

Death Certification and Mortality Review Policy Version: 5.0

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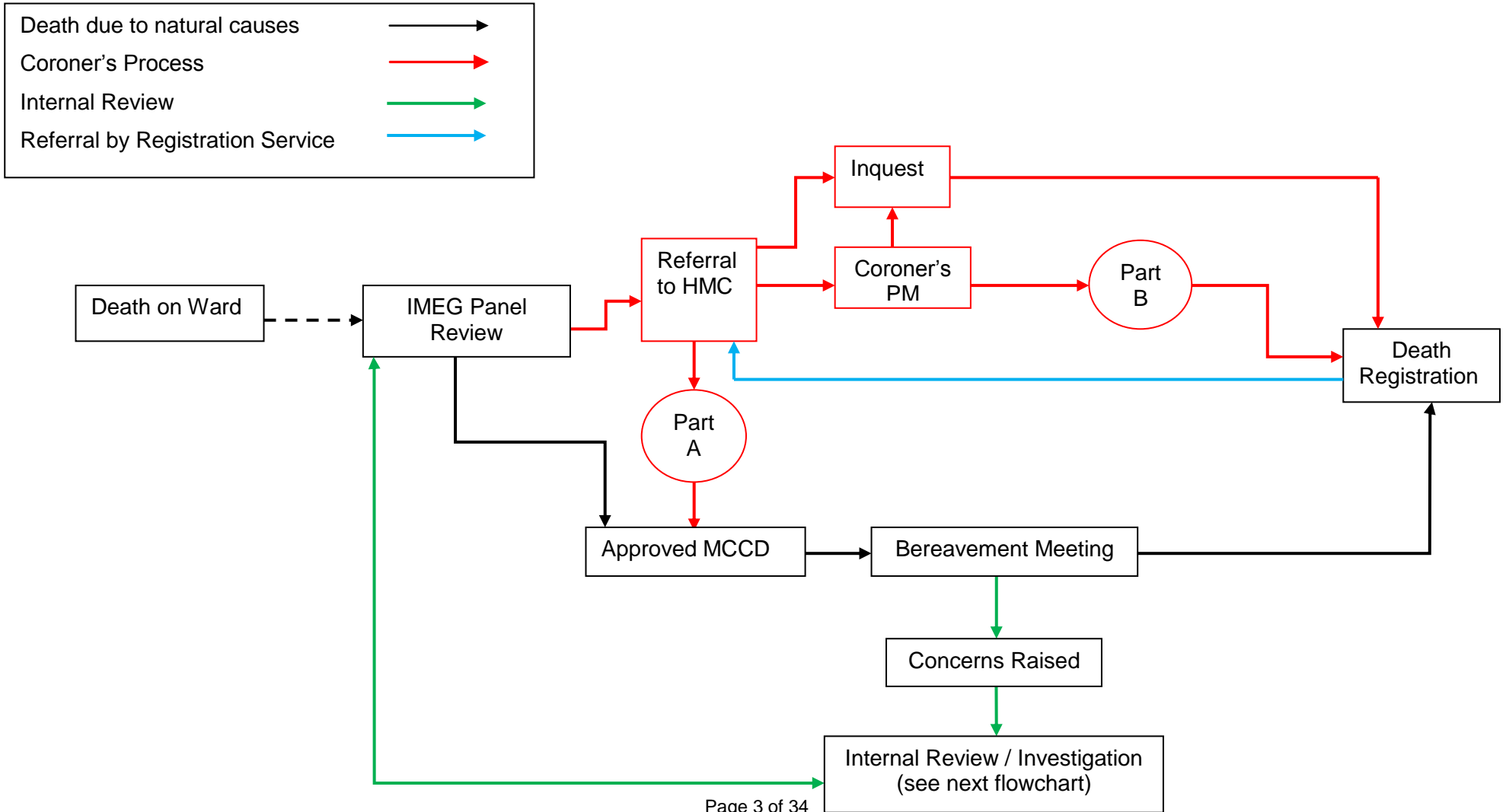
Executive Summary

The purpose of this policy and the associated guidelines is to help improve the quality of the Trust's mortality data by supporting doctors in the completion of Medical Certificates of Cause of Death (MCCDs), determining when a death should be reported to HM Coroner and identifying and investigating (through a variety of means) deaths that might have avoidable features or where an adverse event occurred prior to death. It describes the role of the Internal Medical Examiner Group (IMEG) in the process of post-death scrutiny.

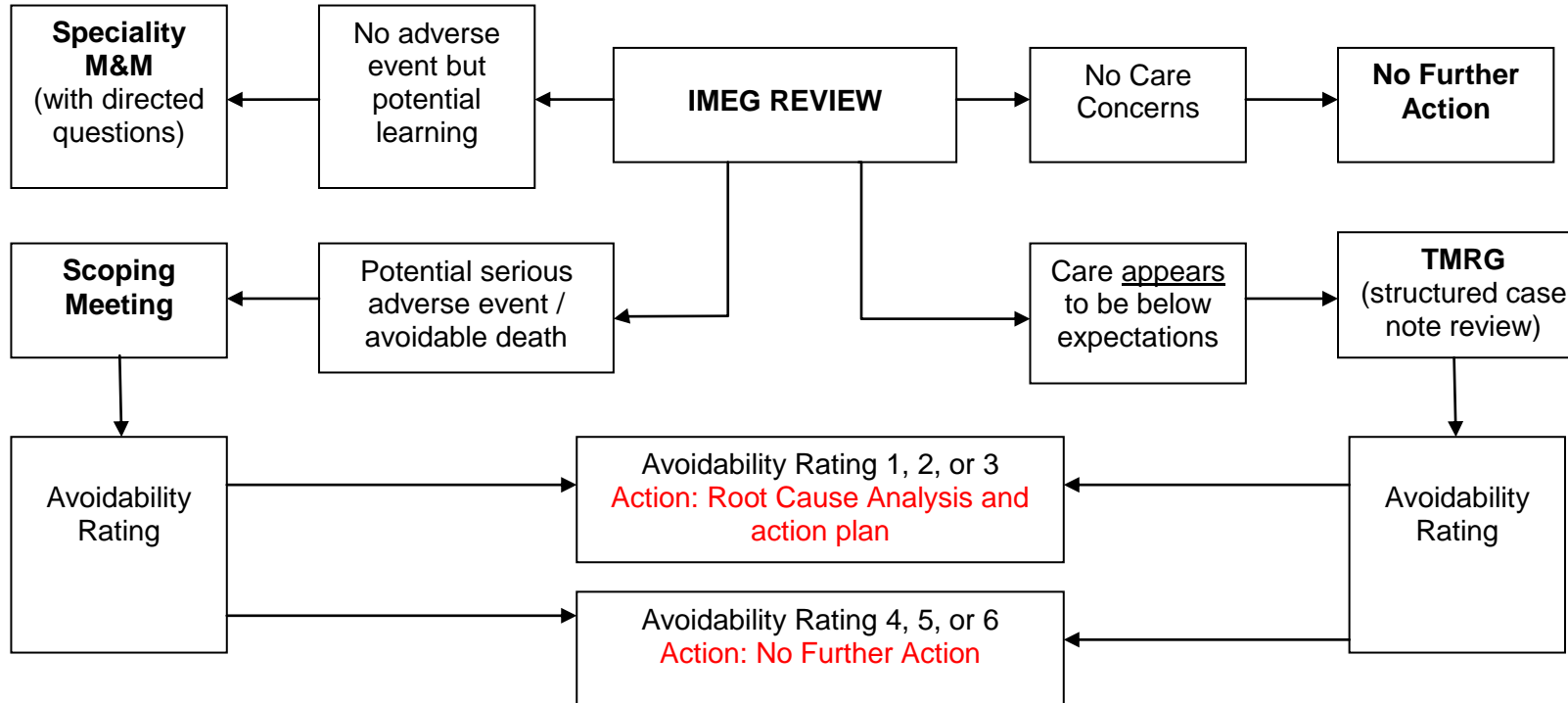
Information about the completion of certificates for stillbirths or children dying under the age of 28 days is not specifically included within this document. The review processes described relate to deaths of patients over the age of 18 years, with the exception of Appendix H which describes the Child Death and Deterioration Group terms of reference.

