NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Learning from Deaths Policy

Policy Number	**CL/Pol/057**
Target Audience	**All Staff including Agency Workers, Volunteers, Contractors, Bank Staff and Learners in Practice**
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Approving Committee	**Corporate Clinical Policy Group**
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The Trust is committed to an environment that promotes equality, embraces diversity, and respects human rights both within our workforce and in service delivery. This document should be implemented with due regard to this commitment.

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Version Control Sheet

Version	Date	Reviewed By	Comment
1.0	Nov 17 Nov 17 Dec 2017	Policy Approval Group Trish Reid S. Arkwright	Approved subject to amendments Amendments completed. Approved by chair action
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2.14	March 24	Andi Sizer	Amendments completed
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Equality impact assessment

Consider if this document impacts/potentially impacts:

- Staff
- Patients
- Family members
- Carers
- Communities

Yes ■ **complete box A**	**No** ☐ **complete box B**
Box A Contact the Trust's equality & inclusion manager at: **Email: ruth.besford@nhs.net** **Date contacted: 08/01/24**	**Box B** Complete details below: **Name:** **Email:** **Date:**

Education & Professional Development Question

In order to ensure that any training requirements are discussed, and resources planned and allocated to meet the needs of the service, you must consider whether this document has additional training requirements. Please answer the following question by entering a cross in the box below:

	Yes	**No**
Does this document have any additional training requirements or implications?		No

This table below must be completed in full for audit and governance purposes. Please note documents will be returned if section 1 in the table below is not completed fully. This will result in a delay in listing the document for approval.

Name of document	Learning from Deaths Policy
Document number	CL/Pol/057
Document author	Andi Sizer/Ted Adams

Section 1 - actions required by author	**Authors response**
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For clinical documents, date document submitted to consultation group for sign-off i.e., IPC, Medicines Management (this applies if the document contains medication or medical gases - update version control sheet to confirm sign-off)	n/a
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The following policies require Board approval and must be submitted to Board following CCPG approval: • Risk Management Framework Policy • Health & Safety Policy • Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies") Date submitted for Board approval: Date approved by Board:	N/A

Contents

Appendix 2 can be accessed under the policy on MyBridgewater.

Appendix 1 Operational process for learning from deaths case reviews - structure judgement review (SJR)

Appendix 2 Learning from deaths (LFD) review – guidance for completion, case note review/assessment tool

Appendix 3 Reporting matrix

1 Introduction

This policy has been developed in accordance with the National Quality Board's "Guidance on Learning from Deaths" (published in March 2017) and Guidance for NHS Trusts on working with bereaved families and carers (published July 2018), as part of a national drive to implement the recommendations of the Care Quality Commission's (CQC's) review "Learning, Candour and Accountability: a review of the way Trusts review and investigate the deaths of patients in England" (2016).

Each Trust should ensure as a minimum there are processes in place for:

- Meaningful engagement and support of bereaved families and carers
- Structured case record review process for reviewing patient deaths, as outlined in this policy.

Case record reviews are a key component of improving the quality and safety of patient care. Mortality governance is a key priority for Bridgewater Community Healthcare NHS Foundation Trust (hereafter the Trust).

The benefits of applying a case review methodology, is that it provides a structured process to review deaths, which examines both intervention and holistic care.

The policy also takes account of the Serious Incident Framework (NHS England, 2015) and existing national processes for reporting and investigating deaths including the Learning Disabilities Mortality Review (LeDeR) programme, Department of Health Working Together to Safeguard Children (2023) and contributions to reports under Regulations 28 and 29 of The Coroner's (Investigations) Regulations (2013).

1.1 Objective

The objective of this policy is to set out how the Trust responds to and learns from the deaths of patients who die under its management and care.

Specifically, this policy describes how the Trust:

- Determines which patients are considered to be under its care for the purpose of responding to deaths.
- Determines which deaths to report as incidents for possible investigation and learning.
- Reports deaths within the organisation and to other organisations who may have an interest.
- Engages meaningfully and compassionately with bereaved families and carers.
- Identifies and acts on learning from the investigation of deaths.

- Responds to all deaths of patients detailed in section 9 “Criteria for reporting a death”.

1.2 Scope

This policy applies to all Trust employees including agency workers, volunteers, contractors, bank staff and learners in practice conducting work on behalf of the Trust.

