Liverpool Women's
NHS Foundation Trust

Learning from Deaths

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The Trust is committed to a duty of candour by ensuring that all interactions with patients, relatives, carers, the general public, commissioners, governors, staff and regulators are honest, open, transparent and appropriate and conducted in a timely manner. These interactions be they verbal, written or electronic will be conducted in line with the NPSA, 'Being Open' alert, (NPSA/2009/PSA003 available at www.nrls.npsa.nhs.uk/beingopen and other relevant regulatory standards and prevailing legislation and NHS constitution)

It is essential in communications with patients that when mistakes are made and/or patients have a poor experience that this is explained in a plain language manner making a clear apology for any harm or distress caused.

The Trust will monitor compliance with the principles of both the duty of candour and being open NPSA alert through analysis of claims, complaints and serious untoward incidents recorded within the Ulysses Risk Management System.

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1 Introduction

1. Each year around 500,000 people die, of which around half die in hospital. In December 2016, the Care Quality Commission (CQC) published its review on the way NHS acute trusts review and investigate the deaths of patients in England: *Learning, candour and accountability*. The CQC found that none of the trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

2. On March 21st 2017 the National Quality Board published "National Guidance on Learning from Deaths" which includes very specific guidance on the roles and responsibilities of the Board of Directors. It is essential that this guidance be read alongside the NHSI/E Serious Incident Framework (March 2015) and its replacement, the Patient Safety Incident Response Framework (Aug 2022). Trust boards are accountable for ensuring compliance with both of these.

3. The guidance states that the learning from mortality reviews should be integral to a provider's clinical governance and quality improvement work. Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in the Trust and provide necessary challenge. The guidance also directs all trusts to publish a Policy on how it responds to, and learns from, deaths of patients, who die under its management and care, including:
    - How its processes respond 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.

- The Trust's approach to undertaking case record reviews. Acute Trusts should use an evidence-based methodology for reviewing the quality of care provided to those patients who die.
- Categories and selection of deaths in scope for case record review.

4. As a minimum Trusts should focus reviews on:
    - All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.
    - All in-patient, out-patient and community patient deaths of those with learning disabilities and severe mental illness.
    - All neonatal and maternal deaths.
    - All deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator).
    - All deaths in areas where people are not expected to die, for example in relevant elective procedures.
    - Deaths where learning will inform the provider's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically.
    - A further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.
    - Following any linked inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths" in order to examine the effectiveness of their own review process.
    - Deaths to be subject to a Serious Incident reporting and investigation.

5. Liverpool Women's NHS Foundation Trust puts patients, families, and carers at the centre of everything we do. Reviewing the care provided to people who have died can help improve care for all patients by identifying problems associated with poor outcomes. We can then work to understand how and why these problems occur so that meaningful action can take place.

6. The Trust has a small number of adult deaths each year (eg 4 in 2021/22) most of which are encountered at the expected end point of a known disease process. Given the Trusts patient population, there are a larger number of extended perinatal (still births and deaths within the first month of life) and infant deaths (within the first year of life) all of which are subject to review using the Perinatal Mortality Review Tool. The Trust

2 Scope

7. This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust's behalf.

3 Purpose

8. Liverpool Women's Hospital will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

9. This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of Liverpool Women's Hospital.

10. It describes how Liverpool Women's Hospital will support people who have been bereaved by a death at the trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the trust supports staff who may be affected by the death of someone in the trust's care. It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

11. This policy should be read with relevant trust procedures and policies including the Adult Mortality and Extended Perinatal Mortality Strategy, the Reporting and Management of incidents, Serious Incident Policy, Complaints Management and Quality Improvement documents.

4 Requirements for the Trust

12. Under the National Guidance on Learning from Deaths, published by the National Quality Board in March 2017, trusts are required to:
    - Publish an updated policy from September 2017 on how their organisation responds to and learns from the deaths of patients who die under their management and care, including:
    - How their processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death.
    - Their evidence-based approach to undertaking case record reviews.
    - The categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed).
    - How the trust engages with bereaved families and carers, including supporting and involving them in investigations.
    - How staff affected by the deaths of patients will be supported by the trust.

13. Collect and report specific information every quarter on:
    - The total number of inpatient deaths in an organisation's care.

- The number of deaths the trust has subjected to case record review (desktop review of case notes using a structured method).
- The number of deaths investigated under the Serious Incident framework (and declared as Serious Incidents).
- Of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care.
- The themes and issues identified from review and investigation, including examples of good practice
- How the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.
- Publish this information on a quarterly basis by presenting a paper to public board meetings.

14. This policy sets out Liverpool Women's Hospital Foundation Trusts approach to meeting these requirements.

5 Duties / Responsibilities

All Staff

15. It is the responsibility of all staff to minimise the risk of adult and extended perinatal mortality and to minimise its impact. To highlight areas for improvement, the Trust's risk management processes may be used. Issues may also be brought directly to the attention of Safety or Effectiveness Leads, Clinical Directors, senior nursing and midwifery staff, Divisional Managers, the Deputy Medical Director, the Medical Director or the Chief Nurse and Midwife for consideration, escalation and action.

Chief Executive

16. The Chief Executive has overall responsibility and final accountability for ensuring that the Trust has appropriate mortality review procedures in place; and that the Trust works to best practice as defined by relevant regulatory bodies.

Medical Director

17. The Medical Director is designated as the Lead Board member with responsibility for mortality review procedures, and as such will ensure that a robust system is in place which provides collated Trust level data on mortality rates, reviews of deaths, avoidable mortality rates and actions taken to address deficiencies in care and/or processes. The Medical Director presents the Quarterly Learning from Deaths Report to the public meeting of the Board of Directors for assurance.

Non Executive Director Chair of Quality Committee

18. The Non-Executive Director who chairs the meetings of Quality Committee, in conjunction with the Medical Director, takes oversight of the process for reviewing and reporting on mortality in the Trust. The Non-executive director will also understand the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny, champion quality improvement that leads to actions that improve patient safety, and assure published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.

Chief Nurse and Midwife

19. The Chief Nurse and Midwifery has joint responsibility for clinical governance, delegated authority for quality improvement and risk management and is the Executive Lead for infection control. They are also the Executive Lead for Safeguarding and Learning Disabilities/Dementia with delegated responsibility sitting with the Associate Director of Nursing for Safeguarding.