Flowcharts showing the review processes are provided overleaf.

DEATH CERTIFICATION REVIEW PROCESS



INTERNAL MORTALITY REVIEW PROCESS



- Avoidability Rating**
1. Definitely avoidable
 2. Strong evidence of avoidability
 3. Probably avoidable (more than 50:50)
 4. Possibly avoidable, but not likely (< 50:50)
 5. Slight evidence of avoidability
 6. Definitely not avoidable

1 Scope and Purpose

This policy relates to all UHS in-patient deaths.

The objectives are:

- To ensure that the medical information recorded on MCCDs accurately reflects the cause of death including where a patient has a hospital acquired infection that has contributed to their death
- To ensure that certificates are completed in a timely manner and comply with the standards set out in this document
- To ensure that where required, deaths are reported appropriately to HM Coroner
- To improve the overall quality of completed certificates
- To identify areas of concern that require further investigation and to co-ordinate and disseminate learning
- To improve the experience of bereaved relatives

2 Definitions

AER – Adverse Event Report

CDAD – Child Death and Deterioration Group

IMEG – Internal Medical Examiner Group

M&M – Morbidity & Mortality Review Groups

MCCD – Medical Certificate of Cause of Death

QSGS – Quality Governance Steering Group

SIRI – Serious Incident Requiring Investigation

SISG – Significant Incident Scrutiny Group

TMRG – Trust Mortality Review Group

3 Details of procedure to be followed

3.1 Attendance at IMEG

- Attendance at the IMEG panel is mandatory, but this must not delay the issuing of the medical certificate of cause of death. Attendance is therefore required **no later** than the day following the death of a patient, or Monday for a death at the weekend.
- The doctor attending the IMEG panel will ensure that they have discussed the patient's care with their Consultant, or in his/her absence their Registrar, to make sure that they are familiar with the patient's case, have agreed a draft cause of death and identified any areas of concern or complaints raised by the patient's family.
- The doctor attending the IMEG panel will bring the patient's medical records with them to the meeting.
- The IMEG panel will meet twice-daily (Monday to Friday), between 9:00am and 10:00am, and between 2:00pm and 3:30pm (4:00pm on Mondays).
- Appointment slots between 9:30am and 10:00am will be reserved for the review of deaths at Countess Mountbatten House via video link
- Appointments will be made via the Bereavement Care office (ext 4587).
- Where a medical certificate of cause of death is issued outside normal working hours, for religious/cultural reasons (**see 4.2**), the issuing doctor will be required to attend the IMEG panel on the next working day for a retrospective review of the case.

3.2 Issuing a Medical Certificate of Cause of Death outside normal working hours for religious or cultural reasons

- There will be occasions where, for religious or cultural reasons, there is a requirement for the rapid issuing of the death certificate and release of the body to facilitate burial within 24 hours. Where this is necessary, the following procedures should be followed.
- The medical certificate of cause of death must be issued by a Consultant or Registrar who has seen the patient prior to death. Where there is no Consultant or Registrar on duty who has treated the patient, a junior doctor who has been involved in the patient's treatment may issue the medical certificate of cause of death, but only after discussing the case and agreeing the cause of death with the responsible duty Consultant.
- Where there is no doctor on duty who has been involved in the patient's care, the patient's named Consultant should be contacted and asked to deal with the certificate.
- Except in cases where the death was expected, contact should be made with the Coroner to ensure that there is no reason for him to investigate the death further. If the Coroner is unavailable, then the death should be discussed with one of his assistants.
- A medical certificate of cause of death book is held in the Hospital Control Room for these cases.
- In all circumstances, the doctor must present the case for a retrospective review by the IMEG panel on the next working day.

3.3 IMEG outcomes

- Potential AERs unrelated to the cause of death and which have not led to serious harm (or have the potential to do so) will be reported on the UHS incident reporting system and investigated via divisional governance and the patient safety team.
- Falls, pressure ulcers and venous thromboemboli will be reported to the relevant safety panels.
- Potential AERs that may have led to serious harm or contributed to the cause of death will be reported to the patient safety team for serious adverse event case review (scoping meeting) under the oversight of SISG and the AMD for safety.
- Cases where there are potentially avoidable features within the patient's care, which may not necessarily constitute clear evidence of an AER should be referred to the Trust Mortality Review Group (TMRG) for further in-depth analysis of avoidability and assessment of relevant learning for the clinical team and hospital trust.
- Cases with questions over elements of clinical care where there is potential for useful learning for the responsible clinical team should be referred for discussion of directed questions at the relevant Morbidity and Mortality (M&M) meeting.
- The patient support services team should be informed of cases with known family concerns and should be made aware of deaths involving potentially serious adverse events.
- Evidence of serious failures in care with implications for the safety of current patients will be escalated via the Associate Medical Director for Safety and the Deputy Director of Nursing and Quality, to the joint chairs of QGSG and the chairs of the Trust Executive Committee and Trust Board as appropriate.

3.4 Adverse Event / Incident Reporting

- Where a death ‘**may be related to a medical procedure or treatment whether invasive or not**’ or ‘**where the death was sudden and unexpected**’, contact should be made with the Trust’s Patient Safety Department by completing and sending an Adverse Event Form as per the Trusts Incident Reporting Policy.

3.5 Complaints Handling / Reporting

- Where relatives express concerns, or complain about care, an early resolution meeting should be offered with the patient’s Consultant and/or a senior member of the nursing team. Advice can be sought from the IMEG panel and in exceptional cases, a meeting may be offered to relatives by the Associate Medical Director for Safety or the Deputy Director of Nursing and Quality.
- Where an early resolution meeting is felt to be inappropriate, where an early resolution meeting fails to meet the needs of relatives, or where relatives wish for a more formal approach to their complaint, they should be referred to the Trust’s Patient Support Services. Further information can be found in the Trust’s Concerns and Complaints Policy.

3.6 Review of deaths in the community within 30 days of discharge from UHS

- Deaths within 30 days of discharge from UHS will be reported to IMEG, either by the primary care provider or the Coroner’s office, either by telephone or by email to the IMEG administrator or the bereavement care team. The information provided, together with information from the patient’s discharge summary and electronic patient record will be reviewed by the associate medical director for safety and a member of the bereavement care team. Deaths will be graded and referred to other Trust processes in the same manner as inpatient deaths. Where appropriate, specific concerns or questions will be addressed to the primary care provider for clarification, reassurance or investigation.
- Currently it is not possible to ensure all deaths in the community within 30 days of discharge will be identified, however processes will undergo further development to establish the highest possible level of reporting.

4 Roles and Responsibilities

Chief Executive Officer

As accountable officer, the Chief Executive is responsible for the overall leadership and management of the Trust and its performance in terms of service provision, financial and corporate viability, ensuring that the Trust meets all its *quality and safety*, statutory and service obligations and for working closely with other partner organisations. The CEO delegates aspects of this responsibility to relevant Executive Directors according to their organisational portfolios. The CEO directly manages communications, information services and corporate affairs.

