Dudley and Walsall NHS
Mental Health Partnership NHS Trust

Document Title
Investigating Deaths (Mortality Review) Policy

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Version	Date	Comments
0.1	15/07/2017	Initial version drafted
0.2	27/07/2017	Appendices added to policy document
1.0	07/09/2017	Policy reviewed and agreed by Mortality Survielance Group and formally ratidied by Trust Board 07/09/2017

Link with National Standards	
National Health Service Litigation Authority	
Care Quality Commission	
National Institute of Clinical Excellence (NICE) Guidance	
National Patient Safety Agency	
West Midlands Quality Review	
Essence of Care	
Aims Standards	
IG Toolkit	

Key Dates	Day	Month	Year
Ratification Date	07	09	2017
Review Date	07	09	2019

Executive Summary Sheet
Document Title: Investigating Deaths (Mortality Review) Policy

Please tick (☑) as appropriate	This is a new document within the Trust	
	This is a revised document within the Trust	

What is the purpose of this document?

This policy confirms the process to ensure a consistent and coordinated approach for the review of all deaths in within Dudley and Walsall Mental Health Partnership NHS Trust.

What key issues does this document explore?

This document covers the processes for ensuring that deaths within the organisation are investigated appropriately

Who is this document aimed at?

This document is aimed at all staff working within Dudley and Walsall Mental Health Partnership NHS Trust

What other policies, guidance and directives should this document be read in conjunction with?

Incident, Near Miss and Serous Incident Reporting Policy
Being open (Duty of Candour) Policy
Investigation and Embedding of Lessons (Improvement) from Incidents
Complaints and Claims Policy
NHS England Serious Incident Framework

How and when will this document be reviewed?

This document will be reviewed on an 2 yearly basis by the Trusts Mortality Surveillance Group or sooner, if legislation changes

1. Introduction

1.1 Dudley and Walsall Mental Health Partnership NHS Trust is committed to ensuring that deaths of service users are investigated appropriately in line with national guidance.

1.2 The requirement for Trusts to better understand their mortality rates and have an understanding of mortality within their organisation has been driven nationally by a number of key national documents namely:

Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015 (Mazars Report 2016) – This report noted that there was a lack of leadership, focus and sufficient time spent in the Trust on carefully reporting and investigating unexpected deaths and that despite the Board being informed by Coroners and CCGs that the Quality of their SI reporting processes and standards of investigations was inadequate, little effective action was being taken to improve the quality of investigations. In addition to this it was noted that there was no effective systematic management and oversight of the reporting of deaths and the investigations that follow.

Learning, Candour and Accountability (CQC 2016) – The report makes recommendations for the improvements that need to be made if the NHS, as a leader for the wider social and healthcare system, is to be more open about these events, and improves how it learns and acts on them. The CQC noted that there was a level of acceptance and sense of inevitability when people with a learning disability or mental illness die. Premature death may often be due to unidentified or unsupported health needs that, in many cases, will offer even greater opportunity for learning. The report identified 5 core areas for improvement, namely

1. **Involvement of families and carers:** Families and carers told the CQC they often have a poor experience of investigations and are not consistently treated with respect and sensitivity and honesty.
2. **Identification and reporting:** There is variation and inconsistency in the way organisations become aware of the deaths of people in their care across the NHS. In addition many patients who die have received care from multiple providers in the months before death and there are no clear lines of responsibility or systems in place. There is no consistent process or method for NHS trusts to record when recent patients die after they have been discharged from the care of the service, either from an inpatient service or from receiving services in the community.

3. **Decision to review or investigate:** Often investigations will only happen if the care provided to the patient has led to a serious incident being reported.
4. **Reviews and investigations:** Most NHS trusts report that they follow the Serious Incident Framework when carrying out investigations. Despite this, the quality of investigations is variable and staff are applying the methods identified in the framework inconsistently.
5. **Governance and learning:** Trust boards only receive limited information about the deaths of people using their services other than those that have been reported as serious incidents. Where investigations have taken place, there are no consistent systems in place to make sure recommendations are acted on.

