NHS
Dudley and Walsall
Mental Health Partnership
NHS Trust

Document Title
Investigating Deaths (Mortality Review) Policy

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Change History – Version Control		
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 Surveillance Group and formally ratified by Trust Board 07/09/2017
1.1	05/11/2019	Policy modified based upon guidance from the Royal College of Psychiatrists. Addition of red-lines and modification of tool

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	05	11	2019
Review Date	05	11	2021

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 Serious Incident 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 In response to the above publications, the Royal College of Psychiatrists have developed a mortality review tool (Learning from deaths guidance 2018) for mental health Trusts. This policy follows the guidance and principles outlined within the Royal College of Psychiatrists guidance, following the agreed template and utilising the same “red lines” as triggers for a case note review. This ensures that the Trust is following what is currently best practice.

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

Medical Director – 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 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 summary report detailing summary level statistical information in relation to investigating deaths for each quarter (4 reports per year), this will be delivered as part of the Medical Directors Update.

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. The committee will receive a summary report detailing summary level statistical information in relation to investigating deaths for each quarter (4 reports per year). As well as detailing summary level statistical information, this report will also detail key learning points from investigations and updates from Coroners inquests involving the Trust.

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: there are therefore 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 and irrespective of whether the Trust had yet seen or assessed the patient
- 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.

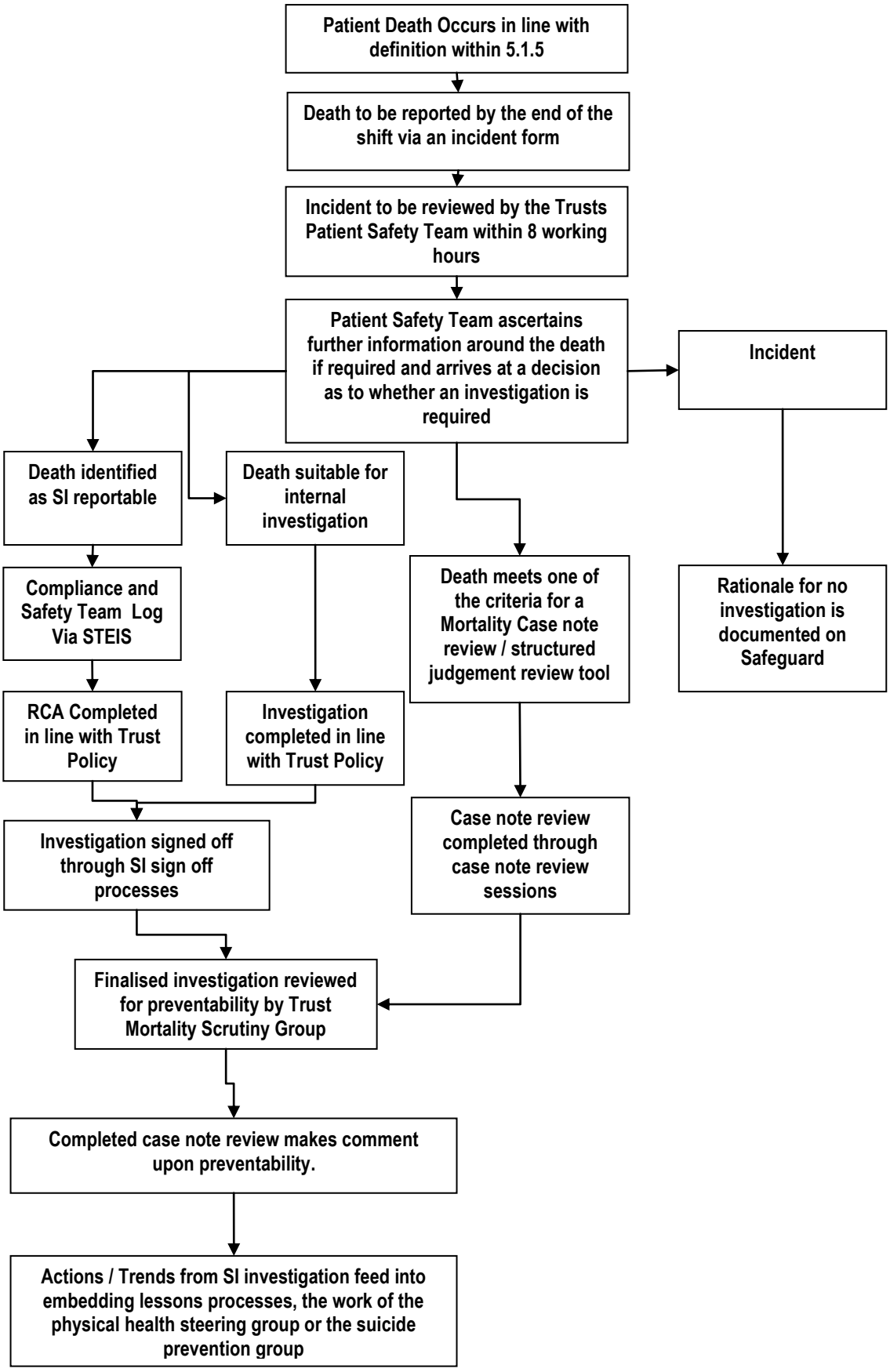
5.1.7 Once completed and submitted, the incident report will then trigger the agreed notification rules, which will inform relevant managers and relevant members of staff.