2 Definitions

The definitions applicable to this policy are as follows:

Death due to a problem in care	A death that has been assessed (by case record review) as being more likely than not to have resulted from problems in healthcare, rather than due to the natural course of the service user’s illness or underlying condition, and therefore to have been potentially avoidable.
Avoidable death	A death which could have been avoided if problems with the patient’s care had not been present.
Preventable death	A death which could have been prevented if certain preventable factors (including patient lifestyle, problems with the patient’s care and health care system failures) had not existed.
Unexpected death of a patient	A patient in whom death was not clinically considered to be a likely outcome at a specific point in time.
Expected death	A patient in whom death was clinically considered to be a likely outcome at a specific point in time. This could be a patient who was terminally ill.
Never event	A wholly preventable serious incident which occurred due to a failure to implement national safety recommendations.
Patient safety incident	Any unintended or unexpected incident that occurred in respect of a service user during the provision of care that appears to have resulted in the death, severe harm, moderate harm, or prolonged psychological harm to the service user. Patient safety incidents are notifiable to the CQC via the Learning from Patient Safety Events (LFPSE) service.
Duty of candour	A legal duty on the Trust to inform and apologise to patients (or, in the case of a patient’s death, their families/carers) if there may have been mistakes in their care that led to harm.

Serious incident (SI)	A health care event where the potential for learning is so great, or the consequences to patients, families, carers, staff, and the organisation is so significant, that a comprehensive response is warranted. These include acts or omissions occurring as part of care that result in unexpected or avoidable death. Serious Incident Framework, NHS England Patient Safety Domain, (March 2015) acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in: ➢ Unexpected or avoidable death of one or more people. This includes: • Suicide/self-inflicted death • Homicide by a person in receipt of mental health care within the recent past. • Unexpected or avoidable injury to one or more people that has resulted in serious harm. • Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent: o The death of the service user; or o Serious harm. ➢ Death of a prisoner while serving a custodial sentence (expected or unexpected) ➢ Within Maternity Services: • Unplanned maternal transfers to Intensive Therapy Unit (ITU) • Hysterectomy • Actual or alleged abuse; sexual abuse, physical or psychological ill- treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking, and modern-day slavery where: o Healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or o Where abuse occurred during the provision of NHS-funded care.
Strategic Executive Information System	A national database that all NHS bodies upload details of patient safety incident investigations (PSIIs).

3 Abbreviations

The abbreviations applicable to this policy are as follows:

<	Less than
CDOP	Child Death Overview Panel
CQC	Care Quality Commission
DHRs	Domestic Homicide Reviews
DIRLG	Directorate Incident Review and Learning Group
GP	General Practitioner
ITU	Intensive Therapy Unit
LeDeR	Learning Disabilities Mortality Review
LFD	Learning from deaths
LFPSE	Learning from Patient Safety Events service
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries – United Kingdom
MNI-CORP	Maternal, Newborn, and Infant clinical Outcome Review Programme
PSII	Patient safety incident investigation
PSIRFaLP	Patient Safety Incident Response Framework and Learning Panel
RCA	Root Cause Analysis
SAR	Safeguarding Adult Review
CSPR	Child Safeguarding Practice Review
SI	Serious Incident
SIRP	Serious Incident Review Panel
SJR	Structure Judgement Review
SMI	Severe Mental Illness
STAG	Safeguarding Trust Assurance Group
STEIS	Strategic Executive Information System

4 Other relevant procedural documents

This policy should be read in conjunction with the following documents:

Risk Management Framework

Incident Reporting Policy

Incident Investigation Procedure

Complaints, Compliments, Comments and Concerns Handling Policy and Procedures

Data Protection and Confidentiality Policy

Duty of Candour (Being Open) Policy and Procedure

Verification of Expected Death by Registered Nurses Clinical Procedure

Consent to Assessment Examination and/or Treatment Policy (including Mental Capacity Act)

Safeguarding Adults Policy

Safeguarding Children Policy

Safeguarding Children and Adult Guidance

Reasonable Adjustments for Patients Policy

Language Interpretation Policy

Health Records Policy

Information Governance Framework Policy

Patient Safety Incident Response Policy

Medication Incident Policy

5 Roles and responsibilities

5.1 Chief executive officer

The chief executive officer is accountable to the Board for ensuring that resources, policies, and procedures are in place to respond to deaths. For practical purposes, the chief executive officer has delegated responsibility for this to the medical director.