National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (National Quality Board 2017): This Guidance document aims to standardise the way acute, mental health and community Trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers. The guidance notes that by September Trusts will have processes for:

- How it responds to the death of an individual with a learning disability or mental health needs, an infant or child death and a stillbirth or maternal death.
- Have a clear approach to undertaking case record reviews.
- Categories and selection of deaths in scope for case record review.

1.3 Further to ensuring the Trust is compliant with the statutory duties outlined within the national guidance on learning from deaths, the Trust will also undertake work in this area to:

- To ensure that the families of deceased service users are appropriately informed and aware of the circumstances around the death of their loved ones and are assured of the actions taken by the organisation
- To identify opportunities for learning and those recommendations the Trust can take to ensure that care is continually improved.
- To provide qualitative and quantitative information to aid the development of a number of other projects and strategies designed to improve services, such as:
    - Trust Suicide Prevention Strategy
    - Trusts Physical Healthcare Strategies
    - Trust Quality Improvement Priorities (QIPs)

2. Scope

2.1 It is expected that this policy will apply across all of the services operated by Dudley and Walsall Mental Health Partnership NHS Trust

3. Roles and Responsibilities

3.1 Individual responsibilities

Joint Medical Director (Dudley) holds the executive responsibility for ensuring that the Trust has robust processes into investigating and learning from deaths and will drive the mortality review agenda within the organisation.

Director of Operations and Nursing holds the responsibility for ensuring that the Trusts Compliance and Safety Team is adequately resourced to support the Trusts mortality review / learning from deaths agenda.

The Non-Executive Director With responsibility for Quality and Safety will be responsible for overseeing and scrutinising the Trusts processes around learning from deaths.

The Trusts Patient Safety and Compliance Manager will ensure that there are appropriate processes in place to ensure that incidents are managed and investigated in a timely manner and will be responsible for ensuring that there are appropriate resources in place to support the investigations of deaths and ensure that reports are prepared for both Trust Board, Quality and Safety Committee and the Trusts Mortality Scrutiny Group

The Trusts Patient Safety Facilitator will be responsible for on a day to day basis the coordination and development of reports for the Trusts Quality and Safety Committee, the Trusts Mortality Scrutiny and the Trust Board.

The Trusts Serious Incident Coordinator will be responsible for on a day to day basis overseeing the Trusts Serious Incident investigation processes and for coordinating investigations.

All staff will be responsible for adhering to the principles outlined within this policy

3.2 Departmental Responsibilities

The Compliance and Safety Team will be responsible for overseeing and coordinating the investigation processes in relation to investigating deaths. The Team will also be responsible for

producing regular reports to the Trusts Quality and Safety Committee, Mortality Surveillance Group and Trust Board

The Trusts Performance and Informatics Department will be responsible for ensuring that where possible informatics solutions to providing figures / statistics in relation this area of work and will work to provide informatics solutions around the investigating deaths agenda.

3.3 Committee responsibilities

Trust Board holds the overall responsibility for the Investigating Deaths (Mortality Review) agenda and will receive a monthly summary report detailing summary level statistical information in relation to investigating deaths.

Quality and Safety Committee holds the delegated responsibility for matters relating to quality and patient safety within the Trust. The Trust is therefore responsible for receiving incident trends / analysis, information / analysis in relation to serious incidents and for receiving regular updates in relation to investigating deaths

Mortality Surveillance Group is responsible for overseeing the day to day implementation of this policy and for providing the Trust with operational direction in respect to this area of work

4. Definitions

4.1 **Duty of Candour –** The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made

5. Processes

5.1 Reporting a death

5.1.1 It is acknowledged that most deaths do not occur as a result of a direct patient safety incident. Nonetheless, it is important that opportunities for learning from deaths are not missed and that when deaths are deemed not to require any further investigation the rationale and justification for this is clearly documented.

5.1.2 All deaths are to be reported using the Trusts Incident Reporting System. This does not mean that the Trust considers every reported death to constitute a patient safety incident and there are mechanisms to differentiate between these.

5.1.3 Any member of staff can report a death via the Trusts incident reporting system, although it is preferable for this to be someone who was involved in a patient's care at the time of death. Alternatively this can be the member of staff who was informed of the death, if, for example, the patient had not accessed services for some time. All staff, particularly within the community setting, will ensure that any information they may receive on a death of a patient is raised to their team management.

