Whittington Health NHS

Learning from Deaths Policy

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List of those consulted	Mortality Leads, Patient Safety Committee, Medical Director and Associate Medical Director for Patient Safety
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Version No	Description of change	Author	Date
1	First draft	Ashleigh Soan	13/07/2017
2	Edits to first draft	Julie Andrews	20/07/2017
3	Addition to involvement of family and carers	Ashleigh Soan	31/07/2017
4	Addition of Dissemination of Learning and further minor amendments	Julie Andrews	03/08/2017
5	Addition of information relating to After Death Proforma	Louise Restrick	27/08/2017
6	Changes suggested by the Patient Safety Committee	Julie Andrews	11/09/2017

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1.0 INTRODUCTION

The *'National Guidance on Learning from Deaths'*[1] was published in response to a number of high level reviews that have concluded that learning from deaths was not being given sufficient priority in some NHS organisations and that this meant that there were missed opportunities to improve NHS services including patient and family experience through the review of deaths. This policy has been written in response to this guidance.

2.0 PURPOSE

This policy has been written to set out how we will respond to and learn from deaths of patients who die while under the management and care of Whittington Health ('the Trust'). This policy also provides guidance for all staff involved in the mortality review process.

The aim of the mortality review process is to:

- Engage with patients' families and carers and recognise their insights as a source of learning, improving their opportunities for raising concerns and involvement in investigations and reviews.
- Embed a culture of mortality review learning in medical, nursing and Allied Health Professional training in the Trust
- Identify and learn from episodes relating to problems in care
- Identify and learn from notable practice.
- Support the review of end of life care including reflecting on whether patients' wishes were identified and met.
- Embed the use of a Trust-wide agreed list of team actions following the death of a patient under the management and care of the Trust (the After Death Proforma)
- Enable informed reporting to Board with a transparent methodology.
- Promote organisational learning and improvement.
- To identify potentially avoidable deaths and ensure these are fully investigated through the serious incident (SI) process.

3.0 SCOPE

This policy relates to all staff involved who may be involved in the mortality review process:

- Medical staff

[1] '*National Guidance on Learning from Deaths*', National Quality Board (March 2017), available from https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

- Nurses and Allied Health Professionals
- Mortuary staff
- Quality Improvement staff
- Performance Analysts

The mortality review process is applicable to all in-hospital deaths in all specialities, including emergency medicine, paediatrics and maternity. All deaths of former inpatients that die within 30 days of discharge may be subject to review in the future.

4.0 DEFINITIONS

Medical Certificate of Cause of Death (MCCD)

Referred to as a 'death certificate'. A MCCD enables the deceased's family to register the death. This provides a permanent legal record of the fact of death and enables the family to arrange disposal of the body, and to settle the deceased's estate.

Coroner

Coroners are judicial office holders. They are completely independent and are appointed directly by the Crown. Coroners investigate all deaths where the cause is unknown, where there is reason to think the death may not be due to natural causes, or which need an inquiry for some other reason.

Category A deaths

Category A deaths are:

- Deaths where families, carers or staff have raised concern about the quality of care provision
- All inpatient deaths of patients with learning disabilities
- All inpatient deaths of patients with a mental health diagnosis
- All deaths in a service where concerns have been raised either through audit, incident reporting processes or other mortality indicators
- All deaths in areas where deaths would not be expected, for example deaths during elective surgical procedures
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had sepsis, diabetic ketoacidosis, or a recent fall
- All inpatient paediatric, neonatal and maternal deaths
- Deaths that are referred to HM Coroner's Office

Category B deaths

Category B deaths are all deaths of inpatients and deaths of patients within 30 days of discharge from hospital that do not meet any of the criteria of Category A deaths.

Case Note Review

The review of a deceased patient's medical records to determine whether there were any problems in the care provided to the patient. The purpose of these reviews is to identify any challenges and issues and learn from any care and service delivery problems, and also to identify notable practice.

Structured Case Review (SCR)

Structured evidence-based case note review form based on the Royal College of Physicians tool (appendix 4).