Deputy Medical Director

20. The Deputy Medical Director produces the Quarterly Learning from Deaths report for Quality Committee and the Trust Board and assists the Medical Director and the Chief Nurse and Midwifery in delivering the commitments made in the Adult and Extended Perinatal Mortality Strategy.

Head of Governance and Quality

21. The Head of Governance and Quality oversees the Annual Mortality Report, includes a summary of it in the Trust's Annual Quality Accounts. The Head of Governance and Quality assists the Deputy Medical Director in producing the Quarterly Learning from Deaths report and includes a summary of the Annual report it in the Trust's Annual Quality Accounts.

Divisional mortality Leads

22. Mortality Leads for the Gynaecology Division and the Family Health Division (both Neonatal and Maternity) are usually consultants who are responsible for ensuring all deaths are reported into the appropriate pathway and reviewed using the appropriate tool. They also provide the Deputy Medical director with the data relating to mortality and the learning from reviews, to populate the learning from deaths quarterly report.

Divisional Safety Leads

23. Safety Leads in each division are usually consultants who are responsible for the promotion of incident reporting, identifying cases requiring Serious Untoward Incident investigations, ensuring completion of action plans after Serious Incident investigations, disseminating clinical lessons learnt and co-ordinating responses to national reports or initiatives.

Divisional Managers

24. Senior managers take a leading role in the management of clinical risks in the Trust, including the management of risks relating to the Learning from Deaths. Examples of their responsibilities include escalating clinical risks from the front line, identifying the actions needed to reduce the risk, assigning owners to elements of Action Plans and monitoring mitigating factors.

Mortality Review Group

25. The mortality review group meet quarterly and will receive divisional data via the divisional governance frameworks. It will oversee the mortality review process and report on the themes emerging for institutional learning. The MRG will sign-off the Trust quarterly mortality report before its review at Quality Committee. Additional responsibilities of the MRG include, investigation of any external mortality alerts received such as those received from CHKS, VON and the Care Quality Commission (CQC). Review of benchmarked mortality data and initiation of further investigations into relevant external alerts.

Divisional Board Meetings

26. Standing items on the relevant Divisional Clinical meeting agenda of relevance to the Learning from Deaths include the review of the Divisional Risk Register, review of progress against the Clinical Audit Forward Plan, review of the actions detailed in SMART Action Plans after a death, review of the actions detailed in SMART Action Plans after a relevant clinical audit and horizon scanning.

Safety and Effectiveness committee

27. The Safety and Effectiveness committee monitors themes arising from clinical incidents that have been reported in the Trust, including those that have arisen following an adult or an extended perinatal death. In addition, after a Serious Incident, although the Divisional Meetings monitor progress against the SMART Action Plans produced, the Safety Senate provides monthly oversight and escalates unresolved risks to Quality Committee.

28. The Safety and Effectiveness committee also monitors progress against the Trust's Clinical Audit Forward Plan, which includes audit work in those clinical activities most closely related to the risk of adult mortality and extended perinatal mortality. In addition, although the Divisional Meetings monitor progress against the SMART Action Plans produced after their clinical audits, the Sub-committee also provides monthly oversight and escalates unresolved risks to Quality Committee.

Quality Committee

29. The Quality Committee is the sub-committee responsible for providing the Board of Directors with assurance on all aspects of quality of clinical care. Quality Committee therefore oversees all clinical governance activity relating to mortality. It meets monthly and receives the Quarterly Learning from Deaths Report and escalates unresolved risks relating to mortality to the Board of Directors. In addition, it receives. via the Safety and Effectiveness Chairs' Reports, risks relating to mortality that have not been resolved at divisional or committee level.

Trust Board of Directors

30. The *National Guidance on Learning from Deaths* places particular responsibilities on boards, as well as reminding them of their existing duties. Organisations must refer to Annex A of the *National Guidance on Learning from Deaths.*

31. The Board of Directors meets in public on a monthly basis. It has the overarching responsibility for activities relating to mortality in the Trust. It therefore receives the Quarterly Learning from Deaths Report for direct consideration. It also receives assurance from Quality Committee with respect to the detailed elements of the report, via the Chair of Quality Committee's Report. In addition, the following items of relevance to adult mortality and extended perinatal mortality appear on the Board Assurance Framework: (i) the isolated site of Liverpool Women's Hospital, (ii) transport of adults across the critical care network, (iii) development and support of a comprehensive Clinical Audit Forward Plan, (iv) ensuring that lessons are learnt and change enacted from the reporting and investigation of incidents locally and across the NHS and (v) considering response to NICE Guidance. The board is required to ensure that its organisation has a board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda.

6 Definitions

32. The *National Guidance on Learning from Deaths* includes a number of terms. These are defined below.

Death certification

33. The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Case record review

34. A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review

35. A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Serious Incident

36. Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

Investigation

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

Death due to a problem in care

38. A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted

from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

Quality improvement

39. A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Patient safety incident

40. A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

7 The process for recording deaths and Selecting cases for Review

Intelligence-Gathering Process

41. Appendices A, B and C are flow charts that illustrate the intelligence-gathering processes that are followed after expected gynaecological deaths, unexpected gynaecological deaths and all adult deaths in obstetrics. Expected gynaecological deaths are those that arise as the predicted end point of a known disease process. In this Trust, most of these result from gynaecological cancers.

Adult Deaths occurring at LWH

42. All expected and unexpected adult deaths that occur in the Trust, are reported on the Ulysses Risk management system as soon after death as practicable by the nurse or clinician providing care to the deceased patient. They will thereafter, complete an Adult Mortality Audit Sheet on Ulysses Risk Management System within 48 hours of the patient's death Appendix D). This records performance against a predefined set of standards, using the recognised and validated methodology detailed in PRISM studies. In each clinical area, the Clinical Director provides feedback to clinicians if individual errors or omissions in care have been identified by use of this audit tool. The forms are sent electronically to the Head of Governance and Quality, the Quality Improvement Lead and Governance Facilitator who analyse the data and identify any emerging Trust-wide themes. These are highlighted and reported in the Quarterly Adult Mortality Report. If any deaths are graded as NCEPOD 5 or <3 (very poor/poor care) on structured judgement review then a second stage review will be performed according to the RCP SJR process.

Adult Deaths of LWH patients occurring at other providers

43. Deaths of Adult patients occurring in other providers for patients receiving care from Liverpool Women's Hospital staff may occasionally be recorded in the LWH data. This situation may arise for women being cared for in other acute providers but whose surgery is conducted by LWH surgeons. These sitauations are managed on a case by case basis with a decision made by the Medical Directors or nominated deputy regarding where the death should be recorded.