5.1.4 In order to report a death, the Trusts incident reporting system should be accessed by following the link below.

http://safeguard.dwmh.nhs.uk/safeguard/

or by using links on the intranet. All staff with network access can log in to Ulysses using their network log in and password details.

5.1.5 It is an agreed Trust standard that the following will be incident reported:

- **ALL** deaths of patients with an open/active referral should be incident reported, irrespective of whether the death was expected or unexpected.
- Deaths of patients who have been discharged from Trust Services within the last 6 months (where staff are aware of this occurring).

5.1.6 The incident report form should be completed as soon as possible within the same shift. The full circumstances around the service user's death may not be known at the point of reporting. The clinical team must however take reasonable and practical steps to attempt to confirm the cause of death or probable cause of death where possible such as telephoning the patient's GP, care home or other providers involved in the patient's care who may have further information regarding the likely cause of the patients death.

5.1.7 As a result the reporter will therefore be asked to select from the following categories:

- Death – Expected – Natural Causes
- Death – Expected – Terminal Illness
- Death – Unexpected – Cause Unknown
- Death – Unexpected – Physical Health / Sudden illness
- Completed Suicide – Asphyxiation
- Completed Suicide – Cut
- Completed Suicide – Ingest foreign object / substance
- Completed Suicide – Ligature
- Completed Suicide – Medication Overdose
- Completed Suicide – Self Injury
- Completed Suicide – Substance Overdose

5.1.8 Once completed and submitted, the Death Notification Form will then trigger the agreed notification rules, which will inform relevant managers and relevant members of staff.

5.2 Incident Review

5.2.1 Any death reported onto the Trust's incident reporting system, will be reviewed initially by the Trust's Quality and Safety Team within 8 working hours of it occurring to screen the incident for:

- **Its applicability as a Serious Incident** – Deaths that meet the Serious Incident criteria must be reported to commissioners (and NHS England) within 48 hours of occurring (by the Compliance and Safety Team) via the Strategic Executive Information System (STEIS)
- **Any reasons why a death may need to be potentially reported externally** – Some deaths may need to be reported to the Health and Safety Executive or the Care Quality Commission
- **Whether further information is required to confirm / fully understand the circumstances around the death** – There are circumstances where the team reporting the death may not fully be able to ascertain the circumstances behind the service users death. The Trust's Patient Safety and Compliance Team and the Clinical Team reporting the death will work together to provide a fuller picture of the death. The Compliance and Safety Team may request a copy of the Trusts Mortality Review tool to be completed (see appendix 1)
- **Whether further action is required –** A death can still be subject to, and benefit from, a root cause analysis investigation, even if it is not reportable as a serious incident. The decision to use the root cause analysis tool will be taken either prior to, or during, the mortality surveillance committee.
- **Whether a case note review is required –** There are instances where a death may not meet the definition of a case note review, but may meet the definitions of a structured case note review, these are required in instances where the death does not meet the definition of a Serious Incident but does meet one of the following definitions:
    - Death of an inpatient on a mental health ward
    - All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
    - Deaths as part of an elective procedure where a patient is not expected to die i.e. during ECT or Transcranial magnetic stimulation (TMS)
    - In any Trust services where the CQC has raised concerns around mortality rates
    - A further sample of 5% of cases per month