Medical Director

The Medical Director has delegated authority and responsibility within the Trust for medical staff – including clinical practices and outcomes; professional regulation and clinical standards; clinical effectiveness; research and development and relationships with general practitioners.

Executive Director of Nursing and Organisational Development (OD)

The Director of Nursing and OD has delegated authority and responsibility for all aspects of infection prevention and control; nursing clinical practices and outcomes; professional regulation and clinical standards; training and development; governance

(including compliance, risk management, patient safety and experience); human resources and workforce.

Associate Medical Director for Safety

The Associate Medical Director for Safety has delegated authority from the Medical Director for matters of safety and governance. The Associate Medical Director for Safety will be responsible for appointing senior doctors to deputise for him as the IMEG clinical lead.

IMEG Clinical Lead

Will either be the Associate Medical Director for Safety or his deputy. The IMEG Clinical Lead will provide scrutiny of clinical events, ensure that the cause of death has been discussed with the senior clinician responsible for the deceased's care and advise if further investigation is required.

Bereavement Care Staff

A member of the bereavement care team will be in attendance at all IMEG meetings to provide advice on the processes of; death certification, family liaison, post mortem examinations and referral of deaths to HM Coroner.

Patient's Clinical Team

The patient's clinical team are responsible for attending the IMEG panel and issuing the medical certificate of cause of death, or referring the death to HM Coroner, in accordance with the standards set out in this document.

5 Related Trust Policies

- Bereavement Care Policy
- Incident Reporting Policy
- Incident Management Policy
- Concerns and Complaints Policy and Procedures
- Supporting Staff Involved in an Incident, Complaint or Claim Policy
- Post Mortem Consent & Human Tissue Disposal Policy
- Being Open: Duty of Candour
- Maternal Death Procedure

6 Communication Plan

- This document will appear in the 'New and Updated' area of Staffnet and circulated to all M&M leads, TMRG and CDAD
- Training will be provided to IMEG reviewers and those undertaking mortality reviews. Medical staff will receive 1:1 training on completion of death documentation at IMEG

7 Process for Monitoring Compliance/Effectiveness

The purpose of monitoring is to provide assurance that the agreed approach is being followed – this ensures we get things right for patients, use resources well and protect our reputation. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

Key aspects of the procedural document that will be monitored:

| What aspects of compliance with the document will be monitored | What will be reviewed to evidence this | How and how often will this be done | Detail sample size (if applicable) | Who will co-ordinate and report findings (1) | Which group or report will receive findings |
|---|---|--|---|---|--|
| Timeliness of death certification | The time taken to attend IMEG / write the death certificate | Quarterly | All | Bereavement Care | Quality Committee |
| Deaths requiring further internal review / investigation | Number of deaths escalated to M&M, TMRG or SISG. Themed outcomes and avoidability ratings for all deaths | Quarterly | All | Bereavement Care | Quality Committee and Trust Board |

(1) State post not person.

Where monitoring identifies deficiencies actions plans will be developed to address them.

8 Arrangements for Review of the Policy

This policy will be reviewed one year from the date of approval.

9 References

- Births and Deaths Registration Act (1953)
- Guidance for Doctors certifying cause of death (Office of National Statistics, Sept 2008)
- Healthcare Associated Infections and Death Certification (Chief Medical Officer, October 2007)
- Coroners and Justice Act (2009)
- Using the structured judgement review method: A guide for reviewers (Royal College of Physicians 2016)

Appendix A: Guidance on completing the Medical Certificate of Cause of Death

You are required to complete the Medical Certificate of Cause of Death, stating the cause of death **to the best of your knowledge and belief**, if you attended the deceased during his/her last illness. You **must not** complete the certificate if you did not attend the deceased during his/her last illness, or if you do not know the cause of death. A blank specimen certificate can be found at Appendix B.

When completing the certificate:

- Please ensure you write legibly
- Ensure that you complete the patient's details correctly
- You **must** circle either:
 - (1) The certified cause of death takes account of information obtained from post-mortem
 - (2) Information from post-mortem may be available later
 - (3) Post-mortem not being held
- or (4) I have reported the death to the Coroner for further action
- and
 - (a) Seen after death by me
 - (b) Seen after death by another medical practitioner but not by me
- or (c) Not seen by a medical practitioner
- **Do not** use medical symbols or abbreviations
- Print your full name clearly after your signature and add your medical qualification(s) and GMC registration number. (If qualifications were obtained in another country, please state which university town it was obtained in and the year it was awarded)
- Give the name of the Consultant responsible for the care of the patient

Completing the Cause of Death Statement

- **Part I**
 - State the disease or condition directly leading to death on the first line [**Part I (a)**]
 - Complete the sequence of diseases or conditions leading to death on subsequent lines
 - State the Underlying Cause of Death on the last completed line of Part I
 - The disease or condition directly leading to the death and the Underlying Cause of Death may be the same. In this case you only need to complete the first line of Part I
- **Part II**
 - If there is some significant condition or disease that contributed to the death but which is not part of any sequence leading directly to death, you should record it in Part II, e.g. Diabetes Mellitus or Parkinson's Disease

Example

I (a) Disease or condition directly leading to death: **Intracerebral Haemorrhage**

(b) Other disease or condition, if any, leading to I(a): **Cerebral Metastases**

(c) Other disease or condition, if any, leading to I(b): **Squamous Cell Carcinoma of the Left Main Bronchus**

II Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition causing it: **Type II Diabetes**

Modes of dying

Do **NOT** state a 'mode of dying' unless you specify the disease or condition which preceded it, otherwise the Registrar of Births and Deaths will report the death to the Coroner as 'cause of death unknown'.

Modes of dying include Organ Failure (e.g. Heart Failure, Renal Failure etc), Cardiac or Respiratory Arrest, Coma, Cachexia, Debility, Uraemia and Shock.

The addition of Acute or Chronic to any of these terms does **not** make them acceptable as a cause of death.

More comprehensive guidance is given in the notes at the beginning of every Medical Certificates of Cause of Death book.

Other administrative tasks

The outcome of all IMEG discussions, including the cause of death or referral to HM Coroner should be recorded in the patient's medical records.

All co-morbidities, whilst not necessarily included on the Medical Certificate of Cause of Death, must be recorded on the patient's e-discharge summary.

Appendix B: Blank specimen Medical Certificate of Cause of Death

BIRTHS AND DEATHS REGISTRATION ACT 1953
(Form prescribed by Registration of Births and Deaths Regulations 1987)

MEDICAL CERTIFICATE OF CAUSE OF DEATH
For use only by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the deceased's last illness, and to be delivered by him forthwith to the Registrar of Births and Deaths.

Registrar to enter
No. of Death Entry
.....

Name of deceased

Date of death as stated to me day of Age as stated to me

Place of death

Last seen alive by me day of

| | | |
|--|--|--|
| <p>1 The certified cause of death takes account of information obtained from post-mortem.</p> <p>2 Information from post-mortem may be available later</p> <p>3 Post mortem not being held.</p> <p>4 I have reported this death to the Coroner for further action. <i>(See overleaf)</i></p> | } <i>Please ring appropriate digit(s) and letter</i> } | <p>a Seen after death by me.</p> <p>b Seen after death by another medical practitioner but not by me.</p> <p>c Not seen after death by a medical practitioner.</p> |
|--|--|--|

CAUSE OF DEATH
The condition thought to be the 'Underlying Cause of Death' as it appears in the lowest completed line of Part I.