5.2 Medical director

The medical director is the nominated director with accountability for developing and implementing this policy. The medical director is responsible for providing assurance to the Board with respect to mortality governance arrangements. This includes the provision of a quarterly report to the Quality and Safety Committee of the Board on the numbers of deaths of patients who were under the care of the Trust and the Trust's response to these, including any resultant learning.

The medical director, together with the chief nurse, has responsibility for monitoring and improving the quality of clinical services. They must ensure systems are in place to identify opportunities for service improvement, including as an outcome of investigation of deaths or serious incidents.

The medical director is responsible for notifying the Board of directors of any deaths which may attract media attention.

5.3 Trust Board

The Board will be appraised of mortality governance arrangements and will receive the "Learning from Deaths (LFD)" thematic annual report, via its Quality and Safety Committee. This will include the numbers of deaths of patients who were under the care of the Trust, the Trust's response to these deaths and any subsequent learning.

5.4 Chief nurse

The chief nurse is the nominated director with accountability for ensuring appropriate systems are in place for reporting incidents and patient safety incidents, including uploading details of incidents that require PSIIs to the Strategic Executive Information System (STEIS) and patient safety incident details to the LFPSE Service.

The chief nurse is also the nominated director with accountability for patient experience and duty of candour. The chief nurse holds the post of Caldicott Guardian for the Trust.

The chief nurse is responsible for:

- Ensuring systems are in place for investigating incidents and learning from them
- Ensuring systems are place for LeDeR.

5.5 Non–executive lead for learning from deaths

The non-executive director lead for LFD will provide constructive challenge to the effectiveness of mortality governance arrangements.

5.6 Chief operating officer

The chief operating officer is responsible for:

- Ensuring all staff report deaths in accordance with this policy
- Ensuring they will promote a learning culture within clinical teams and a willingness to implement service changes resulting from LFD
- Ensuring local structures enable reporting of deaths, engagement in investigations and support for bereaved families and carers. They may discharge these responsibilities through the associate borough directors.

5.7 Director of quality governance

The director of quality governance is the deputy Caldicott Guardian for the Trust and is responsible for:

- Chairing the Patient Safety Incident Response Framework & Learning Panel (PSIRFaLP) where all LFD case note reviews will be reviewed and approved

5.8 Associate borough directors

Associate borough directors are responsible for:

- Ensuring delegated tasks from the chief operating officer are undertaken
- Working with operational managers to ensure that accurate and relevant documentation is submitted in a timely manner and that the operational manager, or their deputy, attends the relevant Directorate Incident Response Learning Group (DIRLG) and PSIRFaLP as required.

5.9 Director(s) of Nursing Services

The director(s) of Nursing Services is responsible for:

- Challenging the investigation findings at DIRLG and PSIRFaLP to identify lessons to be learned.

5.10 Trust secretary

The Trust secretary is responsible for:

- Providing a quarterly report of coroner investigations that the Trust is involved to Quality & Safety Committee.

5.11 Quality Council

The Quality Council will ensure:

- A thematic report is submitted to the Quality and Safety Committee on a quarterly basis, covering the key areas (appendix 1: operational process)
    - Thematic summary/feedback received on a quarterly basis
    - Sample case review undertaken quarterly as part of the above submission
    - Evidence of lessons learnt communicated/actioned
    - Annual Board Report approval.
- Any lessons learned are shared with clinical teams via the Trust's established Clinical Governance routes for sharing of information across the Trust.

5.12 Director and heads of Safeguarding Services

The director and heads of Safeguarding Services will provide a report to the Quality Council regarding information in relation to child deaths and an update on the status of Child Safeguarding Practice Reviews (CSPRs), Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs).

If any escalations are required these will be escalated to the Quality and Safety Committee. This report will include the numbers of open case reviews during each quarter, details of any reviews which have been closed and learning for the Trust from these reviews. These details are also shared at Safeguarding Trust Assurance Group (STAG) by the named nurses for safeguarding.