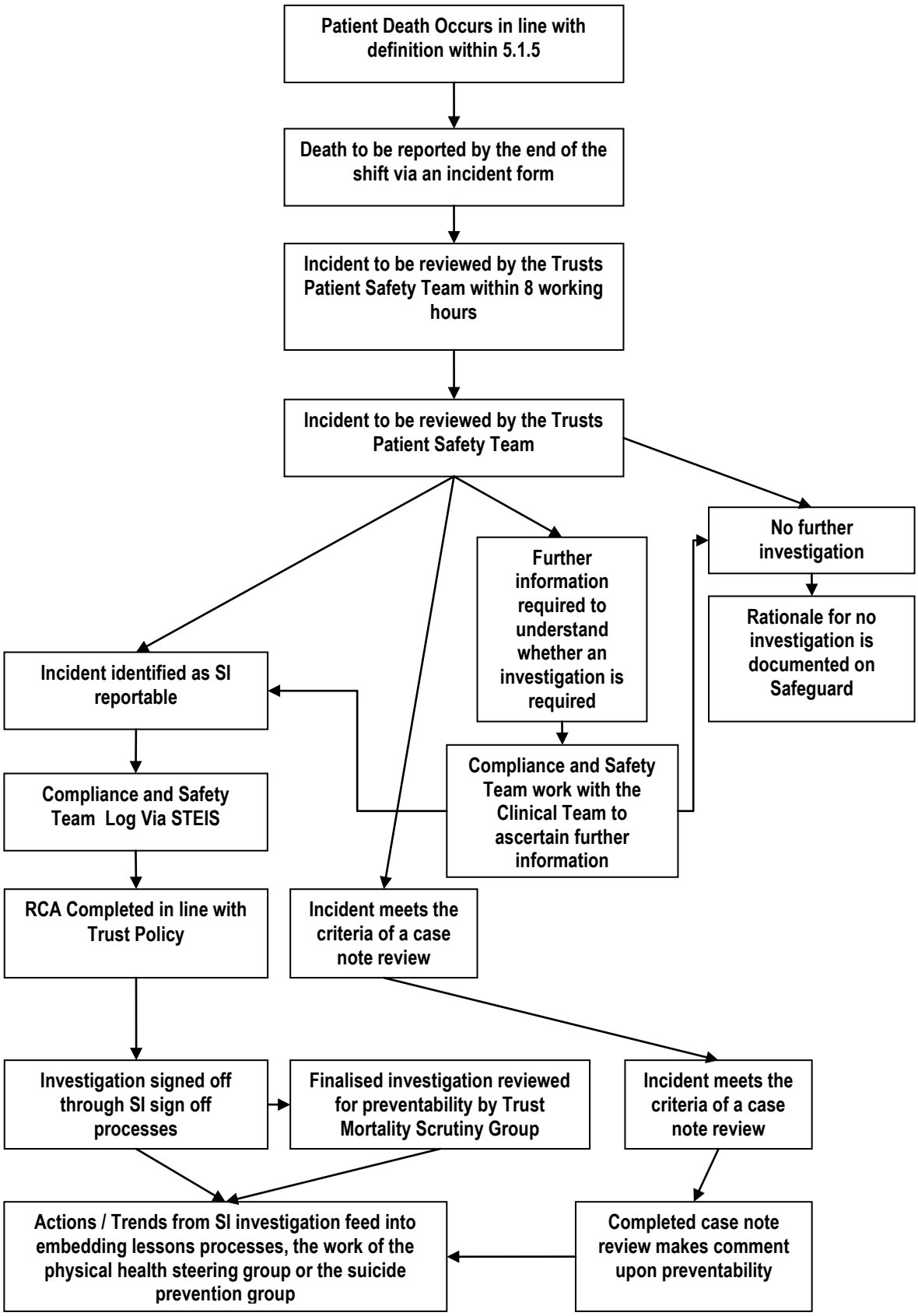
Patient Death Occurs in line with definition within 5.1.5
Death to be reported by the end of the shift via an incident form
Incident to be reviewed by the Trusts Patient Safety Team within 8 working hours
Incident to be reviewed by the Trusts Patient Safety Team
No further investigation
Rationale for no investigation is documented on Safeguard
Further information required to understand whether an investigation is required
Incident identified as SI reportable
Compliance and Safety Team Log Via STEIS
Compliance and Safety Team work with the Clinical Team to ascertain further information
RCA Completed in line with Trust Policy
Incident meets the criteria of a case note review
Investigation signed off through SI sign off processes
Finalised investigation reviewed for preventability by Trust Mortality Scrutiny Group
Incident meets the criteria of a case note review
Actions / Trends from SI investigation feed into embedding lessons processes, the work of the physical health steering group or the suicide prevention group
Completed case note review makes comment upon preventability

Fig 1

6. Investigating procedures

6.1 Serious Incident Investigations

6.1.1 As noted within section 5, every death which is reportable as a Serious Incident under the national framework must have an RCA investigation undertaken in line with the Trust's policy on investigating serious incidents.