Potentially avoidable death

A potentially avoidable death is a death that has been clinically assessed using a recognised methodology of case note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

After Death Proforma (ADP)

Trust-wide agreed list of team actions following the death of a patient under the management and care of the Trust.

5.0 DUTIES (Roles and Responsibilities)

Executive Medical Director

The Executive Medical Director is the executive responsible for the oversight of the mortality review process.

Associate Medical Director for Patient Safety

The Associate Medical Director for Patient Safety is the Trust's Mortality Lead. The Associate Medical Director for Patient Safety is responsible for:

- Oversight and regular review of the mortality review process including use of the ADP for all deaths
- Holding the central Mortality Review Database
- Identifying relevant Departmental Mortality Leads to ensure completion of all relevant mortality reviews
- Reporting to the Trust Board on patient mortality based on the review of the care received by those who die under the Trust's care including use of the ADP
- Ensuring that feedback and learning points are shared across ICSUs or trust-wide.

Departmental Mortality Leads

Departmental Mortality Leads are responsible for:

- Ensuring all deaths within their area have an ADP completed and are reviewed according to this policy
- Identifying suitable clinicians to complete case note reviews
- Ensure all reviews and findings are electronically and retrievably stored on the trust's I-Drive
- Ensure that action plans for improvement are developed where required and shared within the ICSU and with other relevant ICSUs as required
- Overseeing progress on the implementation of action plans.

Nurses and Allied Health Professionals (AHPs)

Nursing staff and AHPs are responsible for participating in mortality reviews.

Mortuary staff

Mortuary staff are responsible for:

- Providing daily lists of deceased patients
- Providing copies of all deaths certificates on a weekly basis.
- Forwarding coroner referral forms when these have been completed and sign off by the coroner.

Serious Incident Executive Approval Group (SIEAG)

The SIEAG is jointly chaired by the Executive Medical Director and Chief Nurse and Director of Patient Experience. Any patient deaths that have been highlighted by the case note review process as being potentially related to problems with care should be reviewed by the trust's multi-disciplinary SIEAG.

The SIEAG will then consider whether any highlighted cases meet the criteria to be investigated as serious incidents, or whether any other process would be suitable, for example feedback of learning to specific services or professional groups.

Informatics team

The informatics team provides monthly lists of patients who died as an inpatient in the previous month. The informatics team also provides a record of all patients who have died within 30 days of discharge from hospital.

6.0 Mortality review process

The mortality review process following the death of a patient under the management and care of the Trust starts with completion of the ADP.

The components of the ADP include:

a) A nurse or doctor speaking to a patient's family and offering condolences from the team.
b) A consultant-led discussion to agree the contents of the death certificate or the need for referral to the Coroner.
c) A 'death discharge summary being completed and shared within 24 hours.
d) Information about a death being shared promptly with other teams/professionals involved in a patient's care.

The full content of the Trust ADP is in Appendix 2. It is downloaded by a ward team as a three part document at the time of a death; Part 1 supports the process of the confirmation of death, Part 2 is the ADP and the third section is the Last Offices Check List for the Ward staff.

The process for the conduct of mortality reviews is outlined in the flow chart at Appendix 1.

6.1 Notification of patient deaths

- Patient deaths are notified through daily lists of deceased patient sent by the Mortuary. The Mortuary also provides information on the content of all death certificates for patients in a weekly email.

6.2 Recording patient deaths

- All patient deaths received are entered onto the Mortality Review Database by the Administration Lead for Patient Safety including information on completion of the ADP.

6.3 Reviewing patient deaths

- The Trust Mortality Lead reviews all patients' deaths on the Mortality Review Database and completes an initial review on whether the death would be considered a Category A death or a Category B death.

- All 'Category A' deaths should be reviewed.

- A minimum of 25% of all Category B deaths should be reviewed, although ideally 100% of all Category B deaths could be reviewed.

- All deaths identified to be reviewed will receive an initial review by an individual practitioner and a second departmental mortality review (usually within the structure of a mortality meeting).