Obstetric/Maternal Deaths

44. For maternal deaths a joint review panel/investigation of all services involved in the care of the women will occur and include representation from all applicable hospitals/clinical settings. This is as per the recommendations in the Ockenden report and will be conducted by the Healthcare Safety Investigation Branch (HSIB). This joint review panel/investigation will have an independent chair, be aligned with local and regional staff and seek external clinical expert opinion where required. The Trust remain responsible for an immediate safety review (72 hour review) and for any other internal reviews that focus on debriefing those involved, for bereavement support for families and for sharing learning across the LMS. Learning from this review will be introduced into clinical practice within 6 months of the completion of the panel and also be shared across the LMS.

45. Any death following IVF treatment or any maternal deaths where the pregnancy has resulted from fertility treatment need to be reported to the HFEA within 24 hours of being aware of said death. These deaths must be reported to the Clinical Lead/Patient Safety Lead for the Hewitt Centre.

Stillbirth

46. The process for reporting still births is described in detail in the Trust wide SOP "PMRT and Pregnancy Loss Review Process" available on the intranet here PMRT and Pregnancy Loss Review Process .

47. All stillbirths (excluding termination of pregnancies) are reported as incidences using the Trust incident reporting system, Ulysses. These cases undergo an initial incident review to ensure there are no patient safety concerns. If required, cases are escalated to be investigated as serious incidences. All stillbirths at > 37 weeks gestational age are also reported to and externally reviewed by HSIB.

48. All stillbirths are then reviewed via the monthly perinatal mortality and morbidity review panel using the Perinatal Mortality Review Tool (PMRT). For these reviews, the Strategic Clinical Network provides an external panel member (Consultant Obstetrician or Senior midwife). These families are also supported by the bereavement team, and invited to engage in the review process. The MDT review panel considers all aspects of the care provided, results of investigations such as post-mortem and placental histology, and parental comments and questions, and grades the care provided in the antenatal and postnatal period according to the matrix provided by MBRRACE. Any care issues identified with the recommendations, learning and actions are detailed in the PMRT report. Findings of the review is shared with staff involved in the delivery of care so that they can be discussed with Educational Supervisors and Senior Midwives as appropriate. The Lessons Learned are shared more widely via email and at the Maternity Clinical Meetings, in keeping with the Trust's Policy for Managing Incidents and Serious Incidents.. Importantly, PMRT review findings and reports are shared with the family who have experienced a stillbirth in a debrief appointment with a Consultant Obstetrician, with the opportunity to ask further questions, and to plan for a future pregnancy.

49. With respect to benchmarking, the Trust receives yearly figures on its performance through MBRRACE-UK, in which an attempt is made to match local outcomes with national peers. The Trust's Deputy Medical Director produces a response to the

annual MBRRACE-UK report at the time of its publication. This response takes into account local factors that have not otherwise been accounted for in the MBRRACE-UK document. This response is included in the Trust's Annual Extended Perinatal Mortality Report.

Neonatal Death

50. The process for reporting neonatal deaths is described in detail in the Trust wide SOP "Neonatal Death Process" available on the intranet here PMRT and Neonatal Death Review Process.

51. At Liverpool Women's Hospital all neonatal deaths are reviewed using the standardised national process PMRT (perinatal mortality review tool). Deaths are notified to the mortality lead and registered on the PMRT system through the CDOP midwife for deaths on delivery suite and for deaths on NICU through the MBRRACE and CDOP link nurse. This process is described in the SOP for neonatal deaths.

52. The neonatal PMRT process involves an MDT panel of obstetricians, midwives, neonatalologists, palliative care and bereavement teams with external representation supported by the strategic clinical network. The MDT review panel consider all aspects of care from antenatal to bereavement care, investigations including placental histology, genetics and post mortem examination (if performed) and parental questions and comments and then grade the care provided according to the MBRRACE matrix. If care issues have been identified the recommendations, lessons learned and actions generated are included in the final PMRT report. The final report is shared with the family at a debrief appointment by the neonatal consultant and obstetrician (where appropriate). The lessons learned are further shared with the wider clinical team through a monthly summary, a quarterly report is shared at the Liverpool Neonatal Partnership (LNP) integrated governance meeting and with LWH mortality review group (MRG).

53. The standardised PMRT process includes early considering of a formal review in the case of any immediate care issue concerns being identified with escalation to an SI if necessary. In addition to the PMRT process, there are also key considerations at the time of the death by the clinical team:

- Does the death require discussion with the coroner?
- Does the death meet the threshold for triggering a SUDI investigation?

54. If the death is a SUDI a police investigation takes place and this has precedence over all other investigatory work. Staff are required to make a written record of their involvement as soon as possible after the event and is converted into a police statement if required. The mothers/infants medical records are retained by the Safeguarding Team for the duration of the SUDI process. Liverpool Women's NHS Foundation Trust follows the Merseyside Joint Agency Protocol for SUDI.

55. If the death is not a SUDI but the Coroner decides that a Coroner's Investigation is required, a post mortem examination will normally be carried out on the Coroner's direction. The Trust is provided with the post mortem result only after being given permission by the Coroner. The Trust will liaise with the corners office regarding the acceptability of continuing internal investigation whilst the Coroners investigation is ongoing.

56. If a Serious Incident (SI) investigation is required, this can progress at a normal pace unless there is a SUDI, which takes precedence. If there is a Coroner's Investigation taking place in parallel with an in-house Serious Incident investigation, the Trust's investigators will normally reach a preliminary provisional conclusion while waiting conclusion of the Coroner's Investigation and complete their report thereafter. Each SI report includes a Lessons Leaned section and a SMART Action Plan, completion of which is monitored through the LNP IG meeting.. Importantly, SI reports are shared with the family who have experienced a neonatal death and an opportunity is given for them to discuss the findings will a Consultant Neonatologist.

57. A summary of the data collected from the Trust's neonatal PMRT reviews is reported to the Cheshire and Mersey neonatal network Clinical Effectiveness Group (CEG), along with any learning points generated. All deaths are also reported to the local Child Death Overview Panel (CDOP) and are discussed there. One of the neonatal Consultants from the Trust attends the CDOP to inform this discussion and to feed back any relevant points from the discussion to the Neonatal Clinical Meeting.