6.1.2 During the investigation, if a Police investigation is also being undertaken then advice MUST be sought from the detective responsible to seek approval to continue to a full investigation.

6.1.3 Liaison and communication with the patient's family should be undertaken in a co-ordinated manner and in such cases a central point of contact should be identified for the family to contact. This should be based on the preferences of the family in terms of method and amount of involvement/communication.

6.1.4 Families should be contacted to offer condolences and give the family contact details of someone they can discuss concerns with should they have any and that they can contribute to the terms of reference of the investigation. Further details around this can be identified in the Trusts policy on investigating serious incidents.

6.1.5 All serious incident investigations when complete will be reviewed by the Trusts Mortality Surveillance Group and assessed for preventability using the preventability matrix outlined within appendix 3.

6.2 Mortality review tool

6.2.1 There may be occasions where following scrutiny by the Patient Safety Team or following scrutiny by the Trusts Mortality Surveillance Group, further information is required.

6.2.2 In such instances the Patient Safety Team may be required to request a mortality review tool from the team who have been most recently involved in the service user's care. The completion of the tool can be done to provide assurances to the Patient Safety Team and / or the Mortality Surveillance Group or can be used to ascertain further information in respect to the death of a service user.

6.2.3 It is expected that a mortality review tool should be completed within 5 days of a request being submitted and will be monitored by the Patient Safety Team.

6.3 **Case note reviews**

6.3.1 There may be occasions where a review of a death is required, however the death is not reportable as a serious incident (in line with NHS England's SI Framework)

6.3.2 As an agreed reporting framework, these will include:

- Death of an inpatient on a mental health ward (where not reportable as a serious incident)
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision (where not investigated already as a serious incident.
- Deaths as part of an elective procedure where a patient is not expected to die i.e. during ECT or Transcranial magnetic stimulation (TMS) (where not already reportable as a serious incident)
- In any Trust services where the CQC has raised concerns around mortality rates (where not already reportable as a serious incident
- A further sample of 5% of cases per month (as selected by the Trusts Mortality Review Group

6.3.3 Where a death meets the above definition a case note review will be completed using the structured judgement review tool outlined in appendix 2.

6.3.4 It is expected that the case note review / structured judgement review would be completed within 28 days with completed reviews reported back to the Trusts Mortality Surveillance Group

6.3.5 As part of the review there is an expectation that an assessment for preventability would also take place in line with the scoring matrix outlined within appendix 2

7. Duty of Candour

7.1 As noted within section 6 Liaison and communication with the patient's family should be undertaken in a co-ordinated manner and in such cases a central point of contact should be identified for the family to contact.

7.2 Further to this the statutory requirement of Duty of Candour (DoC) applies to specific incidents whereby moderate harm, significant harm or death has occurred or may in the future.

7.3 Every NHS Trust, since November 2014, has a statutory responsibility in relation to Duty of Candour and the associated requirements within the legislation.

7.4 When conducting a Serious Incident Investigation the Central Point of Contact Identified for the family to contact should also be responsible for ensuring jointly along with the clinical team involved in the care of the patient and with the Patient Safety Team that processes around statutory Duty of Candour has been applied. The Patient Safety Team will be responsible for ensuring that the details around Duty of Candour in such instances are recorded on the Trusts incident reporting system. All of this should be conducted in line with the Trusts Being Open / Duty of Candour Policy

8. Reporting

8.1 The Trust Board will receive a report on all deaths reported in the Trust on a monthly basis as part of the Trusts Medical Directors update. In addition a quarterly summary report outlining further detail will be presented. Both reports will be prepared with the assistance of the Compliance and Safety Team.

8.2 Furthermore a more detailed monthly report will also be prepared for the Trusts Mortality Surveillance Group by the Compliance and Safety Team.

8.3 In addition to the above the following will be reported to the Trusts Mortality Surveillance Group for Scrutiny:

- Completed SI investigations
- Completed Case Note Reviews

9. Complaints

9.1 Should a the family of a deceased service user make a complaint about the level of care that they have received, this will automatically trigger a case note / structured judgement review. The only exception to this is where a Serious Incident Review is already progressing, it is expected in such instanced that the concerns would be included within the parameters of the Serious Incident Investigation

9.2 Where a complaint has been received the Service Experience Desk should relay this information to the Compliance and Safety Team to ensure that the clinician nominated to complete the Case Review is aware of the concerns and ensure that they are also looked at.