- All first departmental mortality reviews need to include the patient's hospital number, date of death, content of the death certificate, information on completion of the components of the ADP and have a objective `score using the Confidential Enquiry into Stillbirths in Infancy (CESDI) bandings (Diagram 1) or Avoidability of Death Judgement Scoring System (Table 1) as a minimum. An example mortality form is given at Appendix 3.

- Departmental mortality reviews should be multi-disciplinary and include consultant representation.

- If the departmental mortality review records a CESDI score of 2 or 3, or a PAD score of 1-3, then a review thorough structured case review (SCR) will be undertaken. This will be completed by a consultant, specialty registrar or senior nurse/AHP who has not been associated with the care of the patient.
- If a SCR confirms a potentially avoidable death (PAD) score of 1, 2 or 3 then a Datix incident report will be completed. This will also be escalated to the ICSU senior management team and the SCR sent to the SIEAG for consideration. The SCR will act as a '72 hour report' incident form.
- Deaths of inpatients with learning disabilities will be undertaken in compliance with the national LD mortality review programme.
- Deaths of children will be undertaken in compliance with local Serious Case Review policy.

Diagram 1: Confidential Enquiry into Stillbirths in Infancy (CESDI) bandings

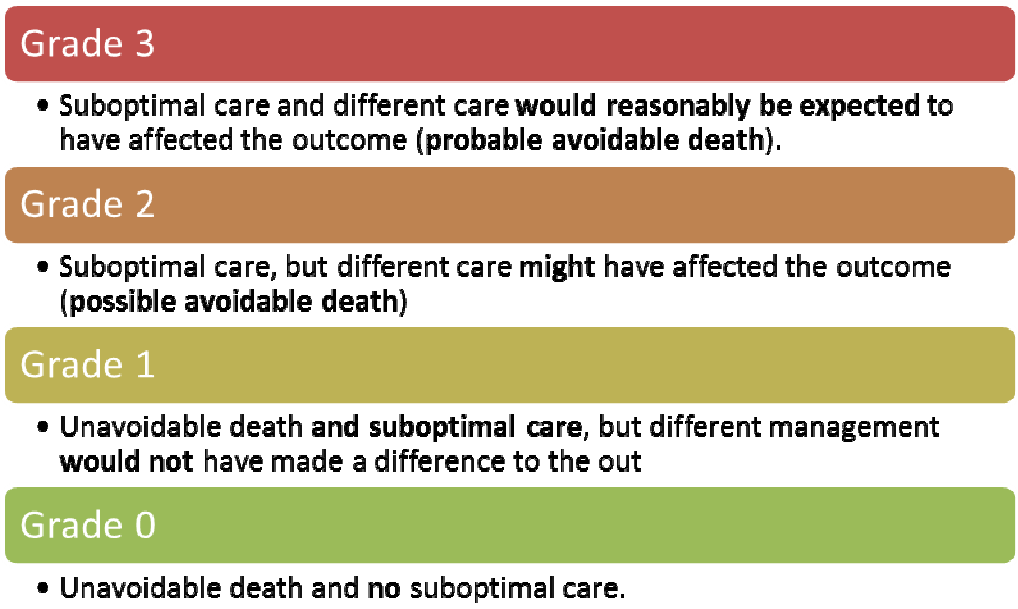


Table 1: Avoidability of Death Judgement Scoring System

Score	Description

1	Definitely avoidable
2	Strong evidence of avoidability
3	Probably avoidable, more than 50/50
4	Possibly avoidable but not very likely, less than 50/50
5	Slight evidence of avoidability
6	Definitely not avoidable

6.4 Recording mortality and structured case reviews

The outcome of all case note reviews and SCRs will be electronically and retrievably stored on the Trust's I-drive, which is accessible to relevant clinical staff.

7.0 Involvement of families and carers

The new national guidance outlines a clear expectation that trusts should be involving bereaved families and carers in the review process of their loved one's death. Previous feedback from families was one of the drivers for the design and formal introduction of the Trust ADP in 2016.

The trust's '*Being Open and the Duty of Candour* Policy[2]', describes the approach to Being Open when an incident has resulted in a patient's death, or where an incident harmed a patient who is now deceased, this includes establishing open channels of communication with the patient's family and/or carers and including them appropriately in the investigation process. The patient's family and/or their carers can reasonably expect to be fully informed of the issues surrounding an incident and its consequences in a face-to-face meeting.