I (a) Disease or condition directly leading to death?

(b) Other disease or condition, if any, leading to: I(a)

(c) Other disease or condition, if any, leading to: I(b)

II Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition causing it

These particulars not to be entered in death register

Approximate interval between onset and death

.....

.....

.....

The death might have been due to or contributed to by the employment followed at some time by the deceased Please tick where applicable

† This does not mean the mode of dying, such as heart failure, asphyxia, asthma, etc: it means the disease, injury, or complication which caused death.

I hereby certify that I was in medical attendance during the above named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature Qualifications as registered by General Medical Council

Residence Date

For deaths in hospital: Please give the name of the consultant responsible for the above- named as a patient

Appendix C: Reporting deaths to HM Coroner

The Coroner's service works within a legal framework. It is the Coroner's duty to investigate deaths which are reported to him/her and which appear to be due to violence, or are unnatural, or are sudden and of unknown cause.

Reportable deaths

- The cause of death is unknown
- It cannot readily be certified as being due to natural causes
- The deceased was not attended by a doctor during his/her last illness, **or** was not seen within the last 14 days **or** seen after death
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was related to the anaesthetic. (In any event, a death occurring within one year of an operation/invasive procedure should be discussed with the Coroner's Officer)
- The death may be related to a medical procedure or treatment whether invasive or not
- The death may be linked to an accident, whenever it occurred, or suicide
- There are any suspicious circumstances or history of violence
- The death could be due to industrial disease or related in any way to the deceased's employment
- The deceased was detained under the Mental Health Act
- The death may be due to self-neglect or neglect by others
- The death occurred during or shortly after detention in police or prison custody
- The death occurred within 24 hours of admission to hospital unless the patient was admitted for terminal care only

Contacting the Coroner's Office

The Coroner's Office can be contacted either directly using the contact numbers below.

Coroner's Office (Direct Dial) 01962 667884 or # 7361

Please ensure you clearly record why you referred the death to the Coroner and the outcome of the conversation.

Appendix D: Internal Medical Examiner Group (IMEG) Terms of Reference

1. Introduction

The internal medical examiners group provides a forum whereby a rapid review can be made of every death within UHS to give advice on death certification and identify concerns related to the deceased's care or cause of death. This process should facilitate communication with the bereaved, the process of death certification, referral to HM Coroner, management of complaints, review at morbidity and mortality meetings, discussion at trust mortality review group (TMRG) and investigation of adverse events.

In due course the role of the Medical Examiner will be established nationally and will replicate some of these functions externally, however it is envisaged that this group will still have a long-term role providing a first line of review for deaths within the hospital.

Related policies:

Bereavement care policy

Death certification and the coroner: guidelines for medical staff

Incident Reporting, Analysis, Investigation and Management Policy

Concerns and Complaints Policy and Procedures

2. Purpose

- 2.1. To provide a daily (Monday-Friday) review of all deaths within UHS prior to issuing a medical certificate of cause of death or discussion with HM coroner; the following exclusions will apply:
 - a. Death under suspicious circumstances, requiring immediate police involvement, (these are referred to HM coroner and the police directly, the death should still be discussed subsequently with the AMD for safety to assess whether further internal investigation is required)
 - b. Those dead on arrival in ED (these are all referred directly to HM coroner and are discussed at the monthly ED M and M)
 - c. Maternal death (discussed at obstetric red review meeting and automatically receive case review meeting)
 - d. Fetal and peri-natal death (discussed at obstetric red review meeting)
 - e. Those with religious beliefs requiring a funeral <24 hours (these are discussed retrospectively at IMEG).
 - f. Paediatric and neonatal deaths, are discussed at the Child Death and Deterioration Group (CDAD), which replicates the function of IMEG for paediatrics and meets weekly.
- 2.2. To ensure appropriate cause of death description in death certification
- 2.3. To ensure appropriate identification of notifiable, work related conditions e.g. asbestos related disease.
- 2.4. To ensure all deaths have been discussed with the senior clinician and nursing staff responsible for the patient's care.
- 2.5. The review will advise on appropriate communication with the deceased's family and ensure that the clinicians have fulfilled the duty of candour, where appropriate.

- 2.6. Ensure that the deceased's general practitioner has been informed by the responsible team
- 2.7. Identify where the relatives are known to have concerns or there may be complaints, so that they can be followed up appropriately to avoid additional distress to the family. This may be through the patient support services team, the bereavement care team, the patient safety team or the clinical team depending on the nature of the concern.
- 2.8. Advise on the death certification process so that death certificates can be completed correctly and in a timely fashion.
- 2.9. Identify cases where it would be appropriate for referral to HM Coroner and ensure that the correct information is presented.
- 2.10. Identify deaths where presentation at specialty M&M and discussion of specific questions raised by the IMEG, would appear to be useful for learning and documentation of events.
- 2.11. Provide an initial assessment of whether the death was likely to have been avoidable, unavoidable or have avoidable features. Those deaths which are potentially avoidable or have avoidable features are to be discussed further at TMRG.
- 2.12. Identify cases where there would appear to have been adverse events unrelated to the cause of death which should be reported for investigation by the patient safety and divisional governance teams.
- 2.13. Identify cases where there should be further investigation of potential adverse events which may have contributed to the cause of death; these should have a scoping meeting within 2 working days and the investigation should subsequently report to SISG.
- 2.14. The discussion and outcomes from the IMEG meeting will be recorded prospectively by a member of the bereavement care team, however this discussion does not form part of the patient record. The agreed cause of death or outcome of discussion with HM coroner will be recorded by the presenting clinician on the final page of the patient record.
- 2.15. Identify cases where a hospital post mortem might be of benefit.
- 2.16. Provide background information on the patient's medical care for the bereavement care team to facilitate discussion with the bereaved family, particularly if there are known concerns or possible adverse events.
- 2.17. The discussion should facilitate completion of the electronic discharge summary and include discussion of primary diagnosis and comorbidity that would be appropriate to record in this document.
- 2.18. The discussion should encompass aspects of end of life care including DNACPR decision-making, treatment escalation plans, end of life care pathway and access to specialist palliative care support.
- 2.19. The discussion should identify patients with learning disabilities, patients on a DOLS, patients with mental health disorders as a primary diagnosis and those lacking capacity for whom formal best interest meetings would be appropriate. This should

then inform further discussion with HM coroner or lead to further case review where appropriate.

- 2.20. IMEG should be a learning opportunity for members of junior staff presenting cases. Where time permits and discussion can reasonably be extended, then the IMEG discussion may form the basis of a recorded case based discussion (CBD) for educational purposes.

3. Constitution

The group will consist of representative from bereavement care, pathology, the patient safety team, patient support services and senior clinicians:

- 3.1 Senior clinician: this will either be the Associate Medical Director for Safety or a nominated deputy. The clinician will chair the meeting and provide scrutiny of clinical events, ensure that the cause of death has been discussed with the senior clinician responsible for the deceased's care and advise if further investigation is required.
- 3.2 Bereavement care: a member of the bereavement care team will provide advice on the processes of; death certification, family liaison, post mortem and referral to HMC
- 3.3 Consultant pathologist: will be available to give advice on the medical certificate of cause of death and ensure that appropriate cases are referred to HMC
- 3.4 Patient support services: a member of the patient support services team will be available to give advice if there are existing or anticipated complaints.
- 3.5 Patient safety team: a member of the PST will be available to be informed about potential inquest cases and significant adverse events in order to initiate scoping meetings and investigations if it seems likely that they may have contributed to the patient's death.