5.1.8 Once the incident form has been submitted, the Compliance and Safety Team will ensure that a death notification form is sent to the Trusts informatics department, this will ensure that any open referrals are closed down on the Trusts electronic patient information systems, thus ensuring that appointment letters are not sent out erroneously.

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, such as the death of a detained patient.
- **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 user's death. The Trust's Patient Safety and Compliance Team attempt to ascertain a fuller picture of the death, through liaising with other parties such as the Coroner
- **Whether further action is required –** A death can still be subject to, and benefit from, a root cause analysis investigation/internal investigation, even if it is not reportable as a serious incident.
- **Whether a mortality case note review is required –** Some deaths reported may meet the requirements of a mortality case note review, in line with the recommendations from the Royal College of Psychiatrists guidance. These "red lines" for investigation are as follows:
    - *"All patients where family, carers or staff have raised concerns about the care provided"*
    - *"All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death"*
    - *"All patient who were under the care of a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death"*
    - *"All patients who were an inpatient in a Trust mental health unit at the time of death or who had been discharged from inpatient care within the last 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
Patient Safety Team ascertains further information around the death if required and arrives at a decision as to whether an investigation is required
Incident
Death identified as SI reportable
Death suitable for internal investigation
Death meets one of the criteria for a Mortality Case note review / structured judgement review tool
Rationale for no investigation is documented on Safeguard
Compliance and Safety Team Log Via STEIS
RCA Completed in line with Trust Policy
Investigation completed in line with Trust Policy
Investigation signed off through SI sign off processes
Case note review completed through case note review sessions
Finalised investigation reviewed for preventability by Trust Mortality Scrutiny Group
Completed case note review makes comment upon preventability.
Actions / Trends from SI investigation feed into embedding lessons processes, the work of the physical health steering group or the suicide prevention group

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 a root cause analysis (RCA) investigation undertaken in line with the Trust's policy on investigating serious incidents.

6.1.2 The Compliance and Safety Team will be responsible for ensuring that Serious Incident investigations are completed in a timely manner.

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, the identification of this central point of contact should be coordinated by the Compliance and Safety Team.

6.1.4 All serious incident investigations when complete will be reviewed by the Trusts Mortality Surveillance Group and assessed for preventability using the preventability based upon the root cause and contributory factors.

6.1.5 Where learning has been identified from Serious Incident Investigations this will be implemented through the Trust's Embedding Lessons Procedures.

6.2 Case note reviews

6.2.1 There may be occasions where a death meets the "red lines" for a mortality case note review: These are "red lines" are as follows.

- *"All patients where family, carers or staff have raised concerns about the care provided"*
- *"All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death"*
- *"All patient who were under the care of a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death"*
- *"All patients who were an inpatient in a Trust mental health unit at the time of death or who had been discharged from inpatient care within the last month".*
- *A sample of other deaths identified for review by the Trusts Mortality Surveillance Group (based upon information provided in a monthly summary report).*

6.2.2 The Compliance and Safety Team will be responsible for identifying those cases which meet these definitions and ensure that this

information is included in a monthly report to the Trust's Mortality Surveillance Group

6.2.3 Those deaths which meet the requirements of a case note review will have their review undertaken at a "Mortality review day" which will occur on at least a quarterly basis where a number of clinicians will be responsible for ensuring that any outstanding case note reviews are completed. The Compliance and Safety Team will ensure that all relevant Clinical Notes are available to ensure the case note review can be completed.

6.2.4 There are 2 red lines which will be exempt from being reviewed at "mortality review days", these are where the patient was an inpatient at the time of death, or where family, carers or staff have raised concerns about the care provided". In these cases, they will be immediately prioritised for a case note review, with a suitable clinician identified to complete the review identified jointly by the Compliance and Safety Team and the Medical Director.

6.2.5 Should a case note review identify during the course of its completion that there was an omission or error in care which contributed to the service user's death, the case-note review will be paused and a Serious Incident Investigation completed.

6.2.6 Where learning has been identified from a mortality case note review this will be implemented through the Trust's Embedding Lessons Procedures.