5.13 Safeguarding Trust Assurance Group

The STAG will:

- Provide direction regarding Child Safeguarding Practice Reviews, safeguarding adult reviews and domestic homicide reviews

- Discuss and manage any learning identified and escalate in accordance to Trust policy.

5.14 Safeguarding team

The Safeguarding team will:

- Coordinate the Trust's contribution to the Child Death Overview Panel (CDOP) and multi-agency safeguarding reviews including Child Safeguarding Practice Reviews, SARs and DHRs

- Attend relevant meetings within the Trust when invited

- Provide advice and support as required.

5.15 Head of risk management and Patient Safety team

The head of risk management and the Patient Safety team, on behalf of the medical director, is responsible for:

- Monitoring the information uploaded onto the online risk management reporting system (Ulysses)

- Supporting staff in accessing Ulysses

- Uploading the LFD case note review assessment tool onto the risk management reporting system (Ulysses) once final recommendations have been signed off by the Serious Incident Reporting Panel (SIRP).

5.16 Directorate Incident Review and Learning Group

Directorate based DIRLGs are responsible for:

- Advising operational managers in relation to the need for further investigation and the applicability of duty of candour following the reporting of a death of a patient under the care of the service

- Supporting the identification of any subsequent learning
- Assessing each case using the LFD case note review assessment tool" (see appendix 2); the senior clinician completes this
- Recommending whether further investigation is required and for setting out the terms of reference for the investigation
- Monitoring the status of investigations into deaths and provide intelligence for PSIRFaLP in respect of deaths investigations
- Providing the monthly LFD updates to PSIRFaLP. This includes numbers of deaths of patients who were under the care of the Trust, the Trust's response to these cases.

5.17 Patient Safety Incident Response Framework and Learning Panel

The Trust's PSIRFaLP, on behalf of the medical director, will:

- Oversee all the Trusts reported deaths by providing a senior level scrutiny
- Share any lessons learned with clinical teams via established clinical governance routes for sharing of information across the Trust
- Consider recommendations made by DIRLGs and confirm level of investigation required
- Review and approve final versions of investigations following review at DIRLG.

5.18 Patient Service team

The Patient Service team will ensure:

- Complaints relating to a deceased patient are recorded as an incident on the risk management reporting system (Ulysses)
- They identify and make reasonable adjustments for patients (and where appropriate family members or carers) including in relation to disability, including communication and language formats, language, religion, or culture.

5.19 Operational managers

Operational managers are responsible for:

- Ensuring a death is reported as an incident in the Trust's incident risk management reporting system (Ulysses) within 48 hours of the service being made aware of the death

- Ensuring complaints relating to a deceased patient are reported as an incident on the risk management reporting system (Ulysses)

- Ensuring an LFD case note review/assessment tool (appendix 2) is completed as per the timescales in section

- Ensuring investigations are completed and staff are supported through the process

- Notifying the Safeguarding team in the event of a child death, unless the Safeguarding team were the operational service's source of notification

- Determining whether Duty of Candour is applicable. They should seek advice in this respect from the director of quality governance or the head of risk management and patient safety

- Documenting their decisions in both the clinical records and on the risk management reporting system (Ulysses) at every stage of the process

- Ensuring documentation in relation to the investigation of deaths is submitted in a timely manner

- Attending the DIRLG / PSIRFaLP as required or arranging for a suitable deputy to attend

- Ensuring any lessons arising as an outcome of the investigation of a death are implemented within the service and shared with the Quality Governance team for wider communication via the weekly Trust bulletin appropriate

- Recording lessons learned and completed actions on the risk management reporting system (Ulysses) before an incident is closed off

- Making reasonable adjustments for patients (and where appropriate family members or carers) including in relation to disability, including communication and language formats, language, religion, or culture.

5.20 All clinical staff

All clinical staff are responsible for:

- Acting in accordance with this policy in respect of responding to deaths of patients under their care

- Being open and transparent with families to ensure effective communication

- Engaging meaningfully and compassionately with bereaved families and carers

- Reporting a death as an incident on the risk management reporting system (Ulysses) within 48 hours of the death being notified, in accordance with the Incident Reporting Policy

- Completing an LFD case note review under the guidance of their operational manager

- Undertaking further investigations as directed by their operational manager/DIRLG/PSIRFaLP

- Documenting their decisions at every stage of the process

- Identifying and making reasonable adjustments for patients (and where appropriate family members or carers) including in relation to disability, including communication and language formats, language, religion, or culture.