9.3 Due consideration should be given during this process as to whether Duty of Candour applies.

10. Monitoring

10.1 The implementation of this policy will be overseen by the Trusts Mortality Surveillance group. Ongoing implementation will be the responsibility of the Compliance and Safety Team on a day to day basis.

Appendix 1

Dudley and Walsall NHS
Mental Health Partnership NHS Trust

The below mortality review tool has been designed with the agreement of the Trusts Mortality Surveillance Group and is designed to gather information on those deaths which are known by the Trust or have been reported to the Trust involving its service users and former service users. It is the aim of this tool to provide the Trust a better understanding of the organisations mortality rates and the underlying causes, contributory factors and reasons.

MORTALITY REVIEW TOOL			
Section 1 – Patient details			
1.1	Patient Forename:		
1.2	Patient Surname:		
1.3	Incident number		
1.4	Patient NHS Number:		
1.5	Patient Date of Birth:		
1.6	Patient Date of Death:		
1.7	Patient Home Address:		
1.8	Patient Home Postcode:		
Section 2 – Initial screening questions			
2.1	Was the patient a current patient of the Trust or one which had been recently discharged from services	Current Patient	☐
		Recently Discharged	☐
2.1	What team(s) was the patient open to at the time of death: (If recently discharged please mark as N/A)		
2.2	Please give details of the patients MH diagnosis		
2.3	What was the medical cause of death / likely medical cause of death:		
2.4	Objectively, was this death expected:	Yes	☐
		No	☐
If yes, please move to question 2.5, If no, please move to Section 3			
2.5	Please give details as to why this death was felt to be expected (e.g. patient was suffering with terminal illness)		

Section 3 – Additional questions			
3.1	Was this patient currently taking medication: (If Yes Please detail)	Yes	☐
		No	☐
3.2	When the patient last presented to services, were there any concerns above and beyond the patient's normal presentation (both physically and mentally). If yes please briefly detail.	Yes	☐
		No	☐
3.3	Has the patient recently missed or DNA'd an appointment If yes, please give details	Yes	☐
		No	☐
3.4	Were there other providers involved in the individuals care If yes, please give details	Yes	☐
		No	☐
Section 4			
4.1	Completed By		
4.2	Date		

Appendix 2

Dudley and Walsall NHS
Mental Health Partnership NHS Trust

Mortality Review –
Structured case note review data collection

<table>
<tr><td colspan="2">Incident number:</td><td colspan="3">Team involved at time of death:</td></tr>
<tr><td colspan="5">Author - Name & Job Title:</td></tr>
<tr><td colspan="5">Biographical details</td></tr>
<tr><td>Age:
_____</td><td colspan="2">Gender:
_____</td><td colspan="2">Years of Life Lost: – see note on next page
_____</td></tr>
<tr><td>Recorded cause of death:</td><td colspan="4"></td></tr>
<tr><td>Marital status:</td><td colspan="4"></td></tr>
<tr><td>Employment</td><td colspan="2"></td><td colspan="2">Social Deprivation Indicator (first part of postcode)</td></tr>
<tr><td>Housing</td><td colspan="4"></td></tr>
<tr><td rowspan="2">Lifestyle</td><td colspan="2">Weight</td><td colspan="2">Smoker</td></tr>
<tr><td colspan="2">Physical activity</td><td colspan="2">Drug and Alcohol use</td></tr>
<tr><td>Diagnosis - Mental Health/Learning Disability</td><td colspan="4">Please provide details of full diagnosis</td></tr>
<tr><td>Co – Morbidities</td><td colspan="4"></td></tr>
<tr><td colspan="5">Date of admission (If an inpatient):
Day:
Time:
Length of stay:</td></tr>
<tr><td colspan="5">Pen Portrait / summary of patient –</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="5"><u>Definition of Number of life years lost</u> – This is calcuated by subtracting the age at death from the gender life expectancy which is 79 for males and 84 for females. For example a female who died at 54, the number of life years lost is 30</td></tr>
</table>