Where a deceased patient's care is subject to a Serious Incident investigation the patient's family and/or carers should be informed that a Root Cause Analysis investigation will be completed, and it would be expected that a patient's family and/or carers will be invited to help develop the terms of reference for the investigation. The final Root Cause Analysis report should

[2] Whittington Health '*Being Open and Duty of Candour Policy'* (2015), available from http://whittnet.whittington.nhs.uk/document.ashx?id=8436

be shared with the patient's family and/or carers. These expectations are outlined in the trust's '*Policy for the Management of Serious Incidents*[3]'.

8.0 Dissemination of Learning

It is essential that clinicians and other stakeholders are informed of the outcomes of the Mortality Review Process if they are to learn and improve outcomes for patients.

Mechanism for the outputs of the mortality governance process to be fed back to clinical staff including plans for improvement, lessons learnt and pathway redesign will be developed and implemented by the Mortality lead

Key metrics on mortality review will be reported to trust board as a mortality dashboard including completion of the ADP.

Key metrics and learning will be shared with staff via the trust's monthly patient safety newsletter, the ICSU Patient Safety Committee, and local education events.

[3] Whittington Health '*Policy for the Management of Serious Incidents'* (2015), available from http://whittnet.whittington.nhs.uk/document.ashx?id=8436

9.0 MONITORING COMPLIANCE and EFFECTIVENESS

What key area(s) need(s) monitoring on this document? (Consider the purpose of the document; processes, procedures, timelines, patient outcomes etc)	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others if any.	What tools / methods will be used to monitor report and review the identified areas? (Consider audit, observation, minutes, complaints, incidents, claims, reports and Documentation etc.)	How often is the need to monitor each area? How often is the need to produce a report? How often is the need to share the report?	Responsible Committee for scrutiny and arrangements for for feedback.
Element/s to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting and feedback arrangements**
Compliance with completed discharge summary to GP practice within 72 hours	Mortality QI team	QIP	Quarterly	Local feedback to non-compliant teams and presentation of data to ICSU boards
Percentage of Category A and category B deaths reviewed in mortality process	Mortality QI team	QIP	Quarterly	Local feedback to clinical teams Trust board report
Compliance with completed after death proforma	Mortality QI team	QIP	Quarterly	Local feedback to clinical teams Trust board report
Evidence of learning from mortality reviews	Mortality QI team	QIP	Quarterly	Mortality report shared with local teams

10.0 ASSOCIATED DOCUMENTS

Title	Intranet Hyperlink
LEARNING FROM SERIOUS INCIDENTS STANDARD OPERATING PROCEDURE (SOP)	http://whittnet.whittington.nhs.uk/document.ashx?id=10427
POLICY FOR THE MANAGEMENT OF SERIOUS INCIDENTS (SI)	http://whittnet.whittington.nhs.uk/document.ashx?id=8436
STANDARD OPERATING PROCEDURE FOR SENIOR MANAGEMENT OF INCIDENTS THAT MAY REQUIRE REPORTING TO THE POLICE	http://whittnet.whittington.nhs.uk/search/?q=serious+incident

11.0 REFERENCES

- '*National Guidance on Learning from Deaths*', National Quality Board (March 2017), available from https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
- '*Learning, candour and accountability'*, Care Quality Commission (December 2016), available from https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf
- Whittington Health Board paper, *Identifying and learning from avoidable mortality - mortality review process for the Whittington* (February 2016)
- Whittington Health Board paper, National Guidance on Learning from Deaths (April 2017)

12.0 APPENDICES

Appendix 1: Mortality review process flowchart
Appendix 2: After Death Proforma
Appendix 3: Example Trust mortality review form
Appendix 4: Royal College of Physicians case note review form

13.0 EQUALITY IMPACT ANALYSIS

Whittington Health – Equality Impact Analysis Form

Access guidance via this link: **http://whittnet/default.asp?c=9308**

1. Name of Policy or Service

Learning from Deaths Policy

2. Assessment Officer

Ashleigh Soan

3. Officer responsible for policy implementation

Ashleigh Soan

4. Completion Date of Equality Analysis 11/September/2017

5. Description and aims of policy/service

The aim of this policy is to set out how the Trust will respond to and learn from deaths of patients who die while under the management and care of the Trust. This policy also provides guidance for all staff involved in the mortality review process.