6 Equipment

The Trust uses an online risk management reporting system (Ulysses) for the recording of incidents (including deaths). The Trust will use their patient management system such as SystmOne, to provide analytical data.

7 Operational process for learning from deaths

The method adopted by Trust is based on the Structured Judgement Reviews (SJRs) for improvement by Royal College of Physicians (version 1.3, June 2018).

The benefits of utilising this type of methodology are that it provides a structured and replicable process to reviewing deaths across the Trust. This method examines not only intervention but also looks at the holistic care, giving a rich data set of information.

Using the SJR method, we have established a community-based LFD case note review process (see appendix 2 - operational process for LFD case review). This method allows for the identification and feedback of both good and 'problematic' care, as there is much to be learned from both.

As part of this process, an LFD case note review assessment tool (see appendix 2) is completed by the lead clinician within a service once it has been identified the patient death has triggered one or more of the reporting criteria outlined in section 9.

8 Response to deaths

8.1 Deciding which patients are "under our care"?

The Trust offers services that are often part of a care system involving more than one provider, e.g., primary care, social care, acute care. On occasions, the Trust may not be the lead provider of a patient's care. When a patient dies it is the lead provider who would be responsible for undertaking a LFD review, and liaising with other providers, including this Trust, if concerns were noted in relation to any aspects of care provided by other organisations.

As a Trust, we will carry out a review or investigation of the death of any patient under our direct care. We are also willing to actively participate in the investigation of any patient death where that patient has been cared for by our staff but where that patient's direct care is the responsibility of another organisation.

The LFD review form is used for initial review of all deaths. It is acknowledged that, for patients not under the Trusts' direct care, the Trust will have to rely on those other organisations to notify us of a patient's death, as there is currently no national system in place that will notify the Trust directly.

Where a patient has died under the Trusts' direct care, but has been cared for by other organisations, the Trust may ask them to be involved in the Trusts investigation. The Trust will share any lessons learnt with external organisations who contribute to Trust reviews.

For the purpose of this policy, the following groups of patients are considered to be "under our care" and would be subject to a LFD review:

- Patients who are being cared for in an inpatient bedded unit/Padgate House by staff who are employed by the Trust

- All child and adult patients with a learning disability who have received consultation either direct face to face or via telephone within the last 30 days**.**

- Any death reported to the Trust of a child (under 18 years) where the Trust has an open patient record either expected or unexpected, except in the case of a baby who died in hospital and who's care has been in hospital from the beginning to the end of their life, or who was not born alive.

8.2 Patients who are under the direct care of another organisation

The Trust will not routinely undertake an LFD case note review for patients who die in hospital under the care of a different provider.

However, where they were under the care of the Trust prior to admission, it is expected that these deaths will be reported and investigated through the current provider's own mortality reporting system.

The Trust will actively involve itself in other providers' investigations about patient deaths if it is notified about the need for an investigation. The Trust may ask other organisations to be involved in that organisation's review if it feels the Trust's care contributed to a patient's death, even if the external organisation does not proactively involve the Trust.

In many circumstances more than one organisation is involved in the care of any patient who dies, with the most common combinations being primary care and acute care, ambulances services and acute care, or mental health services combined with any of these.

The following groups of patients are ones where we are delivering care, but they are under the direct care of another organisation. In these cases, the Trust will rely on being informed by the appropriate organisation until a national notification process is in place.

- Patients within the community who have received care from staff employed by the Trust but are under the care of the General Practitioner (GP).

- Patients who have completed their transfer from our intermediate care bed based facilities into the acute hospital

- Patients who have died within 30 days of leaving our intermediate care bed based facilities

- Patients who have completed their transfer to hospital from the Widnes Urgent Treatment Centre.

8.3 Immediate response following death

- If a patient dies under the Trust care, the first priority for the Trust is to ensure the needs of individuals affected by the death are attended to.

- A safe environment should be established, all equipment or medication retained and isolated, and all relevant documentation copied and secured to preserve evidence to facilitate investigation and learning.

- If there is a suggestion that a criminal offence has been committed, the police must be contacted immediately.

