases in the number of natural and non-natural deaths in prisons over the most recent five-year reporting period. The increase in recent years in non-natural deaths in prisons are due to a number of factors. Prisons contain a high proportion of vulnerable individuals, many of whom have experienced negative life events that increase the likelihood of suicide or self-harm. Issues that increase risk include drug/alcohol abuse, family background, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems. The increase in part reflects an ageing prison population. Prisons are also very challenging environments particularly so for those prisoners who have a learning disability. Average estimates of prevalence of learning disabilities amongst adult offenders in the UK is thought to be between 2-10%. This figure is much higher for children who offend18. Prisoners with learning disabilities are also more likely than other prisoners to suffer mental ill health. As such, the mental wellbeing of prisoners with learning disabilities should be a key consideration for healthcare staff of NHS providers along with all other prison staff.

The Serious Incident Framework states that in prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations. Healthcare providers must fully support these investigations where required to do so. The PPO has clear expectations in relation to health involvement in PPO investigations into death in custody. Guidance published by the PPO19 must be followed by those involved in the delivery and commissioning of NHS funded care within settings covered by the PPO.

Equal Access Equal Care, Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities (2015) available at https://www.england.nhs.uk/.../equal-access-equal-care-guidance-patients-ld.pdf
http://www.ppo

NHS England London Region reporting flow chart



Appendix 5 Children and young people

For all deaths of people in children and young people the Child Death review Process will be followed:

Key points to note are:

Process of Child Mortality Review

Since 1st April 2008, Local Safeguarding Children's Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The relevant legislation underpinning such responsibility is enshrined in the Children's Act 2004 and applies to all children under 18 years of age. The processes to be followed when a child dies are described in Chapter 5 of the statutory guidance document, Working Together to Safeguard Children11. The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children, and to prevent future deaths. Working Together describes two interrelated processes:

i. a "Rapid Response" multi-professional investigation of an individual unexpected death; and

ii. a Child Death Overview Panel (CDOP) review of all deaths in a defined geographical area. The purpose of the CDOP is to establish the exact cause of death, identify patterns of death in community and remedial factors, and to contribute to improved forensic intelligence in suspicious deaths. The family should be kept central to the process.

All Trusts should have a policy in place that sets out how they respond to the deaths of children who die under their care. In doing this they should be mindful of current expectations described within Working Together to Safeguard Children (2015) and of NHS England's current review of child mortality review processes. New statutory guidance on child death review will be published in late 2017.

That policy should also set out how Trusts:

• communicate with bereaved parents and carers. This should include providing an honest and compassionate account of the reasons for death and knowledge of any potential problems in care that may need further review, ensuring initial contacts are managed by clinicians responsible for the care of the patient, and offering support to express concerns about the care given to patients who have died;

• achieve independence (where relevant) and objectivity in the child mortality review process, as well as lay membership within wider clinical governance systems.
Cross-system Reviews and Investigations

Notification of child deaths in Greenwich:

A notification (Form A) is sent to the Designated Doctor for Child Death Reviews following the death of every child in the Borough of Greenwich. This is usually sent within 24 hours of the Child Death to the CDOP Coordinator from Children's Services.

The CDOP Coordinator informs the designated doctor the same working day and the named nurse for Safeguarding.

Unexpected death:

An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.
OR where there is a lack of clarity about whether a death of a child is unexpected.

Following notification, if the death is unexpected a Rapid Response Meeting is arranged by the Designated Paediatrician for Child Deaths in Greenwich. It may require discussion with the hospital Paediatrician, Senior Police Officer, Children's Social Care or other agencies as required.

Where it is uncertain whether the death of the child was unexpected, the Designated Paediatrician (for child deaths') should consult other professionals involved with the child to gain more information. If in doubt the procedures for a Rapid Response Meeting should be followed. Once a decision is made about Rapid Response Meeting, the CDOP Coordinator sends an invitation to all professionals involved with the child.

Ideally a Rapid Response Meeting should be held in 48-72 hours and within 5 days after the child death unless public holidays are involved or availability of the key professionals involved in giving information around the circumstances of the child death is challenging.
Professionals should be aware that, in certain circumstances, separate processes may be taking place alongside those described in this procedure (e.g. police investigations, SUDI processes, Serious case reviews, inquests).

Purpose of the meeting:

The purpose of rapid response meeting is to ensure that the appropriate agencies are engaged and work together to:

• Make immediate enquiries into and evaluate the reasons for and circumstances and/or those factors that may have contributed to the death, in agreement with the coroner when required; Collate information in a standard format (Form B when collecting information about child deaths). This can be requested before/ at/ after the RRM form the key professionals.
• Ensure support for the bereaved family members, any other children or members of staff, as the death of a child will always be a traumatic loss – the more so if the death was unexpected. (Services available from Cruse Bereavement Care);
• Identify and safeguard any other children in the household or affected by the death;
• Potential lessons to be learned may also be identified at this stage.
• Ensure a professional (preferably known to the family) is identified so that they can appropriately inform the family about the Child Death Review Process (unless such sharing of information would place other children at risk of harm or jeopardise police investigations) -Information leaflets are available.
• The DP or equivalent must ensure that the results of the post-mortem examination are shared with parents, (a relevant professional such as the Hospital Paediatrician should be identified at the RRM where relevant) provided this is consistent with the requirements of the coroner and the police.
• Consider media issues and the need to alert and liaise with the appropriate agencies.

The outcome of this meeting will inform the inquest, if there is one.

Minutes: The minutes will be distributed to the key professionals (within 7 working days) who attended the Rapid Response Meeting.
Any action plans from the Rapid Response meetings are time framed and when completed are fedback to the chair or the CDOP Coordinator.

Out of Area/Borough Deaths:
The area in which the death of a child has been declared must take initial responsibility for convening and co-ordinating the rapid response process, until agreement for handover can be secured with the area where the child is normally resident.

Deaths Abroad:
Where notified of a death abroad, the professionals responsible for child death in the local authority where the child is normally resident must consider implementing this procedure as far as is practically possible and fully record any decisions made.
Any records of the meeting (i.e. DCSF Form B / meeting notes) should be forwarded at the time of the review to the CDOP for the area where the child normally resided at the time of death.

Rapid response (Home visits)
We do not provide an out of hours and weekend service. We also do not do undertake a rapid response - home visits to review the place where the child dies.
This is usually undertaken by an investigating police officer in cases of unexpected deaths. For all children aged 2 years and under, the local SUDI protocol is followed.

Expected Deaths: In cases where the child death is expected a request for information (Form B completion or summary request) is sent to the professionals involved in the medical management of the child. These will include the GP, the Health Visitor, the Hospital Paediatrician or Community Paediatrician, the Community or Hospital Nurses, any Specialty Team, Tertiary Hospital Paediatricians and Community Nursing involved in the child's care.

In the case of neonatal deaths information can requested from the Midwifery Unit at Queen Elizabeth Hospital.

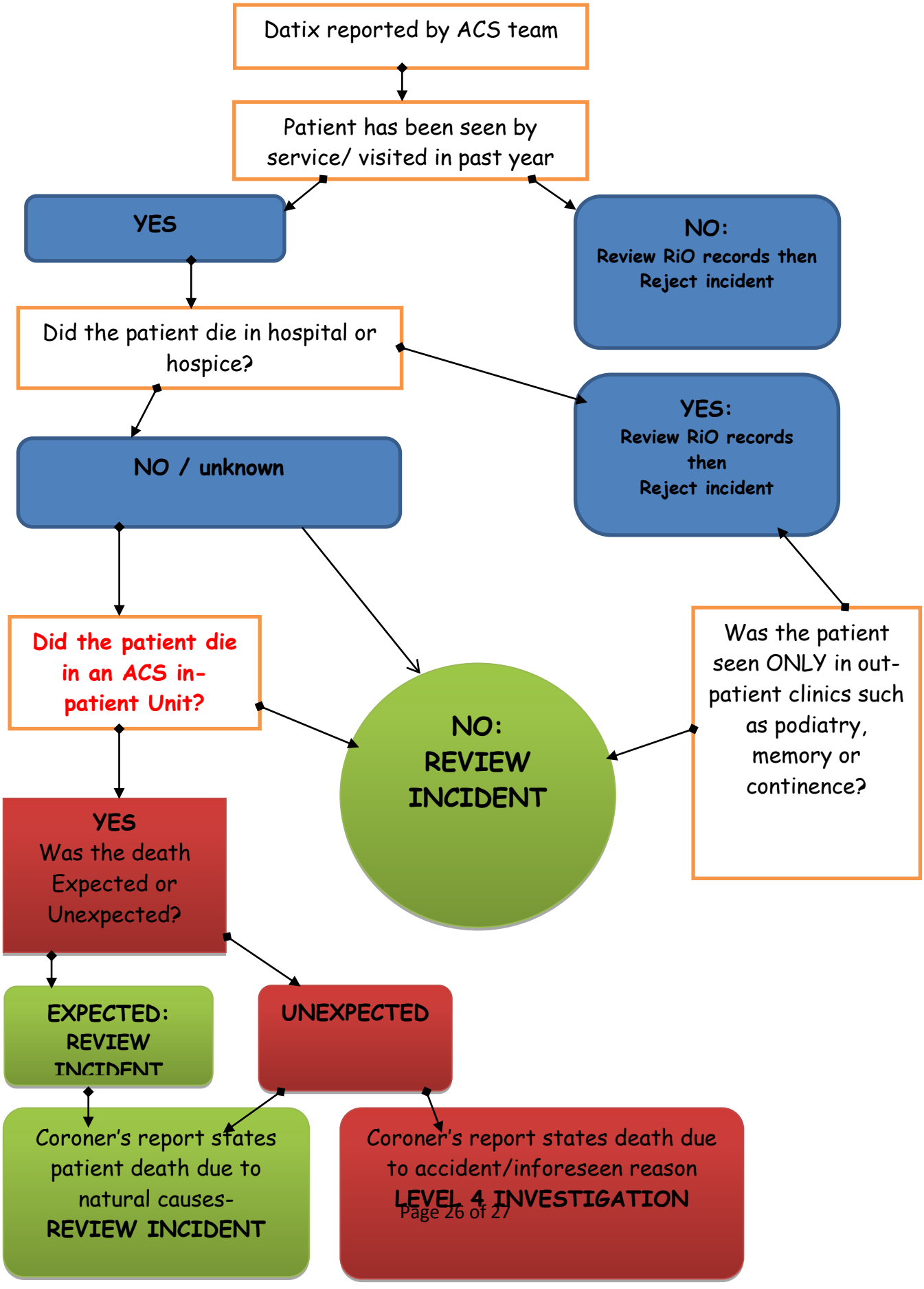
All relevant contact details are updated regularly and stored with a blank notification form and Form B in the CDOP Folder.

In addition information from Great Ormond Street Hospital and Evelina Children's Hospital is also available by contacting the single point of contact (SPOC) via email at these hospitals which again is on the Contact List Form in the CDOP File.

The Social Care and Police information is requested by the CDOP Coordinator.
The final report is compiled at a later date when all investigative reports including inquest and post mortem are available for presentation at the Child Death Overview Panel.

Annual Child death Review reports are also produced by the Greenwich Child death overview panel chair with input from the Designated Paediatrician and submitted to the LSCB and sent to the Dfes.

Appendix 6 Reviewing deaths in Adult and Older People Community Services: Framework for review of incidents



Appendix 7 Monthly data set report to Mortality Surveillance for each directorate / care group

Directorate	Total number of deaths in month of……
Children & Young People/ Forensic & Prison/Greenwich Mental Health & OPMH/Bexley Mental Health & OPMH / Bromley Mental health & OPMH / Greenwich Adult Community / Bexley Adult Community/ Adult Learning Disability	
Classification (Mazars)	Total of deaths classified
EN1	
EN2	
EU	
UNI	
UN2	
UU	
Type of Review Required (only select one type of review per death)	Total of deaths reviewed
Preliminary Case Note Review	
CDOP	
RCA – SI	
RCA – Mortality	
LD – LeDeR	
Number of cases still under review awaiting further information e.g. coroner	
Total Number of Deaths Year to Date (commencing 1 April 2016)	
Structured Judgement Review for the Level 4 and 5 SI RCAs completed during month	
Score 1: Definitely avoidable	
Score 2: Strong evidence of avoidability	
Score 3:Probably Avoidable (>50:50)	
Score 4: Possible avoidable but not very likely (<50:50)	
Score 5: Slight evidence of avoidability	
Score 6: Definitely not avoidable	