7. Duty of Candour

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

7.2 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 Trust Board will receive a summary report detailing summary level statistical information in relation to investigating deaths for each quarter (4 reports per year); this will be delivered as part of the Medical Directors Update.

8.2 The Trusts Quality and Safety Committee will receive a summary report detailing summary level statistical information in relation to investigating deaths for each quarter (4 reports per year). As well as detailing summary level statistical information (which includes numbers of death, number of investigations completed, number of preventable deaths), this report will also detail key learning points from investigations and updates from Coroners inquests involving the Trust and will be prepared by the Trusts Compliance and Safety Team.

8.3 Mortality Surveillance Group is responsible for overseeing the day to day implementation of this policy and will receive a report which details information in respect to each death reported via the Trusts incident reporting system prepared by the Trusts compliance and Safety Team. The report will detail:

- Details provided via the incident report (included cause of death if available)
- Demographic information
- Patient Diagnosis
- Open referral information
- Any recent inpatient admissions

8.4 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 the family of a deceased service user make a complaint about the clinical care 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 that a case note review is completed.

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.

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Section 1

Care review tool for mortality reviews			
Patient Identification number		**Gender**	
Date of Birth (dd/mm/yyyy)		**Age**	
First 3-4 letters + numbers of postcode e.g. DY1		**Ethnicity**	
Date of death		**Time of death**	
Location of death			
Was the patient identified as being within the last 12 months of life?			
Primary diagnosis, including ICD-10 code			
Identified learning disability (Yes/No)? If yes, please specify			
What healthcare teams involved in the patient's care at the time of death			
Dates of last admission to a Psychiatric Hospital (where appropriate)			
Patient summary (an overview of the patients care and known conditions)			
Have any concerns been raised by the family / carers about the patients care (Yes/No)? If yes, please specify			
Have any concerns been raised by the family / carers about the patients care (Yes/No)? If yes, please specify			
Red Flags indicating further investigation is required			
Family, carers or staff have raised concerns about the care provided	☐		
Diagnosis of psychosis or eating disorders during the last episode of care	☐		
Psychiatric inpatient at time of death, or discharged from inpatient care within the last month	☐		
Under the care of Home Treatment Team at the time of death	☐		
Other locally determined criteria for review	☐		
Case selected at random	☐		

Section 2

Please outline the information sources used to complete this review

2.1 – Phase of care: Allocation and initial assessment or review (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:	
5. Excellent Care	☐
4. Good Care	☐
3. Adequate Care	☐
2. Poor Care	☐
1. Very poor care	☐
Section not applicable	☐

2.2 – Phase of care: Ongoing care (where relevant) • **Was mental health monitored adequately?** • **Was physical health monitored adequately?** • **Please list medication if known and relevant, and comment on medication monitoring where appropriate** Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:	
5. Excellent Care	☐
4. Good Care	☐
3. Adequate Care	☐
2. Poor Care	☐
1. Very poor care	☐
Section not applicable	☐

2.3 – Phase of care: Psychiatric Inpatients – comment on care during admission (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:	
5. Excellent Care	☐
4. Good Care	☐
3. Adequate Care	☐
2. Poor Care	☐
1. Very poor care	☐
Section not applicable	☐

2.4 – Phase of care: End of life care (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:	
5. Excellent Care	☐
4. Good Care	☐
3. Adequate Care	☐
2. Poor Care	☐
1. Very poor care	☐
Section not applicable	☐

2.5 – Phase of care: Discharge plan of care (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.	
Please rate the care received by the patient during this phase as:	
5. Excellent Care	☐
4. Good Care	☐
3. Adequate Care	☐
2. Poor Care	☐
1. Very poor care	☐
Section not applicable	☐

2.6 – Other area of care (please specify) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.	
Please rate the care received by the patient during this phase as:	
5. Excellent Care	☐
4. Good Care	☐
3. Adequate Care	☐
2. Poor Care	☐
1. Very poor care	☐
Section not applicable	☐

2.7 – Overall care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:	
5. Excellent Care	☐
4. Good Care	☐
3. Adequate Care	☐
2. Poor Care	☐
1. Very poor care	☐
Section not applicable	☐

2.8 – If care was below an acceptable standard, did it lead to harm? If yes, please provide details and state an action plan (consider whether a serious incident investigation or another Trust process is required).

2.9 – Was the patient's death considered more likely than not to have resulted from problems in care delivery or service provision? If yes, please provide details and state an action plan (consider whether a serious incident investigation is required).

2.10 – If a family member, carer, or staff raised concerns, please outline any feedback provided and state who was responsible for providing this feedback. Please state further action required. If no feedback was provided, please consider how the outcome of this review should be fed back to the relevant people, considering the duty of candour principle.

2.11 – Were the patient records adequate for the purpose of the review?	**Yes**	☐
	No	☐
Please outline any difficulties in accessing appropriate information:		