4. Delegated Authority

IMEG has delegated authority from the Medical Director

5. Escalation routes

- 5.1 HMC will be informed of all cases which meet criteria for referral.
- 5.2 Potential AERs unrelated to the cause of death and which have not led to serious harm (or have the potential to do so) will be reported and investigated via divisional governance and the patient safety team.
- 5.3 Falls, pressure ulcers and venous thromboembolism will be reported to the relevant safety panels.
- 5.4 Potential AERs that may have led to serious harm or contributed to the cause of death will be reported to the patient safety team for case review SIG

- 5.5 Cases where there are potentially avoidable features within the patient's care, which may not necessarily constitute clear evidence of an AER should be referred to the trust mortality review group (TMRG) for further in-depth analysis of avoidability and assessment of relevant learning for the clinical team and hospital trust.
- 5.6 Cases with questions over elements of clinical care where there is potential for useful learning for the responsible clinical team should be referred for discussion of directed questions at the relevant morbidity and mortality meeting.
- 5.7 The patient support services team should be informed of cases with known family concerns and should be made aware of deaths involving potentially serious adverse events.
- 5.8 Evidence of serious failures in care with implications for the safety of current patients will be escalated via the Associate Medical Director for Safety and the Deputy Director of Nursing and Quality, to the joint chairs of QGSG and the chairs of the Trust Executive Committee and Trust Board as appropriate.

6. Administration of meetings

- 6.1 Meetings will occur twice daily from Monday to Friday between 09:00am and 10:00am, with a second meeting between 2:00pm and 3:30pm (4:00pm on Mondays).

Cases from the Countess Mountbatten House are discussed daily (Monday to Friday) via video link at 09:30am.
- 6.2 Each case will be allocated a maximum of 10 minutes. Booking will be via the bereavement care office (extension 4587).
- 6.3 The presenting doctor will bring the patient's notes.
- 6.4 Clinicians will provide a completed paper or electronic referral form for the deceased with a brief description of their presentation, symptoms and signs, co-morbidity, diagnosis, investigation, treatment and clinical course. Where known the cause of death will be provided.
- 6.5 The presenting clinician will be questioned about the patients management, which clinicians the cause of death has been discussed with and any subsequent difficulties with delivery of care or any care concerns raised by medical or nursing staff or the family.
- 6.6 If necessary the senior clinician responsible for the deceased's care will be contacted for additional information or supplementary information requested for representation of the death.
- 6.7 The outcome of the meeting will be recorded on the paper or electronic referral form, the medical certificate of cause of death will also be completed at this point. The outcomes of each meeting will be scanned and sent to the PST at the end of each day for logging on the medical examiner database.
- 6.8 The meeting will be quorate if The Chair or a nominated deputy from the IMEG reviewers group and a member of bereavement care are present.

- 6.9 The outcomes will be collated and presented quarterly to the Quality Committee and Trust Board. Metrics to be assessed include:
- a. Numbers of deaths
 - b. Number of deaths reviewed
 - c. Number of deaths of patients with a learning disability
 - d. Number of deaths of patients with a learning disability reviewed
 - e. Avoidability scores for each death reviewed
 - f. Annually a survey of presenting clinicians experience

7. Service Relationships

IMEG has close inter dependency with the following services and individuals within UHS and externally:

Patient safety team (including falls panel, VTE panel and pressure ulcer panel)

Bereavement Care

Patient support services team

Specialty group M&M meetings

Trust mortality review group (TMRG)

Divisional governance teams

SISG

HM Coroner

HSMR and mortality review

End of life operational group

Quality governance steering group (QGSG)

Medical Director

Appendix E: Trust Mortality Review Group (TMRG) Terms of Reference

1 CONSTITUTION

- 1.1 The Trust Mortality Review Group (TMRG) reports to the Trust Executive Committee (TEC) via the monthly HSMR reports.
- 1.2 The TMRG has been established to supervise a programme of detailed case note reviews of patient deaths from within Southampton General Hospital and the Princess Anne Hospital (but excluding stillbirths and Maternity deaths that are subject to other forms of established review) in order to identify any recurring themes in relation to avoidable features.
- 1.3 The Chair will be selected by the Medical Director and the Director of Nursing & Organisational Development. The duration of office for the Chair will usually be for up to 2 years but might continue for up to 4 years if this was mutually agreeable to the Chair, the Medical Director, the Director of Nursing & Organisational Development and the members of the Group expressing their view through the Co-chair.
- 1.4 The TMRG will select from amongst the membership a Co-chair. The duration of office for the Co-chair will be for up to 3 years.

2 AIMS

- 2.1 Identify any themes relating to avoidable features linked to possible poor standards of care using an agreed proforma and identify important learning points for discussion by the appropriate clinical groups.
- 2.2 Identify any themes relating to avoidable antecedent features in ward based cardiac arrests using an agreed proforma and identify important learning points for discussion by the appropriate clinical groups.
- 2.3 Identify any areas of good practice being used in a defined clinical area that should be disseminated throughout all clinical areas in the Trust.

3 APPROACH

- 3.1 Review national standards and guidance relating to avoidable factors in in-hospital deaths and adopt/adapt these to create and maintain a local proforma for use by the Group when reviewing deaths.
- 3.2 Review a selection of in-hospital deaths from all areas of the Trust with the exception of CMH on a monthly basis looking for avoidable features relating to possible poor standards of care using an agreed proforma and for local good practice not thought to be applied on a Trust wide basis.
- 3.3 Review all ward based PEA cardiac arrests for patterns of avoidable antecedent features using an agreed proforma.
- 3.4 The reviews will look for patterns of avoidable features related to processes of care. If the failure is of a level that requires an Adverse Event report the Patient Safety Team will be asked to check if this was done and, if not, the Chair or Co-chair will arrange for an Adverse Event Report to be completed.
- 3.5 Each case reviewed will be assigned an 'avoidability' score as defined by the Royal College of Physicians Structured Judgement Review
- 3.6 If individual failure is identified the Chair or Co-chair will decide if the correct action is to reflect the incident and the learning to the appropriate member of staff, Line

Manager or Educational Supervisor or to arrange for completion of an Adverse Event Report.

- 3.7 Identify any themes in relation to avoidable features in deaths and PEA cardiac arrests (particularly around early warning systems, emergency cover, senior clinical site cover, Hospital at Night and other out-of-hours initiatives) and agree appropriate actions inform the relevant groups of the required actions. Specifically in relation to PEA cardiac arrests share the outcome of the reviews with the Resuscitation Committee.
- 3.8 Together with the Significant Incident Scrutiny Group consider all Significant Event Clinical and Significant Incidents Requiring Investigation where there is a direct causal link between the standard of clinical care and the death and to confirm that an Action Plan has been agreed so that learning is disseminated and any required changes to policy and practice have been made.
- 3.9 Oversee any work-streams identified and planned by the TMRG.

4 REPORTING AND ESCALATION

- 4.1 The Clinical Data Quality Manager will collate and disseminate the review findings monthly to include in the monthly HSMR reports to TEC.
- 4.2 Issues that the Chair or Co-chair feel are too urgent to wait for the monthly HSMR report to TEC will be resolved by one of the following routes:
 - i Urgent verbal update to the appropriate Care Group Clinical Leads/Matrons and/or to the appropriate Divisional Clinical Directors/Heads of Nursing & Allied Professions;
 - ii Urgent verbal update to the Medical Director and/or the Director of Nursing & Organisational Development.