6. Initial Screening

An initial analysis has been carried out to explore whether the XXXXX is likely to have a detrimental impact in terms of people included in one or more of the following equality categories:

- Race
- Disability
- Gender
- Age
- Sexual orientation
- Religion and belief
- Gender Reassignment
- Marriage and civil partnership
- Pregnancy and maternity

7. Outcome of initial screening

No detriment to any protected characteristic was identified.

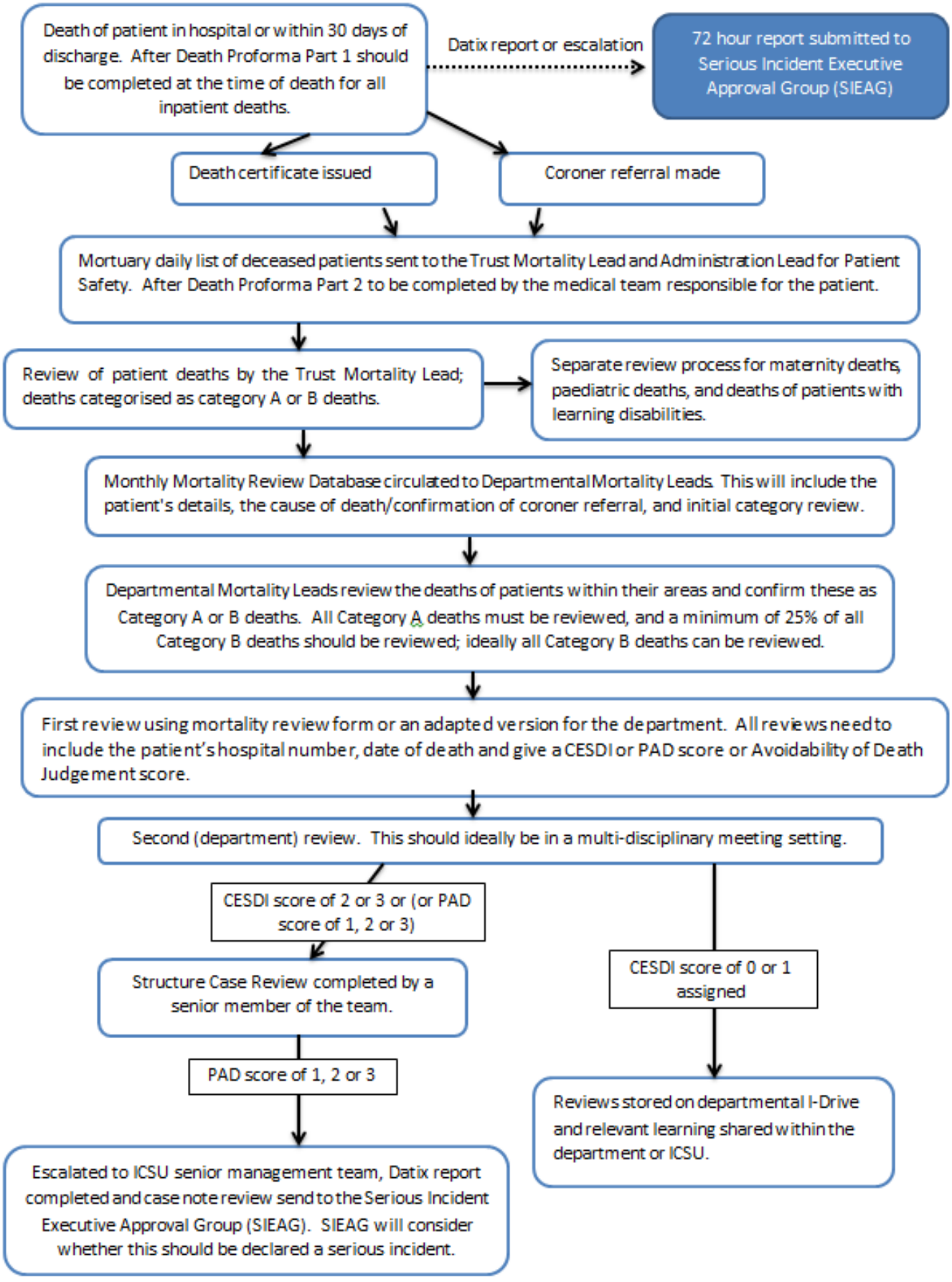
8. Monitoring and review/evaluation

When the Policy is reviewed, a new Equality Impact Analysis should be completed.

9. Publication of document

Trust Intranet.

Appendix 1: Mortality review process flowchart



Appendix 2: After death proforma (ADP)

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PART 1: CONFIRMATION OF DEATH IN HOSPITAL

Please complete at time of death and place in front of the patient's medical records

Patient Name _____

Hospital Number _____ NHS Number _____

Date of Birth _____ Age _____

1) Date of death _____/_____/_____ Certified time of death _____ : _____

2) Print name of clinician who confirmed death _____ Bleep _____

3) Ward _____ Consultant _____

4) Relatives present at death? **Yes / No**

   Name and relationship _____

5) Name of nursing staff present at time of death? _____

6) Has clinician spoken to the family and offered condolences? **Yes / No**

   Name and role of clinician _____

   Name and relationship of family member _____

7) Patient under DOLS? **Yes / No / Unsure**

8) Phone mortuary to inform them of the death (X5330) ☐

Confirming Death
(document in the notes):
- Confirm identity of patient
- Pupils fixed and dilated
- No respiratory effort
- No palpable central pulses
- No heart sounds
- No breath sounds

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PART 2: AFTER-DEATH PROFORMA

To be completed by the medical team responsible for the patient (on the ward/in the mortuary)

Name of Dr completing the death certificate _____

Signature & role _____

Bleep _____ Date completed death certificate ____ / ____ / ____

A) A doctor has spoken to the family and offered condolences ☐

Name & role of doctor _____