58. An annual summary report of all neonatal deaths, including SUDI, coroner's cases, SIs and others, is compiled to demonstrate themes and these are used to drive targeted service change. The annual report is reviewed at the Liverpool Neonatal Partnership (LNP) integrated governance meeting and it is also presented to the Hospital Mortality Group. The data generated after SUDIs, Coroner's Investigations and SIs are also included in the Trust's Annual Extended Perinatal Mortality Report - including Lessons Learned, SMART Action Plans generated and themes arising from early neonatal deaths.

59. With respect to benchmarking, the Trust is involved in several initiatives in addition to the MBRRACE-UK report:

60. The Vermont Oxford Neonatal network collects data that allow us to benchmark our very low birthweight and extreme preterm in-hospital mortality against other neonatal units across UK and across the world, with risk adjustment for case mix.

61. The Quality Account publishes data about neonatal mortality for babies born at the Trust, compared with the national neonatal mortality rates published by the Office for National Statistics, with adjustment for the gestation profile.

62. The Neonatal Neonatal Audit Project also produces an annual report on in-hospital mortality for preterm babies in UK neonatal units.

Involvement of Relatives and Carers in the Review process

63. The PMRT process includes inviting families and carers to be involved in all reviews. All families and carers are also invited to post bereavement meetings with clinicians involved in the care of their babies. For adult deaths, families are invited to provide their opinion on the care they received as well as invited to a debrief with the clinician caring for their relative after the death.

Reporting of Perinatal Deaths to MBRRACE-UK

64. The MBRRACE / CDOP midwife works in collaboration with the neonatal MBRRACE / CDOP link nurse to identify all eligible perinatal deaths through the K2 electronic

patient records and Badgernet. All eligible perinatal deaths are notified to MBRRACEUK within seven working days, and the surveillance information completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. The PMRT report is started after the initial case review, and the report drafted and finalised after the PMRT MDT review panel.

Reporting of Perinatal Deaths to HSIB

65. All perinatal deaths that fulfils the Each Baby Counts Programme criteria (37 weeks or more and experienced an intrapartum stillbirth or early neonatal death) and maternal deaths are reported to the Healthcare Safety investigation Branch via the HSIB Investigation Management System by the Maternity Governance team. HSIB provides an independent review of the case, engaging parents in the process. A report is then produced, with relevant safety recommendations, which is discussed in the maternity clinical meeting and shared with the department. There are some cases where HSIB decide to not investigate, and return back to the trust for an internal review. These cases are then reviewed in the monthly PMRT meeting in an MDT manner, with external representation.

Role of the Medical examiner

66. Medical examiners are senior medical doctors who provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

67. The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.

68. The role will become statutory from April 2023. At Liverpool Women's Hospital we are working with local medical examiners to formalise the process for referral to them for deaths of LWH patients. This SOP will be included in this policy in due course.

Referral to the coroner

69. On occasion referral for coronial investigation is required. In relation to patients at Liverpool Women's Hospital this would usually relate to circumstances where the death was thought to be due to unnatural causes or the cause of death was unknown. A more detailed list of the situations when to refer to the Coroner are in Appendix F. Referrals to the coroner are now via the electronic portal accessible at https://liverpool-portal.coronersconnect.co.uk

70. The Trust will liaise with the corners office regarding the acceptability of continuing internal investigation whilst the Coroners investigation is ongoing.

Deaths involving people with Learning Disabilities

71. The Learning Disabilities Mortality Review (LeDeR) Programme was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England as a result of one of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD).

72. All deaths of people with learning disabilities aged four years and older are subject to review using LeDeR methodology in order to:Identify potentially avoidable contributory factors to the deaths of people with learning disabilities and ways of improving services to prevent early deaths of people with learning disabilities.

73. Develop plans of action to make any necessary changes to health and social care services for people with learning disabilities

74. The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities. The standardised review process involves discussing the circumstances leading up to the person's death with someone who knew them well (including family members wherever possible), and scrutinising at least one set of relevant case notes. Taking a cross-agency approach, the reviewer develops a pen portrait of the individual and a comprehensive timeline of the circumstances leading to their death, identifies any best practice or potential areas of concern, and makes a decision, in conjunction with others if necessary, about whether a multi-agency review is indicated.

75. For Trust guidance, please refer to Trust LeDeR SOP

Deaths in people detained under the Mental Health Act

76. Regulations require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay.

77. Under the Coroners and Justice Act 2009, coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983).

78. In circumstances where there is reason to believe the death may have been due, or in part due to, to problems in care - including suspected self-inflicted death - then the death must be reported to the provider's commissioner(s) as a serious incident and investigated appropriately. Consideration should also be given to commissioning an independent investigation as detailed in the Serious Incident Framework.

Referral to the Coroner

79. On occasion referral for coronial investigation is required. In relation to patients at Liverpool Women's Hospital this would usually relate to circumstances where the death was thought to be due to unnatural causes or the cause of death was unknown. A more detailed list of the situations when to refer to the Coroner are in Appendix G. Referrals to the coroner are now via the electronic portal accessible at https://liverpool-portal.coronersconnect.co.uk.

8 Reviewing outputs from review and investigation to inform quality improvement

Quarterly Learning from Deaths Report

80. The Deputy Medical Director will oversee the production of the Quarterly Learning from Deaths Report. As a minimum, this report contains data about:

- number of deaths (including stillbirths) in our care
- number of deaths (including stillbirths) subject to case record review
- number of deaths (including stillbirths) investigated under the Serious Incident framework
- number of deaths (including stillbirths) that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.

81. This report provides the data relating to the previous quarter, with the learning from reviews from two quarters previous (eg in Q3, Q2 data is presented with learning from Q1). This is due to the multidisciplinary review process which takes several weeks to complete. The report is presented at Quality Committee and also at the Trust board.

Annual Mortality Report

82. A review of the annual mortality data and themes is produced each year. This is presented to Quality committee each year. The report is also presented Trust wide in the Q2 “Great Day” by each of the divisional mortality leads.

Quality Improvement and SMART Action Plans

83. Actions generated from the review of deaths as well as the thematic reviews will be SMART. Each action in a SMART Action Plan has an assigned person responsible for its completion. This may for example be the Safety Lead, the Effectiveness Lead, a senior nurse or midwife or a manager. Progress against Action Plans is reviewed within the relevant Divisional meeting as well as at the Mortality Review Group.