5 ADMINISTRATION OF MEETINGS

- 5.1 The meeting will be led by the Chair or Co-chair or under exceptional circumstances by another member of the Group chosen by the Chair or the Co-chair
- 5.2 The Chair will be responsible for:
 - i Setting the agenda;
 - ii Ensuring the minutes and actions of last meeting are disseminated;
 - iii Ensuring the venue for the meetings is arranged;
 - iv Notifying all members of the Group of the next planned meeting at least 5 working days before the meeting including the agenda, minutes and actions of the previous meeting and any required supporting papers;
 - v Ensuring appropriate administrative support for each meeting.
- 5.3 Papers will not be tabled at the meeting unless by exception and with the prior agreement of the Chair or Co-chair.
- 5.4 Any member of the senior medical or nursing staff can observe the TMRG meetings with the prior consent of the Chair or Co-chair.

6 MEMBERSHIP

- 6.1 The Chair will be chosen by the Medical Director and/or the Director of Nursing & Organisational Development from within the senior medical and nursing staff.
- 6.2 The membership of the initial Group will be agreed between the Chair and the Medical Director and will reflect as broad a spectrum of specialist activity amongst the medical and nursing staff as is practical without the Group becoming too large.
- 6.3 The TMRG will select from amongst the membership a Co-chair.
- 6.4 The current members of the Group can suggest additional members if they would help the business of the Group and recommend nominations to replace members leaving the Group. The Chair and Co-chair will decide on whom to recommend to the Medical Director and the Director of Nursing & Organisational as new members of the Group.
- 6.5 The Chair will ensure that if appropriate to the business of the Group other Trust staff will be invited to a meeting in relation to one or more specific items.

7 QUORUM

- 7.1 It is not envisaged that the TMRG will take votes on matters so there is no pre-defined quorum
- 7.2 The Chair or Co-chair will decide at the start of each meeting whether sufficient members are present to provide an effective range of experience for the purpose of transacting the Group's core functions and making recommendations.

8 FREQUENCY OF MEETINGS

- 8.1 The TMRG will meet in the third or fourth week of each month but the day and time will vary in order to maximise the opportunity of the members attending.
- 8.2 The dates/times of the meetings will be set at least three months ahead.

9 REVIEW OF TERMS OF REFERENCE

- 9.1 The terms of reference will be reviewed on an annual basis and any amendments submitted for approval to the Medical Director and/or the Director of Nursing & Organisational Development.

Appendix F: Maternal Deaths

A maternal death is defined as any death of a woman that occurs during or within one year of pregnancy, childbirth or abortion. When an unexpected maternal death occurs whilst the woman is under the care of UHS, the Trust's Incident Reporting Management Policy must be instigated immediately. A maternal death will be treated as a serious incident requiring investigation (SIRI) and as such is reportable to the Commissioners. The Trust's Maternal Death Procedure (available on Staffnet) must be followed.

Appendix G: Morbidity & Mortality (M&M) Meeting Standards

Rationale

Clinicians need to be able to demonstrate that they discuss and learn from all relevant clinical experience as part of a process of:

- Improving patient care and outcomes
- Reducing avoidable morbidity and mortality
- Learning from clinical and operational situations
- Responding to Quality Accounts in contracts
- Annual revalidation and 5 yearly GMC 're-licensing'
- Demonstrating to the NHS Litigation Authority that the Trust is a safety conscious organisation.

An important part of achieving the above are open, regular, multi-disciplinary and multi-professional M&Ms within defined clinical groups with an effective but brief record of lessons learnt and changes to practice made by whom and when and how to be reviewed to determine benefit. Following guidance from the Francis and Berwick Reports this data needs to be 'visible' within the Trust and cannot be regarded as privileged information although access to it can be controlled by the M&M Coordinators and the Medical Director.

Exceptions to the Trust's M&M process

In Pathology:

- There are long established practices of Quality Assurance to judge Laboratory standards against national criteria
- Screening Programme EQA scheme requires a response from individual Pathologists to externally provided slide sets on a 4 to 12 monthly basis depending on the disease
- Histopathology General EQA scheme requires a response from individual Pathologists to externally provided slide sets on a 6 monthly basis
- There are monthly Consultant meetings to discuss cases of interest
- Pathologists actively participate in most Specialty MDT meetings and many Specialty M&M meetings and these are felt to meet their requirements for general multi-disciplinary and multi-professional learning

In Radiology:

- There is no general meeting of Radiologists as they all work in defined areas
- Radiologists actively participate in most Specialty MDT meetings and many Specialty M&M meetings and these are felt to meet their requirements for general multi-disciplinary and multi-professional learning
- Discrepancy & Error Reporting systems are in place for all Radiologists.
- Radiologists involved in interventional procedures are required to either participate actively in a relevant specialty M&M or undertake M&M as part of an interventional radiology group.

The Trust's M&M Standards require that M&Ms throughout the Trust must:

1. Be held by all Speciality and larger Sub-speciality Groups as laid out in the M&M Meeting Tree
2. Be at a regular time within the working day (0800 to 1800 hours)
3. Be held at least once per quarter but as often as monthly if the number of cases to be discussed requires this. Meetings held less frequently than once per quarter require the agreement of the Associate Medical Director
4. Be advertised well in advance and the Associate Medical Director informed
5. Be visited when possible by relevant Trust Executives (Chief Executive, Director of Nursing, Medical Director), Deputy Medical Director and Associate Medical Directors
6. Have a recognised Coordinator and/or Chair, who does not have to be a Consultant
7. Be multi-disciplinary and multi-professional. The M&Ms must be open to all Speciality or Care Group members. The main purpose of the M&M process is to encourage team work and reflective learning
8. Include other relevant Staff from outside the Speciality/Sub-speciality (Anaesthetist, Intensivist, Radiologist, Pathologist, other type of Physician or Surgeon) if their input is required to discuss a specific case
9. Be attended regularly by the majority of the relevant Speciality/Care Group Medical and Nursing staff. Consultants are expected to attend 50% of the M&M Meetings but the impact of fixed clinical commitments or work patterns in relation to part-time contracts will be assessed. Attendance at M&M Meetings will be included in Job Planning and form part of their required Annual Appraisal
10. Provide a brief written record of the meeting. The M&M Group Coordinator will store the record securely and send an electronic copy to the Divisional Governance Coordinator and to the Associate Medical Director. This electronic record must be stored on the Divisional shared drive or a Staffnet site
11. Record either in the patient's medical records or preferably on eDocs the fact that the case was discussed at a named M&M meeting on a certain date and include a brief description of any specific significant learning points
12. If by nature of the way the groups elect to run their M&M Meetings not all key staff will attend regularly a specific system to pass on learning points must be in place.

Deaths to be reviewed (case selection)

Surgical Specialities, Cardiology and Interventional Cardiology, Critical Care and low volume mortality Medical Specialities

1. All inpatient deaths and all deaths within 30 days of discharge will be reviewed
2. Each death must be assigned an 'avoidability' score as defined by the Royal College of Physicians Structured Judgement Review
3. Questions raised and forwarded from IMEG will be answered
4. Outcomes of each review will be forwarded to the AMD for Safety, or stored on a secure shared drive to which the AMD has access.