Name and relationship of family member _____

B) There has been a consultant led discussion to agree the contents of the death certificate or the need for referral to the Coroner ☐

C) Death Discharge Summary completed on ICE ☐ Date: ____ / ____ / ____

* To be completed and sent **within 24 hours** of the death, to include:
- The cause of death as per the death certificate
- Very short summary to communicate to the GP any issues/pertinent facts about the patient's care
- If referred to Coroner document as 'Referred to Coroner'

D) Consider who else has been involved in the care of this patient and needs to be informed (via the medical team/ward manager/ward clerk?):

a. ☐ Critical Care Outreach Team/ICU/Anaesthetist

b. ☐ CORE team/Specialist nurses/Community teams

c. ☐ Other hospital teams who have cared for the patient (eg. at WH/RFH/UCH)

d. ☐ Learning disability team

e. ☐ District nurses

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LAST OFFICES CHECKLIST

Name	Hosp number (If not known Write D.O.B.)	Ward/Dept.

TO BE COMPLETED PRIOR TO THE DECEASED BEING REMOVED FROM THE WARD
IT MUST BE SENT TO THE MORTUARY WITH THE DECEASED

Religious Denomination			COMMENTS	Signature
Jewellery kept on body If YES, please give details / Description and state location Record in valuables book & on death notice	Y/N			
Any other property If YES, please give details and state location (i.e. false teeth) **Record in property book**	Y/N			
Identification Bracelets *Must have two* *Check same name, DOB & Hospital Number on both*	Wrist	Y/N		
	Ankle	Y/N		
Eyes Closed If NO, use small piece of damp gauze to hold lids closed	Y/N			
Mouth Closed	Y/N			
Artificial Prosthetics left on body e.g. eye, leg, wig, hearing aid,dentures	Y/N			
Pacemaker in situ N.B. can explode during cremation	Y/N			
Internal defibrillator in situ N.B. can explode during cremation	Y/N			
Infectious/Communicable Disease (see appendix 3A for guidance	Y/N			
Body Fluids Leaking If YES, use body bag	Y/N			
Deceased in Body Bag If YES, please state reason if one other than above	Y/N			
Note: If death was anticipated, remove all cannulae and tubing. *In other events, leave all cannulae and tubing in situ, disconnected and sealed.*				