84. When any action in a SMART Action Plan is being closed relating to mortality, evidence must be attached to show how the requirements of that action have been met. In addition, beyond completion of a SMART Action Plan, the Trust ensures that full benefit has been achieved by measuring relevant and related clinical outcomes. These outcome measures are agreed at the Divisional Clinical Meetings and

monitored at those same meetings with the assistance of the Head of Governance and Quality.

85. Quality Improvement methodology is used where applicable. Please refer to the Quality Improvement Framework for more information on the methodologies used and support provided for QI work.

9 Supporting and involving families and carers

86. The Trust will engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles below.

- bereaved families and carers should be treated as equal partners following a bereavement;
- bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;
- bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support;
- bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one;
- bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed;
- bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;
- bereaved families and carers should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations;
- bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in delivering training for staff in supporting family and carer involvement where they want to

87. The Macmillan Team provides bereavement support to family and carers after the death of an adult in the Trust. The team comprises clinical nurse specialists all of whom have advanced communications skills training. They draw upon guidelines from the Cheshire and Merseyside Palliative Care Network to underpin their work[1], in addition to in-house guidelines that are displayed on the Trust Intranet (Policies Procedures and Guidelines > Gynaecology > general Gynaecology > Bereavement Guideline).

[1] North West Coast Strategic Clinical Network: Standards and Guidelines (2017). Available at www.cmscnsenate.nhs.uk/strategic-clinical-network/our-networks/palliative-and-end-of-life-care/audit-group/standards/

88. The Trust is committed to putting families and/or carers at the centre of the investigatory process in cases of unexpected adult deaths in gynaecology and all adult deaths in maternity. The Lead Investigator or deputy consults with the bereaved family and/or carers to inform them that an investigation is taking place and notes any questions that they would like addressed. On completion of the investigation, the Lead Investigator or deputy feeds back findings to the bereaved family and/or carers and gives them the opportunity to ask further questions. A copy of the investigatory report is provided to the bereaved family and/or carers at this time. A further opportunity is given to the bereaved family and/or carers to meet with the Lead Investigator or deputy at a later date, once they have had time to consider the content of the investigatory report.

89. The Honeysuckle Team provides support for families and advice for women and their families following a pregnancy loss at any gestation and after an early neonatal death. We draw upon guidelines from SANDS (Stillbirth and neonatal death charity) and NBCP (National bereavement care pathways). One of the Honeysuckle bereavement midwives will liaise with parents prior to any internal investigations and will attend the PMRT (Perinatal Mortality Review Tool) meetings with the lead investigator and Quality & Safety midwife. Parents can submit questions prior to the investigation. A debrief is then arranged with a consultant and if requested by parents the bereavement midwife will also attend. Parents can attend at a later date or be telephoned if requested to discuss any more questions that may have arisen from the debrief.

10 Key Reference

1. Office for National Statistics, Death registrations summary tables – England & Wales for 2015

2. Learning, Candour and Accountability: a review of the way NHS trusts review and investigate the deaths of patients in England (December 2016). Available online at www.cqc.org.uk

3. National Guidance on Learning from Deaths. National Quality Board (2022) Available at https://www.england.nhs.uk/patient-safety/learning-from-deaths-in-the-nhs/#Provider-policies-on-learning-from-deaths

4. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. Hogan H et al (2012) BMJ Qual Saf 21, 737-745.

5. Learning Disabilities Mortality Review (LeDeR) Programme (2022) https://leder.nhs.uk/

6. Patient Safety Incident Response Framework. https://www.england.nhs.uk/patient-safety/incident-response-framework/

11 Associated Documents

i. Adult Mortality Strategy
ii. Extended Perinatal Mortality Strategy
iii. Serious Incident Case Reviews
iv. Incident Management Reporting Policy
v. Incident reporting SOP

12 Policy Administration

Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Impact Assessment	PGP		
GDPR	PGP		
Have the relevant details of the 2010 Bribery Act been considered in the drafting of this policy to minimise as far as reasonably practicable the potential for bribery?	Yes		
External Stakeholders			
Trust Staff Consultation via Intranet	Start date: Aug 22		End Date: Aug 22

Describe the Implementation Plan for the Policy (and guideline if impacts upon policy) (Considerations include; launch event, awareness sessions, communication / training via CBU's and other management structures, etc)	By Whom will this be Delivered?
This policy will available on the Trust intranet. All staff will be notified that the policy is available on the intranet and will be notified by email if any amendments are made at a later date.	Policy Officer / Quality Improvement Lead

Version History

Date	Version	Author Name and Designation	Summary of Main Changes
Oct 17	1.0	Medical Director	New Document
Oct 18	2.0	Quality Improvement Lead & Safety Manager	Minor updates (Dates and committee name changes), role changes. Updates to CESDI with CEMACH processes
Oct 18	2.0	Safeguarding Manager	Deaths Involving people with Learning Disabilities section, new to the policy.
Aug 2022	3.0	Deputy Medical Director	Major revision of document to mirror National Policy published in 2018 relating to learning from deaths NHS England » Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers. Includes update to PMRt process, medical examiner role, update internal process of reporting and investigating death's,