Methodology – Structured Case note review. The review of case notes should look at the care and treatments provided within the Trust for the following passage of care :

- Risk Assessment
- Allocation/Initial Review
- Ongoing care – Handover, Care Planning and Interventions
- Care during admissions (if applicable)
- Follow up management/discharge (or end of life care if applicable)
- Assessment of care overall

This methodology proposes the reviewer scores the different phases of care:

1. Very poor care
2. Poor care – may have caused moderate or minor harms or led to patient/family distress
3. Adequate care
4. Good care
5. Excellent care

The methodology proposes making structure judgement comments on each phase of care and as part of the overall assessment of care.

Avoidability of death Score:

1. Definitely avoidable
2. Strong evidence of avoidability
3. Probably avoidable, more than 50 – 50
4. Possibly avoidable, less than 50 – 50
5. Slight evidence of avoidability
6. Definitely unavoidable

Phase of Care – Risk Assessment

We are interested in comments about the quality of care the patient received overall and whether it was in accordance with current good practise (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please comment on the care received by the patient during this phase of care, including anything particular you have identified. Use short explicit comments to describe your judgement on care.

Please rate the care received by the patient during this phase.
Very Poor 1 2 3 4 5 Excellent

Please circle only one score

Phase of care – Allocation/Initial Review

We are interested in comments about the quality of care the patient received overall and whether it was in accordance with current good practise (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please comment on the care received by the patient during this phase of care, including anything particular you have identified. Use short explicit comments to describe your judgement on care.

Please rate the care received by the patient during this phase.

Very Poor 1 2 3 4 5 Excellent

Please circle only one score

Phase of Care – Ongoing Care

We are interested in comments about the quality of care the patient received overall and whether it was in accordance with current good practise (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please comment on the care received by the patient during this phase of care, including anything particular you have identified. Use short explicit comments to describe your judgement on care.

Please rate the care received by the patient during this phase.
Very Poor 1 2 3 4 5 Excellent

Please circle only one score

Phase of Care – Care during admssions (if applicable)

We are interested in comments about the quality of care the patient received overall and whether it was in accordance with current good practise (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please comment on the care received by the patient during this phase of care, including anything particular you have identified. Use short explicit comments to describe your judgement on care.

Please rate the care received by the patient during this phase.
Very Poor 1 2 3 4 5 Excellent

Please circle only one score

Phase of Care - Follow up Management/ Discharge / (End of life care if applicable)

We are interested in comments about the quality of care the patient received overall and whether it was in accordance with current good practise (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please comment on the care received by the patient during this phase of care, including anything particular you have identified. Use short explicit comments to describe your judgement on care.

Please rate the care received by the patient during this phase.
Very Poor 1 2 3 4 5 Excellent

Please circle only one score

Phase of Care – Assessment of Care Overall

We are interested in comments about the quality of care the patient received overall and whether it was in accordance with current good practise (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please comment on the care received by the patient during this phase of care, including anything particular you have identified. Use short explicit comments to describe your judgement on care.

Please rate the care received by the patient during this phase.
Very Poor 1 2 3 4 5 Excellent

Please circle only one score

Avoidability of death judgement score

We are interested in your view on the avoidability of death in this case. Please choose from the following scale

Score 1 - Definitely avoidable
Score 2 - Strong evidence of avoidability
Score 3 - Probably avoidable, more than 50 – 50
Score 4 - Possibly avoidable, less than 50 – 50
Score 5 - Slight evidence of avoidability
Score 6 - Definitely unavoidable

Please rate the avoidability

1 2 3 4 5 6

Please circle only one score

Please explain the reasons for your judement of the level of avoidability of death in this case, including anything in particular that you have identified

What has been learned from this review?

Appendix 3

Scale of Preventability

Scale used to judge preventability of death	
1.	Definitely not preventable.
2.	Slight evidence for preventability.
3.	Possibly preventable but not very likely, less than 50-50 but close call.
4.	Probably preventable, more than 50-50 but close call.
5.	Strong evidence for preventability.
6.	Definitely preventable.