Body details checked by:

RN. Nurse Print Name Date

RN / Support staff Print Name

Relatives/Next of Kin Informed Yes/No Print Name of Informant

Whittington Health NHS

Mortality Review: screening form

Appendix 3: Example Trust mortality review form

Patient's NHS/Hospital Number	
Patient Name	
Patient's Age	
Reviewer 1	
Date of review 1	
Reviewer 2	
Date of review 2	
Date of admission	
Date of death	
Day of the week of admission (ie Mon/Tues)	
Time of admission (ED front sheet)	
Location of death	

REVIEWER 1

The Patient	
Main diagnosis on admission	1. 2. 3. etc
Significant co-morbidities	1. 2. 3. etc
Certified Cause of Death	1a 1b 1c 2

Was there a hospital post mortem?	Y/N	*Comment*
Was the Coroner informed/consulted?	Y/N	*Comment*
Was there a Coroner's Post mortem?	Y/N	*Comment*

***Brief Narrative**/ summary of events (100-500 words only):*

Any concerns about care or events? *If Yes, please list concerns below and describe:*

Standard of documentation was: *score 1 to 5 (1 = very poor, 5 = excellent)*		
Cancer present		**10 words or less comments**
Was malignancy present even if not the main diagnosis? Specify primary only, local or distant mets	Y/N	
Start of the Admission	**Hours**	**10 words or less comments**
Number of hours from time seen by clerking doctor to first consultant review		
In the first 24 hours:	**Yes/No**	**10 words or less comments**
Was there evidence of a clear management plan? (ie PTWR)		
Were the initial management steps appropriate? (in your judgement)		
During the admission	**Yes/No**	**10 words or less comments**
Were there any periods when the patient was not reviewed by a consultant >72 hours? If yes, how many such periods?		

General Care. During the admission that led to the patient's death did the patient have any of the following?	**Yes/No**	**10 words or less comments**
Documented patient fall?		
Documented fall resulting in significant harm (e.g. a fracture).		
Sepsis (as currently defined in the trust guideline – see appendix A)? If yes, was the sepsis pathway followed?		
Acute kidney injury? If yes, then was a medicines review carried out in a timely manner?		
Documented Learning Disability? If yes, was any note made of the patient's particular needs?		
Pressure sores at the time of admission?		
Pressure sores that developed during the admission?		
Mental capacity a) Was this assessed on PTWR? b) Was a formal mental capacity assessment described/ on ICE? b) Was a DOLS assessment appropriate and if so, was it requested?		
Escalation of care: did the following take place?	**Yes/No**	**10 words or less comments**
Was the patient transferred to Intensive Care/ High Dependency Unit?		
Was a treatment escalation plan completed on admission?		
Was a Do Not Attempt Resuscitation form completed? If yes, a) Was this documented on Anglia ICE?		

b) Is there a clear record of a discussion between a named clinician and the patient or a named relative?		
Surgery or procedure or invasive procedure (e.g. OGD, endoscopy, central venous catheter)	**Yes/No**	**10 words or less comments**
Did the patient have a surgical procedure? If yes: a) What was the investigation b) What date was the investigation c) Is there clear documentation of consent d) If yes, does the consent documentation include evidence that there was a discussion around risk vs benefits, including the do nothing option.		
Medication	**Yes/No**	**10 words or less comments**
Is there any evidence of a drug error?		
Never events	**Yes/No**	**10 words or less comments**
During admission, did any of the following Never Events occur: *Wrong site surgery* *Retained instruments* *Misplaced naso- or orogastric tube* *Inpatient suicide* *Absconding of prisoner* *In-hospital maternal death post-partum* *Administration of concentrated potassium chloride*		
End of life care	**Yes/No**	**10 words or less comments**
Was a decision made that end of life care was appropriate? If yes, *a) Were appropriate end of life care medicines prescribed?* *b) Was the patient referred to the inpatient palliative care team?* *c) Was the patient referred to the community palliative care team?* d) *Was specific advice given by palliative care specialists?*		
Organ and tissue donation	**Yes/No**	**10 words or less comments**
Is there evidence that organ and tissue donation was discussed?		