- If the death is a potential safeguarding concern, staff must contact their borough's named nurse for safeguarding immediately, in accordance with the safeguarding policies for children and adults.

- Where the death occurs outside a normal working day and the police are involved, then in accordance with Trust on call procedures, the senior on call manager must also be informed.

- In accordance with a culture of openness and a general duty of candour, information and support should be provided to relatives and carers, and staff affected by the incident in accordance with the Duty of Candour (Being Open) Policy requirements as relevant.

- Local documentation should be available regarding the Patient Service team, complaints, occupational health or counselling services and referrals made on behalf of staff by their manager.

9 Criteria for reporting the death of a patient who is under the direct care of the Trust on the risk management reporting system (Ulysses)

Notification received regarding a patient death or if a patient dies whilst under our care (as defined above):

- The bereaved family have expressed a concern about the care their relative received from the Trust or other partner services
- Staff employed by the Trust have expressed a concern about the quality of care received by the deceased e.g., did not die in their preferred place of care
- The death occurred whilst the patient was under the care of a service where concerns have previous been raised (e.g., through audit or CQC inspection)
- The deceased patient had a learning disability or autism
- Any death reported to the Trust of a child (under 18 years) where the Trust has an open patient record either expected or unexpected, except in the case of a baby who died in hospital and who's care has been in hospital from the beginning to the end of their life, or who was not born alive
- The death was unexpected, and the last service intervention was less than (<) 30 days ago.

If any of the above criteria apply, the death must be reported as an incident, in accordance with the Incident Reporting Policy, using the risk management reporting system (Ulysses) within 48 hours of the death being notified.

An LFD case note review/assessment tool (appendix 2) must be completed within the timescales below of the death being notified and the incident being reported onto the risk management reporting system (Ulysses). This applies to all UNEXPECTED deaths where there has been contact with a Trust service WITHIN THE LAST 30 DAYS.

If there has been NO contact in the last 30 days, a LFD is not required, unless there are specific concerns relating to the care raised by staff or the family.

Circumstances	Timescale for completion of LFD
Patient is currently in an intermediate care bed where Trust services are providing care.	Within 72 hours / 3 working days of the incident being reported*
Patient had a learning disability/autism	Within 72 hours / 3 working days of the incident being reported*
A child aged < 18 years (expected or unexpected) except in the case of a baby who died in hospital and who's care has been in hospital from the beginning to the end of their life, or who was not born alive.	Within 72 hours / 3 working days of the incident being reported*
Initial concerns noted in relation to the circumstances surrounding the patient's death or the care provided by the Trust.	Within 72 hours / 3 working days of the incident being reported*
No initial concerns identified relating to the circumstances surrounding the patient's death or the care provided by the Trust, where the is the main provider and the patient has been seen by a service within 30 days.	Within ten working days of the incident being reported*
Expected death e.g., patient on an end-of-life pathway where there were no concerns identified or if the person had learning disability or autism	No LFD review required.

*All incidents must be reported within 48 hours.

The LFD case note review must then be presented at DIRLG the following week. Once approved at DIRLG, the review will then be submitted to PSIRFaLP for final approval.

10 Reporting process

1. The operational manager must ensure a death (using the reporting criteria shown in section 9) is reported as an incident, in accordance with the Incident Reporting Policy, via the risk management reporting system (Ulysses) within 48 hours of the death being notified.

2. An LFD case note review must be completed (appendix 2) and uploaded onto the risk management reporting system (Ulysses) once approved at PSIRFaLP. Based on the findings of this review, DIRLG and PSIRFaLP will determine whether further investigation is required and for setting out the terms of reference for the investigation.

3. The operational manager must document their decisions in both the clinical records and on the risk management reporting system (Ulysses) at every stage of the process, ensuring documentation in relation to the investigation of deaths is submitted in a timely manner.

10.1 Reporting process for complaints related to a deceased patient

1. On receipt of a complaint related to a deceased patient, the Patient Service team must report this as an incident on the risk management reporting system (Ulysses).

2. The Patient Service team must then inform the operational manager of the complaint in order for a LFD review to take place within the timescales laid out in section 9. Any corresponding investigation and action must also be recorded on the risk management reporting system (Ulysses).