High volume mortality Medical Specialites, including Cancer Care, AMU & Countess Mountbatten House

1. The M&M lead for each speciality will select the cases with potential learning highlighted by colleagues, where questions have been raised at IMEG, where there has been a complaint or an SAE has occurred and for cases scored 1, 2 or 3 for avoidability by TMRG.
2. Each of these cases must be assigned an 'avoidability' score as defined by the Royal College of Physicians Structured Judgement Review
3. Questions raised and forwarded from IMEG will be answered
4. Outcomes of each review will be forwarded to the AMD

The M&M record must include the following:

1. Basic information:
 - a. The Speciality/Care Group
 - b. The period being considered
 - c. Record of attendance with presence/absence of Consultant Staff specifically recorded
 - d. The date of the M&M meeting.
2. Recording of avoidable features:
 - a. The six grades for avoidable features are as follows:
 1. Definitely avoidable
 2. Strong evidence of avoidability
 3. Probably avoidable (more than 50:50)
 4. Possibly avoidable, but not likely (< 50:50)
 5. Slight evidence of avoidability
 6. Definitely not avoidable
3. Mortality:
 - a. Number of deaths occurring in the period under discussion
 - b. The number of deaths discussed
 - c. The key deaths to be reviewed in relation to avoidable factors for:
 - i. any death identified prior to the meeting as having avoidable features
 - ii. deaths within 24 hours of admission
 - iii. deaths within 72 hours of an operation or interventional procedure
 - iv. unexpected deaths
 - d. Record very brief clinical details and learning points/changes in practice of any cases with avoidable factors.
4. Morbidity:
 - a. Record very brief clinical details and learning points/changes in practice of any cases with avoidable factors for:
 - i. Specific pre-determined morbidity (disease or procedure based) previously determined by the Speciality/Care Group
 - ii. Unexpected admission to a higher level of care
 - iii. Unexpected return to Theatre, repeat interventional procedure and unexpected additional treatment after an interventional procedure
 - iv. Unexpected readmission within 28 days for the same condition or a complication of previous treatment and, if possible, for regional

services readmission to other Acute Hospital for the same condition or a complication of previous treatment

- v. Trust determined key morbidities, currently hospital acquired DVT or PE, hospital acquired pressure ulcer, hospital acquired MRSA, CVC related sepsis, ventilator acquired pneumonia
- vi. "One off" morbidity of interest to the participants.
- vii. Missed or incorrect diagnoses, delay in treatment times or failure to recognise deterioration or escalate appropriately should also be noted, particularly in acute admissions and medical specialties.
- viii. Morbidity may be graded using the internationally recognised Clavien Dindo classification, this allows complications of treatment whether surgical, interventional or medical to be graded and aggregated for comparative purposes.

| Clavien Dindo Classification | |
|-------------------------------------|--|
| Grade I | Any deviation from the normal course without the need for pharmacological treatment or surgical, endoscopic and radiologic interventions. This grade also includes wound infections opened at the bedside. |
| Grade II | Requiring pharmacological treatment with drugs other than such allowed for grade I complications. Blood transfusions and total parenteral nutrition are also included |
| Grade III | Requiring surgical, endoscopic or radiological intervention III a: Intervention not under general anesthesia III b: Intervention under general anesthesia |
| Grade IV | Life-threatening complication (including Central Nervous System complications except TIA) requiring ICU management IV a: Single organ dysfunction (including dialysis) IV b: Multiorgan dysfunction |

5. Regular review:

- a. Trust-wide Safety issues with the frequency depending on the volume of data and the nature of the clinical service but it is suggested:
 - i. VTE prophylaxis (assessment, pharmacological or mechanical prophylaxis, possibly 3 monthly, possibly presented by ward nursing staff)
 - ii. DNACPR, treatment escalation plan and end of life care pathway decisions (appropriateness and documentation, possibly 3 monthly, possibly presented by ward nursing staff)
 - iii. Failure to recognise deterioration
 - iv. Failure to escalate care concerns or intervene in a timely fashion (possibly 3 monthly, possibly presented by the junior medical staff)
 - v. Medication issues (significant interactions missed, missed doses, inappropriate dose or route, missed allergies, failure to reconcile pre-admission with post-admission medication, possibly 3 monthly, possibly presented by the ward pharmacists)
 - vi. Other topics like delayed discharge, WHO Surgical Checklist compliance, Surgical Sepsis Bundle compliance, patient falls, MRSA bacteraemia, wound infections, C Diff infections, Day Case rates, prolonged length of stay (possibly 6 monthly)
- b. Key learning from Adverse Event Reports focused on process not individuals (Never Events, Significant Incidents Requiring Investigation, Significant Events Clinical, Unexpected Clinical Outcome) obtained from the Divisional Governance Coordinator
- c. Key learning from response to Complaints focused on process not individuals obtained from the Divisional Management Team
- d. Outcome of local audits or national audits related to Speciality
- e. Optional review of outcomes from important or common interventions or diseases previously determined by the Speciality or Care Group
- f. Review of all ward-based Cardiac Arrests focused on pre-arrest status, immediate outcome, survive to discharge and relevance of a DNACPR decision

6. Favourable events

Notable favourable events should be described so that the positive behaviour and outcomes can be recognised and disseminated within the team.

7. Learning points (related either to Speciality or Care Group or applicable to Division or Trust to be shared with the relevant group/s):

- a. Related to mortality
- b. Related to morbidity
- c. Related to regular reviews
- d. Related to favourable events
- e. Review of previously recorded learning points to confirm that action to implement these has been undertaken.

8. Recording of discussion in the patient's notes:

- a. A note recording that a case was discussed at a specific M&M meeting on a certain date will be left in the patient's hospital notes or preferably as a document in eDocs but not the actual details of the discussion.

Neil Pearce.
Associate Medical Director.

Appendix H: Child Death and Deterioration Group (CDAD) – Terms of reference

1.0 Introduction:

The child mortality and morbidity review group enables an oversight of all child deaths that occur within University of Southampton Hospitals. It was an acknowledged fact that prior to establishing this group there was no universal record of child deaths and no overview of what was happening.

The child mortality and morbidity review group provides a forum where a rapid review of every child death within UHS can be made. It allows concerns related to the deceased's care or cause of death to be identified, facilitates reviews at the mortality and morbidity meetings, and investigations of adverse events.

The information collected is held on a single database which will allow Southampton Children's hospital to keep accurate and up to date records and identify any developing trends and act as necessary.

The group should be used to review morbidity in terms of 2222 calls and unplanned PICU.

2.0 Purposes

- 2.1 To provide a weekly review of all child deaths within UHS without exception (excludes stillbirth).
- 2.2 To ensure all deaths have been discussed with the senior clinician and nursing staff responsible for the patients care.
- 2.3 To ensure appropriate identification of notifiable conditions
- 2.4 To advise on appropriate communication with the deceased's family and ensure that the clinicians have fulfilled their duty of candour.
- 2.6 To ensure the deceased's general practitioner has been informed by the responsible team.
- 2.7 To identify where relatives are known to have concerns or are likely to make a complaint so that they can be followed up appropriately to avoid additional distress to the family.
- 2.8 To advise on death certification process if not already completed.
- 2.9 To ensure the correct processes of notification of a child death have been followed. This will include CDOP and rapid response procedures.
- 2.10 To ensure that an appropriate debrief for staff members is organised.
- 2.11 To identify deaths where presentation at QUEST would appear to be useful for learning.
- 2.12 To provide an initial assessment of whether a death was likely to have been avoidable, unavoidable or have avoidable features.
- 2.13 To identify cases where there would appear to have been adverse events unrelated to the cause of death which should be reported for further investigation.
- 2.14 To identify cases where there should be further investigation of adverse events which may have contributed to the cause of death.
- 2.15 To record the outcomes of the Child mortality and morbidity review groups on the patients' electronic record.
- 2.16 To use the same tool to identify and review 2222 calls and unplanned PICU admissions from G level. To identify any adverse events surrounding these admissions.
- 2.17 To monitor any developing trends in cases and initiate further investigations and identify learning opportunities.