Monitoring Compliance with the Policy

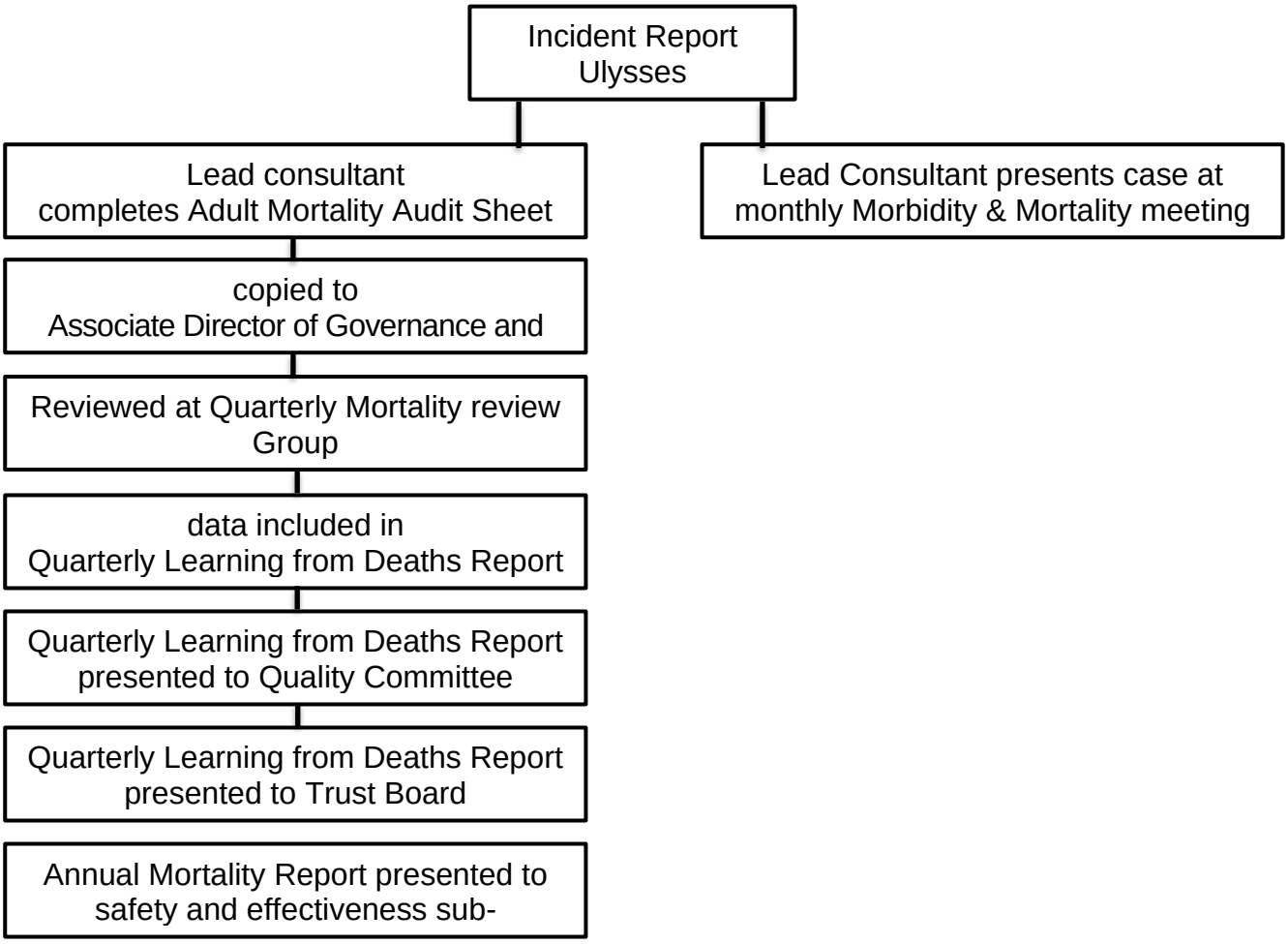
Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Compliance with the commitments made against adult mortality in this policy document will be monitored via the Quarterly Adult Mortality at Quality Committee and at the Public meeting of the Board of Directors.		will be monitored via the Quarterly Adult	Quality Committee / Public meeting of the Board of Directors.	Quarterly	
Compliance with the commitments made against extended perinatal mortality in this policy document will be monitored via the Annual Extended Perinatal Mortality Report at Quality Committee			Quality Committee	Annual	

Performance Management of the Policy

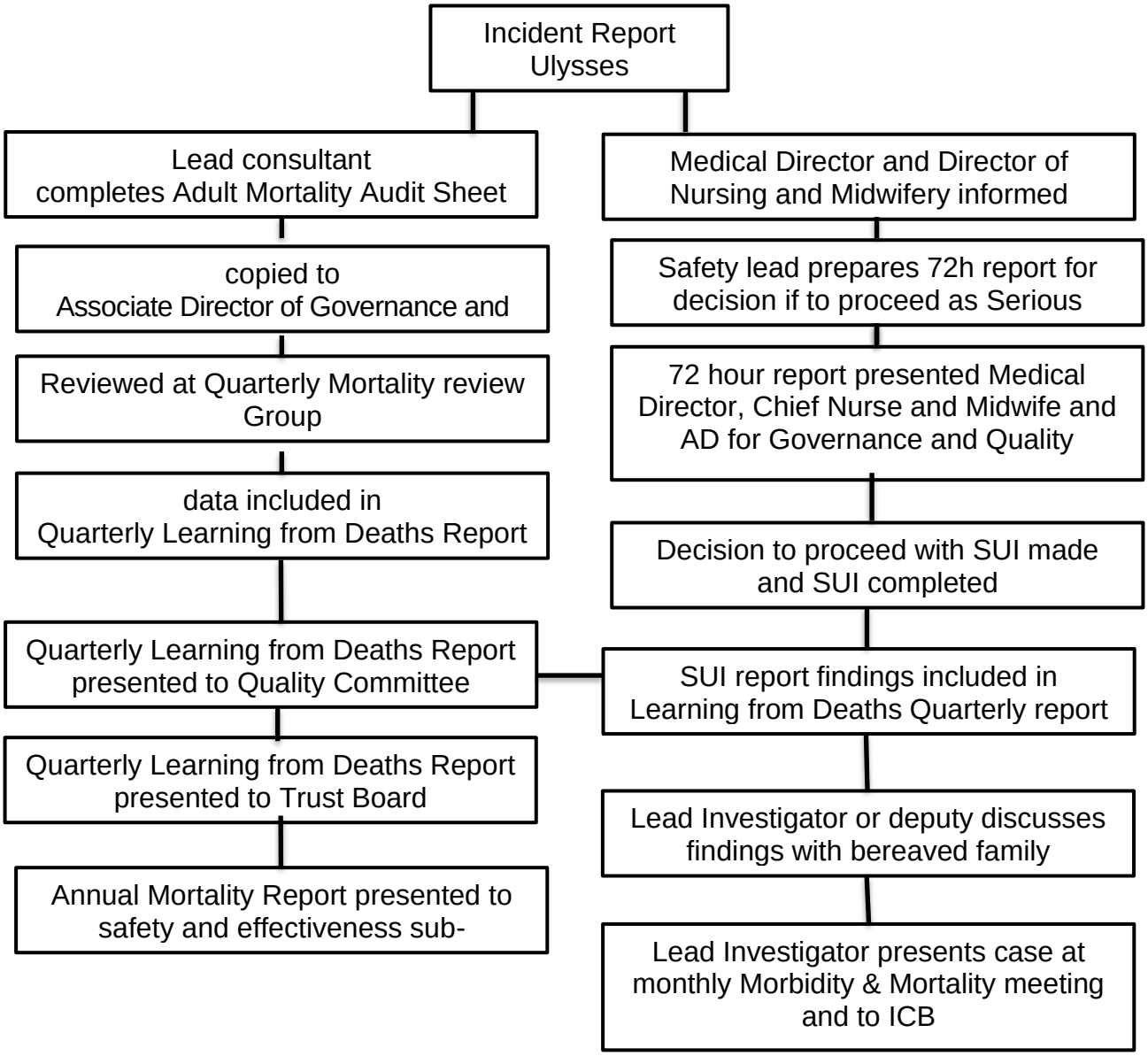
Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
This Policy will be reviewed and updated annually by the Medical Director and the Deputy Medical Director for Quality Committee	Quality Committee	Annually