Avoidability of Death Judgement Score	
Definitely avoidable	1
Strong evidence of avoidability	2
Probably avoidable (more than 50:50)	3
Possibly avoidable but not very likely (<50%)	4
Slight evidence of avoidability	5
Definitely not avoidable	6

If concerns have been raised about care how could it have been better and what is the key learning? *(Please list, 250 words maximum)*	
SECOND REVIEW	
Additional comments by second reviewer	
M&M Meeting Review	
Senior team present	
Date of meeting	
Final CESDI Score	
Clinical concern raised	Y/N/Action (datix/feedback/ other)
Learning from case	
Method and date for sharing learning	?newsletter/ email
Action plan (if appropriate)	
Person responsible for action	
Deadline for action completed by	

Appendix 4: Structured Case Review (SCR)

National Mortality Case Record Review Programme: Structured case note review data collection

Please enter the following.

Hospital number:	
Date of Birth:	
Age at death (years):	
Gender:	M/F
Ethnicity:	
Day of admission/attendance:	
Time of arrival:	
Day of death (Date of incident) :	
Time of death	
Number of days between arrival and death:	
Month cluster during which the patient died:	Jan/Feb/Mar Apr/May/Jun Jul/Aug/Sept Oct/Nov/Dec
Specialty team at time of death:	
ICSU:	
Specific location of death:	
Type of admission:	
The certified cause of death (if known):	

Guidance for reviewers

1 Did the patient have a learning disability?

- No indication of a learning disability.

Action: proceed with this review.

- Yes – clear or possible indications from the case records of a learning disability.

Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Learning Disability Mortality Review Programme.

2 Did the patient have a serious mental health issue?

- No indication of a severe mental health issue.

Action: proceed with this review.

- Yes – clear or possible indications from the case records of a severe mental health issue.

Action: after your review, please refer the case to the hospital's clinical governance group.

3 Is the patient under 18 years old?

- No the patient is 18 years or older.

Action: proceed with this review.

- Yes – the patient is under 18 years old.

Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Child Death Review Programme.

Structured Case Review

Phase of care: **Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase. **1 = very poor care** **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care** Please circle only one score.

Phase of care: **Ongoing care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

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

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **Care during a procedure (excluding IV) cannulation)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

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

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **Perioperative care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

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

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **End-of-life care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

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

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **Overall assessment**

Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (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 rate the care received by the patient during this overall phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Please rate the quality of the patient record.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here) **Yes** ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1 **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

2 **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

3 **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

4 **Problem with infection management Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

5 **Problem related to operation / invasive procedure** *(other than infection control)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

6 **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

7 **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

8 **Problem of any other type not fitting the categories above Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239

Avoidability of death judgement score (most appropriately used at second-stage review, if required)

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 but not very likely (less than 50:50)

Score 5 Slight evidence of avoidability

Score 6 Definitely not avoidable

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

For scores of 1 or 2, you must report this as an incident on DATIX and escalate to your ICSU Leads for discussion at SIEAG. Please note, this case review represents the 72 hour report required

DATIX number		Date incident discussed at M&M (Date identified):	
Reporter name:		Reporter job title:	
Duty of Candour/Being Open Lead:		Has Duty of Candour process been completed?	
Were any junior/trainee staff involved?		Are there any safeguarding concerns? If so, contact the Adult Safeguarding Lead	
Any media interest? If so, contact the communications team		Is this externally reportable? Please Indicate who externally reported to; (i.e HSE, DoH, NHS England, CQC, Information Commissioner.)	

Provide brief chronology

Date/ Time	Description

Describe any risk mitigating action taken