3.0 Constitution

The group will consist of a representative from senior clinicians, senior nursing staff, bereavement support services, Patient support services/patient safety team/RISK, Administrative support and presenting doctor and nurse.

3.1 Senior Clinician: this will either be a member of the Child death review group or a nominated deputy. The clinician will chair the group and provide scrutiny of the clinical events, ensure that the cause of death has been discussed with the senior clinician responsible for the patients care and advise if further investigation is necessary.

3.2 Senior nursing staff: Will provide insight and scrutiny into the clinical events and care provided to the patient. Ensure that the cause of death has been discussed with the senior nurse responsible for the patients care.

3.3 Clinical governance team: a member of the clinical governance team should be present to help provide oversight of the process.

3.4 Administrative support to collate information and add patient information to the database.

3.5 Patient Support services: a member of the complaints team will be available to give advice if there are existing or anticipated complaints.

3.6 Presenting doctor: lead clinician for patients care or designated representative

3.7 Presenting nurse: lead nurse for ward where patient received care or designated representative.

3.8 The Associate Medical Director for Safety will attend meetings on an ad hoc basis to give further oversight and scrutiny.

4.0 Delegated Authority

Child death review group has delegated authority from the division care group lead and medical director.

5.0 Escalation routes

If required

5.1 HMC would have been expected to have been informed (if required) prior to discussion at the child death review group however if it is felt that a case has met the criteria and the coroner has not been informed they will be do so at this point.

5.2 Adverse events unrelated to the cause of death will be reported and investigated via division C governance.

5.3 Adverse events that may have contributed to the cause of death will be reported to the AMD for safety and SISG for urgent investigation

5.4 Evidence of serious failures in care with implications for the safety of patients will be escalated to the divisional lead for patient safety for urgent action to prevent further harm.

6.0 Administration of meetings

6.1 Meetings will occur once a week on Monday afternoon between 1430 and 1530 for General Paediatrics and Emergency department deaths.

6.2 Each case will be allocated a maximum of 15 minutes. Booking will be via administrator responsible for meetings. This is expected to be completed by the consultant (or designated deputy) and nurse from the area the death occurred.

6.3 The presenting doctor and nurse will bring the notes

6.4 The clinicians will provide a completed "checklist following a child or young person's death"

(as per bereavement policy) with a brief description of the patients presentation, symptoms and signs, co-morbidity, diagnosis, investigation and clinical course. Where known the cause of death will be provided.

6.5 The presenting clinician will be questioned about the patients' management, difficulties with the delivery of care or any concerns raised by medical or nursing staff or family. It will also be identified which clinicians the cause of death has been discussed with.

6.6 If necessary further information may be sought for representation of the death.

6.7 The outcome of the meeting and information provided on the child death checklist will be recorded on the child death record form. The information will also be recorded on to the child death database. The outcome of the meeting should be represented on the electronic record with the child death record form scanned onto the electronic patient record once completed.

6.8 The meeting will be quorate if the chair (who is familiar with the environment where the death occurred), a member of the senior nursing team and governance team member are present.

6.9 Trainees will be encouraged to attend for learning purposes.

6.10 The outcomes will be collated and discussed at a quarterly child death review group at which point a member of the pathology team will attend and Palliative care team when available.

6.11 The information collated and outcomes identified will be presented quarterly at the QUEST mortality and morbidity meetings. Metrics to be assessed:

- a) % of cases referred to HMRC.
- b) Causes of death grouped within CDOP classification.
- c) Areas that child death occurred.
- d) Numbers of child death as per age ranges.
- e) Classification of conclusion.

7.0 Morbidity (deterioration) reviews

All unplanned PICU admissions will also be discussed and reviewed within these meetings. The same process as described above will be followed. The same escalation routes will be followed as necessary. A separate database will be created for these events.

The information collated will allow common themes to be identified which will be presented quarterly at the QUEST mortality and morbidity meetings. Further investigations will be initiated as required and learning opportunities identified.

8.0 Service Relationship

Child mortality review group has a close relationship with the following UHS services:

Interim Medical Examiner Group
Patient Safety Team
Paediatric Palliative care team
Divisional Governance Team
Divisional Mortality and Morbidity meetings / QUEST meetings
HM Coroner
Complaints office
Pathology Team
Bereavement support
Child Death Overview Panels (CDOP)
Occupational therapy

Appendix I: Learning Disabilities Mortality Review Meeting Pro Forma

Learning Disabilities Mortality Review (LeDeR) Meeting Proforma

| | | | | | |
|----------|--|--------|--|----------------------|--|
| Patient: | | D.O.B: | | Cause of death: | |
| URN: | | D.O.D: | | Referred to Coroner: | |

Meeting Date:

Present:

| | |
|--|--|
| | |
|--|--|

| | |
|---|--|
| Terms of Reference: | <ul style="list-style-type: none"> • Identify any potentially modifiable factors associated with a person’s death • Determining whether this case falls under the definition of a SIRI or significant event and requires further investigation • Determining whether there are any safeguarding issue and whether an alert needs to be raised • Consider involvement of Patient Support Services • Identify trust wide learning regarding care of LD patients |
| When was patient identified as having learning disabilities? | |
| What was the normal background baseline status of this patient in terms of physical and mental function, social environment and general health? | |

| | |
|--|--|
| Were there any concerns from the clinical team or that were made known to the clinical team about pre hospital care? Including medical care and nursing care. | |
| Did the patient have capacity to make relevant decisions about medical care? When was capacity to make these decisions last assessed? | |
| If patient deemed as having capacity, what information was provided to the patient and what support were they given with decision-making? | |
| If patient deemed to lack capacity, who was involved in decision-making and what was their relationship to the deceased? What information was provided to them and what support were they given with decision-making? | |
| How did the treatment that was offered differ from that which might have been given to a patient without learning disabilities? What was the justification for this approach? | |
| What other alternative treatment Pathways might have been considered? | |
| Were any difficulties encountered in delivering care for this patient? | |
| Were there any adverse events or complications of treatment during care? | |

| | | | | | |
|--|-----------------|-----------|--------------------|------------------------|--|
| Was the environment in which this patient was treated suitable to their holistic and health-care needs? If not why not? | | | | | |
| Who was involved in DNACPR and end-of-life care decisions? Could end of life care have been better? | | | | | |
| Did the diagnosis of learning disability (not any associated medical condition) significantly affect any aspect of the outcome in this case? | | | | | |
| Actions: | Action Required | | Person Responsible | | |
| | | | | | |
| GP Practice Code: | | CCG Code: | | CCG briefing required: | |

Death Certification and Mortality Review Policy

Version: 5

| Document Monitoring Information | |
|---|---|
| Approval Committee: | Patient Safety Steering Group |
| Date of Approval: | 26 th September 2017 |
| Ratification Committee: | Ratified by Medical Director & Director of Nursing by exception |
| Date of Ratification: | 29 th September 2017 |
| Signature of ratifying Committee Group/Chair: | Dr Derek Sandeman (Medical Director) Gail Byrne (Director of Nursing & Organisational Development) |
| Lead Name and Job Title of originator/author or responsible committee/individual: | Mark Green Head of Bereavement Care |
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| Target audience: | Doctors / Surgeons of all grades, M&M groups, TMRG, CDAD & IMEG reviewers |
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The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This document has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it, regardless of their individual differences, and the results are available on request.