3. The operational manager must follow points 2 and 3 detailed in section 10 above.

10.2 Child death

In the case of all child deaths, expected or unexpected (including neonatal deaths and stillbirths), the operational manager must notify the Safeguarding team immediately (unless the safeguarding team were the source of notification to the operational service) and confirm the death has been recorded on the risk management reporting system (Ulysses).

10.3 Expected death (adults only)

Where an adult death is expected and no concerns about care or treatment are raised, then these need not be reported, unless the patient was a resident in Padgate House, or the patient had a learning disability or autism.

However, if the length of time following intervention was greater than 30 days and there is a concern about care, the death must be reported as an incident on the risk management reporting system (Ulysses).

All decisions must be documented in the patient's health records, together with any criteria which were considered to be met.

10.4 Lessons learned

Lessons arising as an outcome of the investigation of a death must be implemented within the service by the operational manager and shared with the director of quality governance for wider communication, via the Trust bulletin, as appropriate.

Lessons learned must be completed and recorded on the risk management reporting system (Ulysses) before the incident is closed off.

11 Engaging meaningfully and compassionately with bereaved families and carers

If a patient dies under the care of the Trust's services and any of the criteria within section 9 are met, the following steps must be followed by the person conducting the learning from death review to ensure meaningful engagement with bereaved family and carers:

1. Inform bereaved families/carers about the process for reporting and investigating the death

2. Inform bereaved families/carers that the purpose of reporting and investigating is to establish whether there is anything that can be learned from the death of their loved one which could help to prevent a future death.

3. Offer to inform bereaved families/carers of the outcome of any investigation.

12 Reporting deaths to other providers who may have an interest.

12.1 Patients who die within 30 days of discharge from hospital

If a patient who is under the Trust care dies within 30 days of being discharged from another hospital provider, the Trust (person conducting the review) must notify the hospital provider that the patient has died, as the provider may wish to report and investigate the death through their own mortality reporting system.

The death will still need to be reported on the risk management reporting system (Ulysses) if it meets the criteria detailed in section 9.

It should be noted a case can be reopened and discussed at PSIRF if deemed appropriate.

12.2 Shared care arrangements

If a deceased patient's care was shared between the Trust and another provider (e.g., primary care), the Trust (person conducting the review) must notify the other provider of the patient's death.

If the criteria in section 9 apply, the death must still be reported as an incident using the risk management reporting system (Ulysses) within 48 hours of the death.

13 Contributing to external investigation of deaths

13.1 Coroner's inquests

The Trust will fully cooperate with the investigation of a death as requested by the coroner. Any learning which is identified will be included in the Trust secretary's monthly report.

13.2 Child safeguarding practice reviews, safeguarding adult reviews and domestic homicide reviews

The Trust will contribute to the above reviews as directed by the Safeguarding teams in each borough locality. Any learning which is identified will be discussed and managed through the STAG and escalated in accordance to Trust policy.

13.3 Specific requirements for responding to deaths of patients with a learning disability or autism

Reports and case studies have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities.

The National Quality Board has specified that all inpatient, outpatient, and community patient deaths of people with learning disabilities should be reviewed in order that learning from these deaths can contribute to service improvements.

The National LeDeR programme commenced in June 2015 and is rolling out a review process for the deaths of people with learning disabilities. The Trust will notify all deaths of people with learning disabilities to the LeDeR programme where the patient dies in their own home.

When undertaking investigation into the death of a patient with learning disability, the Trust (person conducting the review) will complete the Learning from Death Review and report to LeDeR..

13.4 Specific requirements for responding to deaths of patients with a mental health condition

The National Quality Board guidance requires that all inpatient, outpatient, and community patient deaths of people with severe mental illness (SMI) should be subject to case record review.

In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis, and schizoaffective disorder.

13.5 Specific requirements for responding to deaths of infants or children.

Infant or child (under 18) death reviews should be undertaken in accordance with national guidance:

Royal College of Pathologist (2016) Sudden Unexpected Death in Infancy and Childhood – Multi-Agency Guidelines for Care and Investigation.

The CDOP should be notified whenever a child dies. The CDOP will gather appropriate intelligence, investigate the death, and make recommendations for lessons learned.