13 Appendices

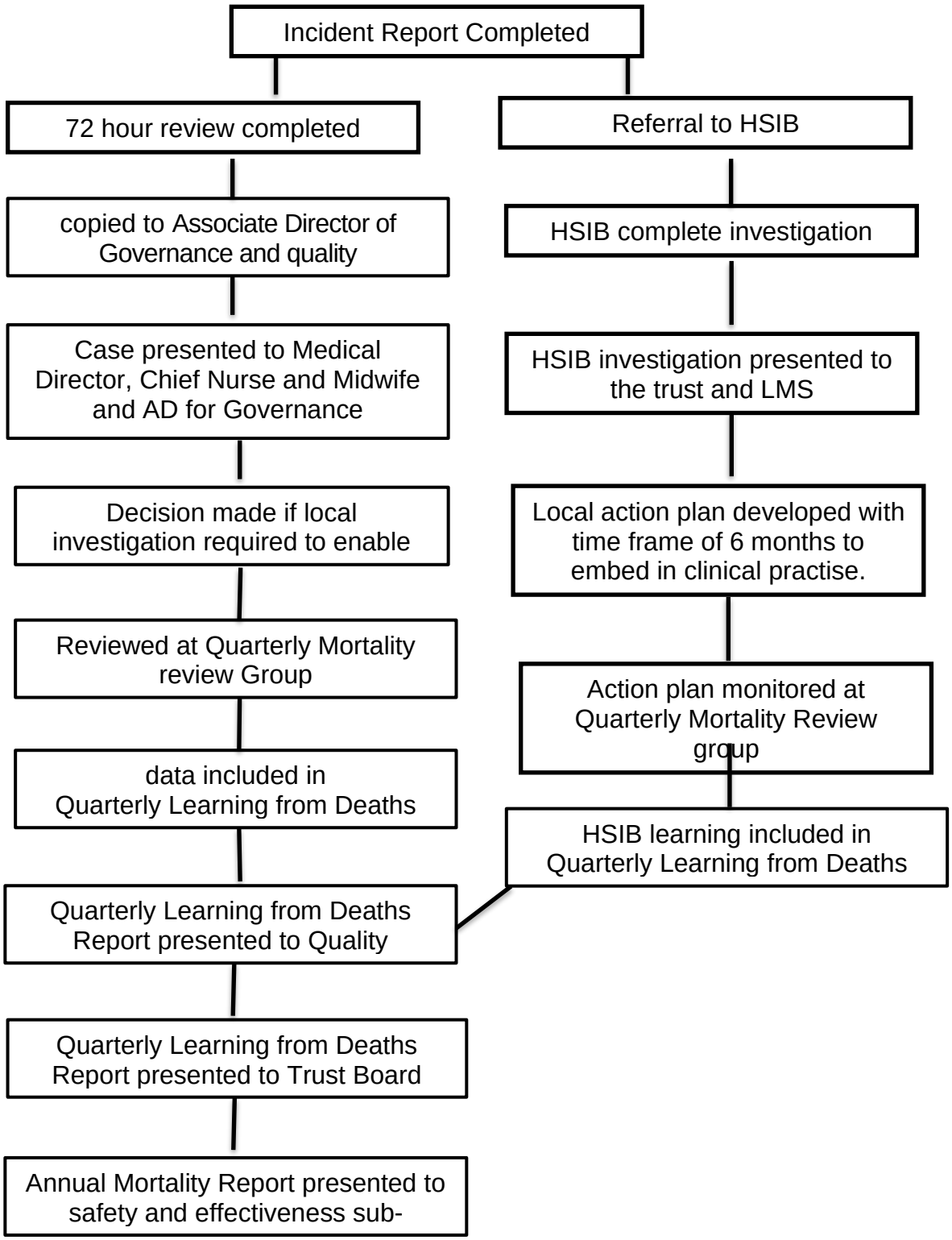
Appendix A: Response to an Expected Gynaecological Death



Appendix B: Response to an Unexpected Gynaecological Death



Appendix C: Response to a Maternal Death



Appendix D: Adult Mortality Audit Sheet

The content of the Adult Mortality Audit Sheet is as follows:

- Date and time of admission:
- Date and time of death:
- Cause of death 1a: disease or condition directly leading to death
- Cause of death 1b: other disease or condition if any, leading to 1a
- Cause of death 1c: other disease or condition if any, leading to 1b
- Cause of death 2: other significant disease or condition contributing indirectly to death
- PM performed: Y/N
- Documentation of DNAR in case notes: Y/N
- Was the patient on an End of Life Care Pathway: Y/N
- Did the patient receive any treatment prior to admission:
- Was the patient seen in the emergency department prior to admission:
- On initial clerking, were the history and examination appropriate: (If not, specify why)
- Was the initial differential diagnosis appropriate: (If not, specify why)
- Were the initial investigations (if any) appropriate: (If not, specify why)
- Was this an unplanned readmission of a previous discharge?
- Time of first review:
- Number of hours after admission of first review:
- Grade of doctor performing first review:
- On first review, were the history and examination appropriate: (If not, specify why)
- Was the differential diagnosis on first review appropriate: (If not, specify why)
- Were the investigations on first review (if any) appropriate: (If not, specify why)
- Time of first Consultant review:
- Number of hours after admission of first Consultant review:
- Was the NEW score recorded appropriately throughout:
- Frequency of observations prescribed:
- Clinical deterioration recognised:
- Appropriate graded response to deterioration:
- Clearly documented medical response to deterioration:
- Did the deterioration result in cardiac arrest:
- Did the patient receive CPR/resuscitation:
- Did the separate location of LWH from an adult acute site contribute to the patient's death:
- Did the separate location of LWH from an adult acute site reduce the quality of care provided: (If so, please specify)
- Should the patient's management have been handled differently: (If so, please specify)
- Are there any lessons to be learnt from this case: (If so, please specify)

-

Hogan scale:

1 definitely not preventable
2 slight evidence of preventability
3 possibly preventable but not very likely, a little less than 50/50
4 probably preventable but not certain, a little more than 50/50
5 strong evidence of preventability
6 definitely preventable

NCEPOD

1 good practice
2 room for improvement – some clinical care could have been better
3 room for improvement – some organisational care could have been better
4 room for improvement – some clinical & organisational care could have been better
5 less than satisfactory – several aspects of care below an acceptable level

How would you rate the overall quality of care provided by the trust: Excellent / Good / Adequate / Poor / Very poor

Please give a brief clinical resume of the patient:

Appendix E: When to Refer to the Coroner

Circumstances in which the duty to notify a coroner are below

1. The registered medical practitioner suspects that that the person's death was due to:
   (i) poisoning, including by an otherwise benign substance;
   (ii) exposure to or contact with a toxic substance;
   (iii) the use of a medicinal product, controlled drug or psychoactive substance;
   (iv) violence;
   (v) trauma or injury;
   (vi) self-harm;
   (vii) neglect, including self-neglect;
   (viii) the person undergoing a treatment or procedure of a medical or similar nature; or
   (ix) an injury or disease attributable to any employment held by the person during the
   person's lifetime;
2. The registered medical practitioner suspects that the person's death was unnatural but does
   not fall within any of the circumstances listed above
3. The registered medical practitioner;
   (i) is an attending medical practitioner required to sign a certificate of cause of death in
   relation to the deceased person; but
   (ii) despite taking reasonable steps to determine the cause of death, considers that the
   cause of death is unknown;
4. The registered medical practitioner suspects that the person died while in custody or
   otherwise in state detention
5. The registered medical practitioner reasonably believes that there is no attending medical
   practitioner required to sign a certificate of cause of death in relation to the deceased person;
6. The registered medical practitioner reasonably believes that—
   (i) an attending medical practitioner is required to sign a certificate of cause of death in
   relation to the deceased person; but
   (ii) the attending medical practitioner is not available within a reasonable time of the
   person's death to sign the certificate of cause of death;
7. The registered medical practitioner, after taking reasonable steps to ascertain the identity
   of the deceased person, is unable to do so.

Appendix F: Glossary and Abbreviations

Action	A response to control or mitigate a risk
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted.
Board Assurance Framework (BAF)	A matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available
BoD	Board of Directors
Clinical Audit	A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit previously stated standards
Corporate Governance	The system by which Boards of Directors direct and control organisations in order to achieve their objectives
CQC	Care Quality Commission
Escalation	Referring an issue to the next appropriate management level for resolution, action, or attention
Quality Committee	Quality Committee
LeDeR	Learning Disabilities Mortality Review Programme
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
NHSLA	NHS Litigation Authority
NICE	National Institute for Health and Care Excellence
NPEU	National Perinatal Epidemiology Unit
RCOG	Royal College of Obstetrics and Gynaecology
Risk	The uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance
Risk Management	The processes of identifying, assessing & judging risks, assigning ownership, taking actions to mitigate & anticipate them, monitoring and reviewing progress
Risk Register	A tool for recording identified risks and monitoring actions and plans against them
Strategy	A document that sets out the corporate approach and overview to a particular area or work activity.

Appendix G: Equality Impact Assessment

Equality Impact Assessment

Section 1: **Title of Project Proposal:**	Learning From Deaths Policy
Brief Description of the Project Proposal	The policy sets out the trusts approach to reviewing deaths using standardizes approaches, collecting data and then disseminating learning form those reviews.
EIA Carried Out By (Name & Job Title):	Chris Dewhurst, Deputy MD
Date:	13/03/2023
EIA Authorised By **(Name & Job Title):**	
Date:	
Consultation/Engagement Guidance note: How have stakeholders been consulted with? Who were the stakeholders? What level of engagement took place?	Shared at mortality review group and Quality Committee.

Does The Policy Affect:	**Staff**		**Patients**		**Both**	X

Equality Group	Impact (Positive/Negative/Neutral)
Race (All Ethnic Group)	Neutral
Disability (Inc Physical, long term health conditions & Mental Impairments)	Neutral

Sex	Neutral
Gender Re-Assignment	Neutral
Religion Or Belief	Neutral
Sexual Orientation	Neutral
Age	Neutral
Marriage & Civil Partnership	Neutral
Pregnancy & Maternity	Neutral
Other e.g., caring responsibilities, human rights etc.	Neutral

For each protected characteristic, consider whether the impact is positive. If so, provide supporting evidence to demonstrate how your decision was made and the impact that the policy will have with consideration of each protected characteristic (e.g., protected characteristic – impact – rationale)
The policy is applied to all deaths. Information is collected on ethnicity, race, disabilities and spoken language as part of the routine data collection during mortality reviews.
For each protected characteristic, consider whether the impact is negative. If so, provide supporting evidence to demonstrate how your decision was made and the impact that the policy will have with consideration of each protected characteristic (e.g., protected characteristic – impact – rationale)
The policy is applied to all deaths. Information is collected on ethnicity, race, disabilities and spoken language as part of the routine data collection during mortality reviews.

If your assessment has identified any negative impacts, please detail any actions that have been put in place to mitigate these (upon approval of EIA these actions will be shared with the Equality, Diversity and Inclusion Committee):

Outcome	Actions Required	Time Scale	Responsible Officer

Is there evidence that the s. 149 Public Sector Equality Duties (PSEDs) will be met? Consider whether the proposed policy will…

- Eliminate discrimination, victimisation, harassment, and any unlawful conduct that is prohibited under this act
- Advance Equality of opportunity
- Remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic
- Take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
- Encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (Consider whether this is engaged. If engaged, consider how the project tackles prejudice and promotes understanding -between the protected characteristics)

Explain your answers below.

The policy is applied to all deaths. Information is collected on ethnicity, race, disabilities and spoken language as part of the routine data collection during mortality reviews.

Does the EIA have regard to the need to reduce inequalities for patients with access to health services and the outcomes achieved? (this section is a requirement for any services outlined within the NHS England and Improvement Core 20 Plus 5 approach to health inequalities) Explain.
Section 2: **To be completed by the EDI Manager authorising the EIA** **Anything for noting or any recommendations for consideration by the Board** *Guidance Note: Will PSEDs be met? Are Core 20 Plus 5 services considering patient health inequalities?*

Review Date:	

Additional Supporting Evidence and Comments: