Learning from deaths (mortality review)

Policy Summary
This policy outlines the ways in which the Trust will learn from patient deaths and provides a framework for engaging with bereaved families and carers

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Status: FINAL

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Ratified: 26th September 2017
## Version History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date Issued</th>
<th>Brief Summary of Change</th>
<th>Author</th>
</tr>
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<tbody>
<tr>
<td>1.0</td>
<td>September 2017</td>
<td>New document</td>
<td>Julie Nott, Head of Risk &amp; Safety</td>
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<tr>
<td>1.1</td>
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<td>Interim review – no changes made. Policy rebranded. Full review to take place in April/May 2020</td>
<td>Julie Nott, Head of Risk &amp; Safety</td>
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For more information on the status of this document, please contact:

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- **Policy author**: Julie Nott, Head of Risk & Safety
- **Policy owner**: Julie Nott, Head of Risk & Safety
- **Accountable director**: Nick Strouthidis, Medical Director
- **Department**: Risk & Safety
- **Applies to (audience)**: All staff
- **Groups / individuals who have overseen the development of this policy**: Quality team
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- **Responsible committee/group for approval**: Policy and Procedure Review Group
- **Ratified by (name | date)**: Trust Management Board 11th September 2017
- **Date of issue**: December 2019
- **Date of next formal review**: August 2020
Executive Summary

This Policy, which is to be read in conjunction with the Moorfields ‘management of the death of a patient’ and the ‘incident and serious incident (including never events) policies, describes the processes by which all deaths that fall within the scope of the policy will be reviewed.

The purpose of any review is to maximise the learning for the organisation and to ensure that families/carers of the deceased are provided with the opportunity to ask any questions that they may have or raise any concerns. Specifically the Trust is required to:

- Provide a clear, honest and sensitive response to bereavement in a sympathetic environment;
- Offer a high standard of bereavement care, including support, information and guidance;
- Ensure families and carers know they can raise concerns and these will be considered when determining whether or not to review or investigate a death;
- Involve families and carers from the start and throughout any investigation as far as they want to be;
- Offer to involve families and carers in learning and quality improvement as relevant;
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 upon¹.

There is an increased drive for Trust Boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.

2. **Scope**
This policy is relevant at all Moorfields UK sites, including Moorfields Private.

The following inclusion and exclusion criteria apply:

**Included** within the scope of this Policy:
- All in-patient deaths;
- Patients who die within 30 days of discharge from inpatient services (where the Trust becomes aware of the death);
- Mandated patient groups identified by the NQB Learning from Deaths guidance including individuals with a learning disability, mental health needs or an infant or child;
- The death of any patient who is transferred from a Moorfields site and who dies following admission to another provider hospital;
- The death of any patient, of which the Trust is made aware, within 48 hours of surgery;
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision by Moorfields;
- Deaths of which the Trust becomes aware following notification, and a request for information, by HM Coroner;

• Persons who sustain injury as a result of an accident (e.g. a fall down stairs) whilst on Trust premises and who subsequently die;
• Individual deaths identified by the Medical Examiner or through incident reporting or complaints or as a result of the Inquest process;

Excluded from the scope of this Policy:
• People who are not patients who become unwell whilst on Trust premises and subsequently die;

Note: there is no correlation between the number of case record reviews undertaken and the number of incidents for which death is recorded as the outcome.

Example 1: an adult patient (without mental health needs or a learning disability) attends for an outpatient procedure (e.g. intravitreal injection) and becomes unwell on leaving the department. The patient subsequently dies at another hospital, following admission. A case record review is undertaken and no incident is identified. The transfer of the unwell patient to another provider is recorded via the e-reporting system but the actual impact of harm is recorded as ‘no harm’;

Example 2: an adult patient (without mental health needs or a learning disability) attends for an outpatient procedure (e.g. fluorescein angiography) and becomes unwell during the procedure. The patient is admitted to another hospital and subsequently dies. The death of the patient is linked to the allergic reaction to contrast medium. The actual impact of harm is recorded on the incident e-reporting system as ‘death’;

3. Purpose

This policy provides guidance for all staff involved in mortality reviews and identifies the governance arrangements and processes within the Trust which will support implementation of the policy.

The aim of the Policy is to:
• Identify and minimise deaths that have occurred at Moorfields (see ‘section 2 - scope’ for inclusion and exclusion criteria);
• Identify and learn from episodes of sub-optimal care;
• Engage with patients’ families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken. The
involvement of families and carers during an investigation will be promoted, recognising the value of their insights;

- Enable informed reporting with a transparent methodology;
- Promote organisational learning and improvement;

4. Explanation of key terms used
The following definitions, which have been taken from guidance issued by NHS Improvement in July 2017 (Implementing the learning from deaths framework: key requirements for Trust boards), apply to this policy:

**Case record review:**
A structured desktop review (see appendix 1) 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 in the absence of any particular concerns about care, to learn and improve. 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 the bereaved or staff raise concerns about care;

**Investigation:**
A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigation draws on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first;

**Death due to a problem in care:**
A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel the death is more likely than not to have resulted from problems in care delivery/service provision. Note, this is not a legal term and is not the same thing as ‘cause of death’. The term ‘avoidable mortality’ should not be used as this has a specific meaning in public health that is distinct from ‘death due to problems in care’.
Quality improvement:
A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

5. Policy
Patient deaths at Moorfields are an extremely rare occurrence, however the Trust will comply fully with the national requirements cited in ‘A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care’1. Learning from a review of the care provided to patients who die will be an integral part of the Trust’s clinical governance and quality improvement work.

The Trust will engage fully with bereaved families and carers and will provide them with the opportunity to raise questions or share concerns relating to the quality of care received by their loved one.

All patient deaths, which fall within the scope of this policy, will be reviewed as individual cases and an informed decision will be made regarding whether or not the death will be investigated as a serious incident (SI), in accordance with the national SI framework and the Trust SI policy.

6. Duties

6.1 Chief Executive
Has overall responsibility for ensuring that this policy is suitable and sufficient and that it has been effectively implemented;

6.2 Medical Director
The Medical Director has been nominated as the patient safety director with responsibility for the learning from deaths agenda and will ensure that:

- in the event of a patient death, appropriate medical staff are identified to support the Clinical Lead – Quality & Safety with the Structured Judgement Review (SJR)2 and/or inform an investigation;
- quarterly information is published, through a paper and an agenda item to a public Board meeting. Information on deaths will be published in the quarter after that in which the death occurred. The NQB dashboard will not be used to present the data, however the paper will include the following information and will identify nil returns:

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2 A case note review methodology that is being rolled out by the Royal College of Physicians
- total number of Trust deaths (see ‘section 2 - scope’);
- the number subject to case record review (SJR);
- the number investigated under the serious incident framework;
- the numbers thought to be more likely than not to be due to problems in care;
- the themes and issues identified through review and investigation;
- the actions being taken in response and the progress made towards implementing the actions;
- where reviews or investigations are ongoing, the number of ongoing reviews will be specified and an update will be provided in subsequent publications;
  o in the absence of the Medical Director the responsibility for reporting to the Trust Board will be assumed by the Director of Nursing and Allied Health Professions;

6.3 **Chair of the Quality and Safety Committee**
Nominated as the non-executive director lead who will take oversight of progress with the implementation of the learning from deaths agenda;

6.4 **Trust Board**
Responsible for ensuring that the Trust:
  o pays particular attention to the care of patients with a learning disability or mental health needs;
  o has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;
  o 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;
  o 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;
  o 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 should be discussed at the public section of the board level with data suitably anonymised;
  o 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;
o shares relevant learning across the organisation and with other services where the insight gained could be useful;

o 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;

o offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death;

o 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; and,

o works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services;

6.5 Non-Executive Directors (NEDs)
Responsible for holding the Trust to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been avoidable. Specifically NEDs are responsible for:

o Ensuring that the processes in place are robust and can withstand external scrutiny, by providing challenge and support;

o Champion and support learning and quality improvement;

o Ensure that information published is a fair and accurate reflection of the Trust’s achievements and challenges;

6.6 Director of Nursing and Allied Health Professions
Is responsible for:

o Maintaining oversight of the engagement with bereaved families/carers and for providing assurance to the Trust Board that the requirements set out in section 11 are satisfied and that the key principles/engagement with families/carers – must do’s in appendices 5 and 6 are applied in the event of a patient death;

o Identifying appropriate nursing staff to support the completion of SJRs, as necessary, and will provide quarterly reports to the Trust Board in the absence of the Medical Director;

o Approving the reporting of a death to the LeDeR programme;

6.7 Director of Quality & Safety
Responsible for ensuring that the Quality Account includes information relating to the learning from deaths agenda, as required (from June 2018 onwards);
6.8 **Clinical Lead – Quality & Safety**
Responsible for:
- completing SJRs with the assistance of other clinicians (e.g. a consultant anaesthetist), as required;
- communicating the findings of the SJR to the patient's family/carer;

6.9 **Head of Risk & Safety**
Responsible for the following:
- Development and review of this policy;
- Liaising with the Head of Communications to ensure that the current version is published on the Trust internet page;
- Ensuring that all deaths are reported as incidents, escalated to the Medical Director and the Director of Nursing and Allied Health Professions as soon notification has been received and reviewed at the SI panel;
- Ensuring that a SJR is undertaken for all deaths included within the scope of this Policy;
- Recording the outcome of SJRs undertaken to inform the quarterly report to the Trust Board;
- Ensuring that deaths involving patients with a learning disability are notified to the LeDeR programme, following approval by the Director of Nursing and Allied Health Professions;
- Confirming with Performance and Information, on a monthly basis and in advance of finalisation of the integrated performance report for the Trust Board, whether or not any deaths have been recorded for the previous month;
- Ensuring that other organisations involved in the care of the patient, and who’s co-ordination of care may have contributed to the death of the patient, are informed of the patient’s death;

6.10 **All clinicians**
All clinicians are responsible for:
- Immediately reporting any death, via the incident e-reporting system, of which they become aware that falls within the inclusion criteria (see ‘section 2 - scope’);
- Supporting the Clinical Lead – Quality & Safety to complete the SJR, following nomination by either the Medical Director or the Director of Nursing and Allied Health Professions;
7. **Responding to the death of an adult**
The death of an adult, without mental health needs or a learning disability, and which satisfies the inclusion criteria in ‘section 2 – scope’ will be subject to the following reviews:
- Case record review (using SJR methodology);
- Review at the SI panel;
- Root Cause Analysis (RCA) investigation (where agreed by the SI panel);

The following policy must be referred to:
- Management of the Death of a Patient at Moorfields Eye Hospital NHS Foundation Trust

8. **Responding to the death of a person with a learning disability**
See appendix 2.

9. **Responding to the death of a person with mental health needs**
See appendix 3.

10. **Responding to the death of an infant or child**
See appendix 4 and the following policies:
- Safeguarding Children and Child Protection (0-18 years) Policy and Procedures;
- Management of the Death of a Patient at Moorfields Eye Hospital NHS Foundation Trust;

11. **Engaging with bereaved families and carers**
It is essential, following the death of a patient, that bereaved families and carers are given the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one.

The Trust is required to:
- Provide a clear, honest and sensitive response to bereavement in a sympathetic environment;
• Offer a high standard of bereavement care, including support, information and guidance;
• Ensure families and carers know they can raise concerns and these will be considered when determining whether or not to review or investigate a death;
• Involve families and carers from the start and throughout any investigation as far as they want to be;
• Offer to involve families and carers in learning and quality improvement as relevant;

The key principles for engaging with bereaved families and carers are shown in appendix 5. The principles of openness, honesty and transparency as set out in the duty of candour must also be applied.

A list of ‘must do’s’ to be followed when engaging with bereaved families/carers is provided in appendix 6.

Findings of case record reviews must be communicated to the family and/or carers where any problems with care are identified and any lessons the review has contributed to for the future.

See also the:
• Death of a patient policy;
• Being open and duty of candour policy

12. Scrutiny of the care provided to someone who has died
There are three levels of scrutiny that a provider can apply to the care provided to someone who dies, as outlined in appendix 7.

Any death that is notified to the Trust, and which falls within the scope of the Policy, will have a SJR completed. All deaths will also be reviewed at the weekly SI panel.

13. Undertaking case record reviews
See appendix 1.

To generate learning for improvement in healthcare, clinicians and staff should engage in robust processes of retrospective case record review to help identify if a death was more likely than not to have been contributed to by problems of care. 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.

Case record reviews will be undertaken, in the first instance, by the Clinical Lead – Quality & Safety using the Royal College of Physicians SJR methodology, using the pro-forma in appendix 8. Other clinical staff will be co-opted to assist, as appropriate and following nomination by the Medical Director and the Director of Nursing and Allied Health Professions.

https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources

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.

As part of the overall care assessment a judgement on the quality and legibility of the health records will be made by the reviewer.

- **Cross-system reviews and investigations**

There will be occasions when more than one organisation is involved in the care of a patient who dies (e.g. when a patient is transferred from a Moorfields site to an acute provider for admission and on-going care or a patient is referred to Moorfields for treatment by another provider). Where possible problems are identified relating to other organisations, it is important the relevant organisation is informed, so they can undertake any necessary investigation or improvement.

Where an SI is declared by Moorfields then the Head of Risk & Safety will be responsible for ensuring that other relevant organisations, are notified.

**14. Data collection and reporting**

Data relating to patient deaths and completed SJRs will be collated by the Head of Risk & Safety and will be used to inform the quarterly report to the Trust Board.
15. Training
Training to enable the completion of SJRs will be provided for the Clinical Lead – Quality & Safety and a small cohort of staff as nominated by the Medical Director and the Director of Nursing and Allied Health Professions. This training must be delivered by a person who is registered by the Royal College of Physicians as a ‘tier one trainer’.

16. Stakeholder engagement and communication
As part of the engagement process, this policy was sent to the following staff groups for review:
- Medical Director (accountable director for the policy);
- Chair of the Quality & Safety Committee (accountable non-executive director);
- Director of Nursing and Allied Health Professions;
- Safeguarding lead – adult;
- Named nurse for child protection;
- Monitoring lead(s);
- Divisional management teams;
- Members of the Clinical Governance Committee;
- Trust Management Board;

17. Approval and ratification
Following consultation the policy will be approved by the Policy and Procedure Review Group, prior to ratification by the Trust Management Board.

Future amendments to the document, which do not result in significant process change, may be approved by the Policy and Procedure Review Group.

18. Dissemination and implementation
This policy will be made available to all staff, through the intranet. Awareness of any new content/change in process will be through the weekly staff bulletin.

Notification of a substantive revision or minor amendment to this policy will, in the first instance, be communicated via the staff e-bulletin. Following ratification by the Trust Management Board or approval of a minor amendment by the Clinical Governance Committee, the Head of Risk & Safety will e-mail the staff identified
within section 16 to advise that a change has been made, along with a request that the information be cascaded.

Where a substantive revision is made (e.g. a process changes) then a separate plan for communicating and implementing this change will be devised by the Policy Owner, and will be tailored specifically to reflect the change that has been made.

19. Review and revision arrangements
The Policy Owner is required to undertake a review of the document, at least once every 3 years. This may happen at intervals of shorter than 3 years if an incident occurs that prompts a review, a gap in existing policy/procedure is identified or if further national guidance is released that needs to be incorporated.

20. Document control and archiving
The current and approved version of this document can be found on the Trust’s intranet site. Should this not be the case, please contact the Quality and Compliance team.

Previously approved versions of this document will be removed from the intranet by the Quality and Compliance team and archived in the policy repository. Any requests for retrieval of archived documents must be directed to the Quality and Compliance team.

21. Monitoring compliance with this Policy
Compliance with this Policy will be monitored via the following mechanisms:

- An annual audit will be undertaken by the Head of Risk & Safety to verify that all known patient deaths, that satisfy the inclusion criteria, have had a structured judgement review undertaken. The outcome of this audit will be reported to the clinical governance committee;

22. Supporting references/evidence base
Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards “from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals”.

13
This was reinforced by the recent findings of the Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

### 23. Supporting documents

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<thead>
<tr>
<th>Supporting Documents/References</th>
<th>Owner</th>
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<tbody>
<tr>
<td>Management of the death of a patient policy</td>
<td>Director of Nursing and Allied Health Professions</td>
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<tr>
<td>Incident and Serious Incident (including Never Events) Reporting Policy and Procedure</td>
<td>Head of Risk &amp; Safety</td>
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<tr>
<td>Serious Incident Framework</td>
<td>NHS England</td>
</tr>
<tr>
<td>Being open and duty of candour policy</td>
<td>Head of Clinical Governance</td>
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Flowchart to show the case record review/investigation process (appendix 1)

Patient death occurs which is within the scope of the Policy:
- All in-patient deaths;
- Patients who die within 30 days of discharge from inpatient services (which the Trust becomes aware of);
- Mandated patient groups identified by the NQB Learning from Deaths guidance including individuals with a learning disability, mental health needs or an infant or child;
- The death of any patient who is transferred from a Moorfields site and who dies following admission to another provider hospital;
- The death of any patient, of which the Trust is made aware, within 48 hours of surgery;
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision by Moorfields;
- Deaths of which the Trust becomes aware following notification, and a request for information, by HM Coroner;
- Persons who sustain injury as a result of an accident (e.g. a fall down stairs) whilst on Trust premises and who subsequently die;
- Individual deaths identified by the Medical Examiner or through incident reporting or complaints or as a result of the Inquest process;

1st stage review, using Structured Judgement Review (SJR) methodology completed by the Clinical Lead – Quality & Safety and other nominated representatives, as appropriate.
Reviewer(s) to judge which phases of care forms are relevant to the case

Overall care score of 3 (adequate care) or above
- Consider need to declare and investigate the death as a serious incident (SI)

Overall care score of 1 (very poor care) or 2 (poor care) or where harm has been identified
- 2nd stage SJR by another person/group (repeat validation)

Completed SJR to be sent to the Head of Risk & Safety for filing and to inform the quarterly reports to the Trust Board
Responding to the death of a person with a learning disability (appendix 2)

The lives of people with learning disabilities often involve a complex array of service provision with multiple care and support staff. A cross-sector approach to reviewing deaths of people with learning disabilities is imperative; one that includes families, primary and secondary healthcare, and social and third sector care providers. Such a balanced approach across acute and other settings is needed from the outset of a review process, in order to accurately determine if there are any concerns about the death, or to identify examples of best practice that could lead to service improvement.

The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities. It currently supports local reviews of deaths of people with learning disabilities aged 4 years and over. The lower age limit is set at 4 years of age because before that age, it can be difficult to be sure that a child has learning disabilities.

All deaths of people with learning disabilities aged four years and older are subject to review using Learning Disabilities Mortality Review (LeDeR) methodology. All deaths are to be reported to the LeDeR programme and those meeting the criteria for mortality review receive an initial review of their death by an independent, trained reviewer. The current process is shown in figure 1, below.

Figure 1
A full multi-agency review is required if the criteria for the current themed priority review are met (death of a person from a Black and Minority Ethnic background or aged 18-24), or where an assessment of the care received by the person indicates deficiencies in one or more significant areas. A full multi-agency review is recommended if there have been any concerns raised about the death, if any 'red flag alerts' have been identified in the initial review, or if the reviewer thinks that a full multi-agency review would be appropriate. The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.

Any death involving a person with a learning disability will be notified to the LeDeR programme by the Head of Risk and Safety, following approval by the Director of Nursing and Allied Health Professions or the Medical Director.

A report should be submitted via the following link:

http://www.bristol.ac.uk/sps/leder/notify-a-death/

or notification can be made via telephone on 0300 777 4774
Responding to the death of a person with mental health needs (appendix 3)

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 people. 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 difficulties¹.

Moorfields is highly unlikely to experience the death of a patient who has been detained under the Mental Health Act (1983). In the event that such a death does ever occur, and it is 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 will be reported as a serious incident and it will be investigated appropriately. The need to initiate an independent investigation will be considered.
Responding to the death of an infant or child (appendix 4)

New statutory guidance on child death review will be published in late 2017.

Cross-system Reviews and Investigations
When the death of a child involves treatment across the health care pathway (primary: secondary: tertiary care) it is expected that child mortality review processes will not be duplicated and that a single overarching meeting will be convened. Child mortality review processes should interface with existing organisational governance systems. The NHS England child death review programme is mindful of expectations arising from the Serious Incident Framework, which sets out the circumstances in which further investigation is warranted in certain situations. It is therefore anticipated that when a 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 is reported via local risk management systems to the National Reporting and Learning System (NRLS). Regardless of the type of review, its findings must form an integral part of and feed into the organisation’s clinical governance processes and structures. Review findings should be considered alongside other information and data including complaints, clinical audit information, patient safety incident reports and other outcomes measures to inform the Trust’s wider strategic plans and safety priorities¹.