Stillbirths, perinatal deaths and infant (<1 year) deaths must be reported to the National Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP) via the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries – United Kingdom (MBRRACE-UK) online reporting system available at:

www.mbrrace.ox.ac.uk (log-in required)

The national programme conducts surveillance and investigates the causes of maternal deaths, stillbirths, and infant deaths. Guidelines for using the system can be downloaded by clicking on the link below:

14 Consultation

Key individuals/groups involved in the development of the document to ensure it is fit for purpose once approved.

Name	Designation
Kristine Brayford-West	Director for Safeguarding Services
Jim Eatwell	Head of Safeguarding Adults
Sarah Wilson	Head of Safeguarding
Jeanette Hogan	Deputy Chief Nurse
Mary Corkery	Policy Officer
Hitesh Chandarana	Head of Service Experience
Alan Lee	Head of Risk Management and Patient Safety
Jan McCartney	Trust Secretary
Ted Adams	Medical Director
Susan Burton	Director of Nursing Services Warrington
Andi Sizer	Principal Lead for Public Health
Abby Bird	SIRP

Name	Designation
SIRP	
Corporate Clinical Policy Group	

15 Dissemination and implementation

15.1 Dissemination

The medical director will disseminate this policy to executive directors for onward dissemination to operational managers.

Operational managers will disseminate to staff using the most appropriate mechanism(s) available, including management meetings, and recording this in their minutes or meeting notes.

The policy will be made available on MyBridgewater and published in the team brief.

15.2 Implementation

Operational managers will implement this policy within their services. Step by step flowcharts for quick reference support this document for staff to access on the MyBridgewater.

The head of risk management and patient safety will incorporate the operational process for LFD into the incident reporting training.

16 Process for monitoring compliance and effectiveness

Process for reviewing compliance and effectiveness i.e., audit, review, survey, incident reporting	Responsible	Frequency of monitoring	Assurance group
LFD report, which will include the numbers of deaths of patients who were under the care of the Trust, the Trust's response to these and any resultant learning.	PSIRFaLP	Quarterly	Quality and Safety Committee

17 Standards/key performance indicators

The establishment of New Board reporting model, which is in line with the National Quality Account requirements, as outlined in appendix 3 - reporting matrix.

18 References

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Bridgewater Community Healthcare NHS Foundation Trust

Operational process for LFD case notes review - structure judgement review (SJR)

Trigger criteria:

- Patients with learning disability or mental health concerns.
- Child death.
- Family/carer concerns
- Staff concerns
- Unexpected death within 30 days since last service.

Update once changes to policy are agreed..

Problem identified.

RCA/investigation implemented as deemed appropriate by PSG/ PSIRF. Duty of Candour applied.

Inter-agency Review: where appropriate to undertaken with other partners.

Clinical record review is completed by clinician, using the Learning from Deaths Case Note Review tool, and submitted to DIRLG – (please note: to be uploaded onto incident management system, once process is completed).

Actions agreed & monitored by PSIRF

No concerns identified case closed –file report in incident report system.

Thematic learning points and good practice identified. Quarterly report outlining findings submitted to Quality & Safety Committee.

Quality & Safety Committee:

- Thematic summary/feedback received on quarterly.
- Sampler case review undertaken quarterly as part of the above submission.
- Evidence of lessons learnt communicated/actioned.
- Annual Board Report .approval.

The following appendix can be accessed under the policy on MyBridgewater:

Appendix 2 - Learning from Deaths (LFD) review – guidance for completion/template

Appendix 3

Reporting matrix

a) The number of patients who have died during the report period, including a quarterly breakdown of the annual figures was:

Q 1	Q2	Q3	Q4	Total

b) The number of deaths as a %, including which were subjected to a case record review or an investigating to determine what problem (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure was:

Q 1	Q2	Q3	Q4	Total

c) Number of deaths as % during the reporting period for which a case record review or investigation had been carried out which the organisation judges as a result of the review or investigation were more likely than not to have been due to problems in care provided to the patient:

Q 1	Q2	Q3	Q4	Total

d) A summary lessons learnt from case record reviews and investigation conducted in relation to deaths:

e) A description of the actions which the organisation has taken in the reporting period, and proposes to take following the reporting period, as consequence of what we have learnt during the reporting period:

f) An assessment of the impact of the actions which were taken by the organisation during the reporting period is still to be determined and will be reviewed in the coming year.