Bereaved Families and Carers
Working Together² places the family at the heart of its processes. However it is recognised that the multitude of investigations that may unfold following a child’s death can cause great confusion and distress to parents. The national bereavement group and bereavement charities are closely involved with developing NHS England’s child death review programme – both in the co-design of systems and public guidance that explains processes¹.

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Bereaved families and carers – key principles (appendix 5)

Providers should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles below:

- 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 with Trusts in delivering training for staff in supporting family and carer involvement where they want to.
Engagement with families/carers – must do’s (appendix 6)

The following list is a summary of requirements identified in the Serious Incident and Learning from Deaths frameworks⁴:

<table>
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<tr>
<th>Requirements</th>
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<tbody>
<tr>
<td>Begin with a genuine apology and early meeting.</td>
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<tr>
<td>All staff supporting the bereaved must have the necessary skills and knowledge of the incident.</td>
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<td>One person should be identified as the lead for liaison with the family/carer; consider the need for an independent advocate with the skills to work with bereaved individuals.</td>
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<tr>
<td>Involvement of the clinicians caring for the patient who died should be considered on a case-by-case basis; this is not always appropriate.</td>
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<tr>
<td>Action being taken should be explained in person and in writing.</td>
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<tr>
<td>Set out how the will be kept informed and supported.</td>
</tr>
<tr>
<td>Describe what to expect from an investigation, including timescales and outcomes.</td>
</tr>
<tr>
<td>Clearly explain the Serious Incident investigation’s rationale and purpose: these investigations are conducted to support learning, not to hold anyone to account. Be clear: if wrongdoing is found, separate processes are followed.</td>
</tr>
<tr>
<td>Give the family/carer the chance to express concerns and raise questions. Their contribution can provide valuable insight into what happened.</td>
</tr>
<tr>
<td>Provide an opportunity for family/carers to inform the terms of reference for the investigation.</td>
</tr>
<tr>
<td>Once agreed, terms of reference should be shown to the family/carer so they can see their questions are reflected.</td>
</tr>
<tr>
<td>Explain how the family/carer can contribute to the investigation: for example, by providing evidence.</td>
</tr>
<tr>
<td>Provide access to the findings, including interim findings.</td>
</tr>
<tr>
<td>Provide the family/carer with the opportunity to comment on the findings and recommendations in the final report and ensure their comments are considered in the quality assurance process. Be clear: their feedback may not be included if it is not considered relevant/appropriate.</td>
</tr>
<tr>
<td>Keep them informed of any delays in the process.</td>
</tr>
<tr>
<td>Consider meeting transport, disability and language/translation costs/needs.</td>
</tr>
<tr>
<td>Consider the need for counselling and referral to organisations that can provide this.</td>
</tr>
<tr>
<td>Ensure there is a co-ordinated approach if multiple agencies need to contact the family/carer; for example, where regulators, coroners or the police are involved. A single point of contact with the family should be appointed to keep them engaged.</td>
</tr>
</tbody>
</table>

---

⁴ Implementing the Learning from Deaths framework: key requirements for Trust Boards, NHS Improvement, July 2017
Scrutiny of the care provided to someone who has died (appendix 7)

There are 3 levels of scrutiny that may be applied to the care provided to someone who dies. 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. The case record review will inform the information gathering phase of an investigation together with interviews, observations and evidence from other sources.

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.

Investigation:
Providers should apply rigorous judgement to the need for deaths to be subject to a Serious Incident reporting and investigation and should be guided by the circumstances for investigation in the Serious Incident Framework.

Some deaths will be investigated by other agents, notably the coroner. The coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable.
Using the Structured Judgement Review method: Data collection form (appendix 8)

Royal College of Physicians

National Mortality Case Record Review Programme: structured case note review data collection

Please enter the following.

Age at death (years):

Gender: M/F

First 3/4 digits of the patient’s postcode:

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between arrival and death:

Month cluster during which the patient died:

Jan/Feb/Mar  Apr/May/June  Jul/Aug/Sept  Oct/Nov/Dec

Specialty team at time of death:

Specific location of death:

Type of admission:

The certified cause of death if known:
Guidance for reviewers

1 Did the patient have a learning disability?
   • No indication of a learning disability.
     Action: proceed with this review.
   • Yes – clear or possible indications from the case records of a learning disability.
     Action: after your review, please refer the case to the hospital’s clinical governance group for linkage with the Learning Disability Mortality Review Programme.

2 Did the patient have a serious mental health issue?
   • No indication of a severe mental health issue.
     Action: proceed with this review.
   • Yes – clear or possible indications from the case records of a severe mental health issue.
     Action: after your review, please refer the case to the hospital’s clinical governance group.

3 Is the patient under 18 years old?
   • No, the patient is 18 years or older.
     Action: proceed with this review.
   • Yes – the patient is under 18 years old.
     Action: after your review, please refer the case to the hospital’s clinical governance group for linkage with the Child Death Review Programme.
Structured case note review data collection

Phase of care: Admission and initial management (approximately the first 24 hours)

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.

<table>
<thead>
<tr>
<th>Please rate the care received by the patient during this phase.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = very poor care    2 = poor care    3 = adequate care    4 = good care    5 = excellent care</td>
</tr>
<tr>
<td>Please circle only one score.</td>
</tr>
</tbody>
</table>
**Phase of care: Ongoing care**

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.

<table>
<thead>
<tr>
<th>1 = very poor care</th>
<th>2 = poor care</th>
<th>3 = adequate care</th>
<th>4 = good care</th>
<th>5 = excellent care</th>
</tr>
</thead>
</table>

Please rate the care received by the patient during this phase. Please circle only one score.
Phase of care: Care during a procedure (excluding IV cannulation)

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 this phase.

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

Please circle only one score.
Phase of care: Perioperative care

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 this phase.

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

Please circle only one score.
Phase of care: End-of-life care

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 this phase.
1 = very poor care  2 = poor care  3 = adequate care  4 = good care  5 = excellent care
Please circle only one score.
Phase of care: Overall assessment

Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). 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 this overall phase.
1 = very poor care  2 = poor care  3 = adequate care  4 = good care  5 = excellent care
Please circle only one score.

Please rate the quality of the patient record.
1 = very poor  2 = poor  3 = adequate  4 = good  5 = excellent
Please circle only one score.
Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem[s] were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)
No ☐ (please stop here) Yes ☐ (please continue below)

If you did identify problems, please identify which problem type[s] from the selection below. Please indicate whether it led to any harm and in which phase(s) of care the problem was identified. Please tick all that relate to the case.

Problem types

1. Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls) Yes ☐ No ☐

Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

In which phase(s) did the problem occur?
Admission and initial assessment ☐ Ongoing care ☐
Care during procedure ☐ Perioperative care ☐
End-of-life care ☐

2. Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic) Yes ☐ No ☐

Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

In which phase(s) did the problem occur?
Admission and initial assessment ☐ Ongoing care ☐
Care during procedure ☐ Perioperative care ☐
End-of-life care ☐
3. Problem related to treatment and management plan *(including prevention of pressure ulcers, falls, VTE)* Yes □ No □

Did the problem lead to harm? No □ Probably □ Yes □

In which phase(s) did the problem occur?
Admission and initial assessment □ Ongoing care □
Care during procedure □ Perioperative care □
End-of-life care □

4. Problem with infection management Yes □ No □

Did the problem lead to harm? No □ Probably □ Yes □

In which phase(s) did the problem occur?
Admission and initial assessment □ Ongoing care □
Care during procedure □ Perioperative care □
End-of-life care

5. Problem related to operation / invasive procedure *(other than infection control)* Yes □ No □

Did the problem lead to harm? No □ Probably □ Yes □

In which phase(s) did the problem occur?
Admission and initial assessment □ Ongoing care □
Care during procedure □ Perioperative care □
End-of-life care □

6. Problem in clinical monitoring *(including failure to plan, to undertake, or to recognise and respond to changes)* Yes □ No □

Did the problem lead to harm? No □ Probably □ Yes □

In which phase(s) did the problem occur?
Admission and initial assessment □ Ongoing care □
Care during procedure □ Perioperative care □
End-of-life care □
7. Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR)) Yes ☐ No ☐

Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

In which phase(s) did the problem occur?
- Admission and initial assessment ☐
- Ongoing care ☐
- Care during procedure ☐
- Perioperative care ☐
- End-of-life care ☐

8. Problem of any other type not fitting the categories above (including communication and organisational issues) Yes ☐ No ☐

Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

In which phase(s) did the problem occur?
- Admission and initial assessment ☐
- Ongoing care ☐
- Care during procedure ☐
- Perioperative care ☐
- End-of-life care ☐
Policy applicability to Trust sites (appendix 9)

This document applies to all premises occupied by Trust staff/activities, unless explicitly stated otherwise.

For any sites that are excluded from the policy, the policy must list those sites together with a brief explanation as to why the site is excluded, and name the local/host policy and any other documents that are used in its place.

<table>
<thead>
<tr>
<th>Excluded sites</th>
<th>Reason for exclusion</th>
<th>Host policy and any other documents used in its place</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Where the list indicates that the policy does not apply, this implies that the Trust will adhere to the policy of the host. Where a query exists then this must be referred, in the first instance, to either the:

- Divisional management team
- Policy owner
- Accountable director
- Service director

Moorfields Dubai will adhere to their own local policies and procedures and Trust-wide documents will not apply, unless explicitly stated otherwise.
Equality Impact Assessment (appendix 10)

The equality impact assessment is used to ensure we do not inadvertently discriminate as a service provider or as an employer.

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

<table>
<thead>
<tr>
<th></th>
<th>Comments / Evidence</th>
</tr>
</thead>
</table>
| 1 | **Which groups is the policy/guidance intended for?**  
Who will benefit from the policy/guidance? (refer to appropriate data)  
|   | All patient groups  |
|   | • Race  
• Gender (or sex)  
• Gender Reassignment  
• Pregnancy and maternity  
• Marriage and civil partnership  
• Religion or belief  
• Sexual orientation including lesbian, gay and bisexual people  
• Age  
• Disability (e.g., physical, sensory or learning)  |
| 2 | **What issues need to be considered to ensure these groups are not disadvantaged by your proposal/guidance?**  
|   | None  |
| 3 | **What evidence exists already that suggests that some groups are affected differently?** (identify the evidence you refer to)  
|   | N/A  |
| 4 | **How will you avoid or mitigate against the difference or disadvantage.**  
|   | N/A  |
| 5 | **What is your justification for the difference or disadvantage if you cannot avoid or mitigate against it, and you cannot stop the proposal or guidance?**  
|   | N/A  |

If you have identified a potential discriminatory impact of this procedural document, please refer it to the director of quality and safety, or the human resources department, together with any suggestions as to the action required to avoid/reduce this impact.
For advice in respect of answering the above questions, please contact the director of quality and safety (ext. 6564).

Please ensure that the completed EIA is appended to the final version of the document, so that it is available for consultation when the document is being approved and ratified, and subsequently published.
Checklist for the review and approval of documents (appendix 11)

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Learning from deaths (mortality review)
Policy (document) Author: Julie Nott, Head of Risk & Safety
Policy (document) Owner: Julie Nott, Head of Risk & Safety

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes/No/Unsure/NA</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Title</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the title clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is it clear whether the document is a guideline, policy, protocol or standard?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Scope/Purpose</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the target population clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the purpose of the document clear?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are the intended outcomes described?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are the statements clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Development Process</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there evidence of engagement with stakeholders and users?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Who was engaged in a review of the document (list committees/individuals)?</td>
<td>See section 16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has the policy template been followed (i.e. is the format correct)?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Evidence Base</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the type of evidence to support the document identified explicitly?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are local/organisational supporting documents referenced?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does the document identify which</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Committee Approval (Policy and Procedure Review Group)</td>
<td></td>
<td></td>
<td></td>
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<td>--------------------------------------------------------</td>
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</tr>
<tr>
<td>If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Chair</td>
<td>Niloufar Hajilou</td>
<td>Date</td>
<td>19th December 2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ratification by Trust Management Board</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If the [Trust Management Board or Management Executive] is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner</td>
<td></td>
</tr>
<tr>
<td>Date: 26th September 2017</td>
<td></td>
</tr>
</tbody>
</table>