

MORTALITY REVIEW PROCEDURAL GUIDELINES (REVIEW OF INDIVIDUAL DEATHS)

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KEY CHANGES FROM PREVIOUS VERSION	Updates to processes in place	
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PROCEDURE SUMMARY		
<p>These Procedural Guidelines should be read in conjunction with the Mortality Review Policy and set out the operational processes to be followed by staff for the review of individual deaths (as per section 5 of the Policy).</p> <p>The purpose of these Procedural Guidelines is to ensure a consistent and coordinated approach for the review of deaths on an individual basis, to identify any areas of practice both specific to the individual case and beyond that could potentially be improved as well as good practice. This will enable the Trust to implement and share lessons learned and to ultimately ensure that services are as safe and effective as possible.</p>		
The Trust monitors the implementation of and compliance with this procedure in the following ways:		
<p>The Mortality Review Sub-Committee is responsible for ensuring that these Procedural Guidelines are appropriately implemented and for monitoring their effectiveness. To support the Mortality Review Sub-Committee in their monitoring of effectiveness of the processes in place, a random audit of an appropriate sample size of deaths designated as “Unexpected deaths” which are closed by the DPRG at Grade 1 review will be undertaken on an annual basis to assess the appropriateness of the definitions and associated levels (grades) of investigation assigned. An independent assessment of the quality of SI investigations within EPUT will also continue to be commissioned on an annual basis by the Executive Medical Director.</p>		
Services	Applicable	Comments
Trustwide	✓	
Essex MH&LD		
CHS		

**The Director responsible for monitoring and reviewing this procedure is the:
Executive Medical Director**

MORTALITY REVIEW PROCEDURAL GUIDELINES
(REVIEW OF INDIVIDUAL DEATHS)

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

**MORTALITY REVIEW PROCEDURAL GUIDELINES
(REVIEW OF INDIVIDUAL DEATHS)**

1.0 INTRODUCTION AND CONTEXT

- 1.1 The Chief Executive and Board of Directors are fully committed to the continuous development of a safety culture throughout the Trust, whereby the safety and health of all service users, residents, staff, carers and visitors is paramount.
- 1.2 The Trust has approved a Mortality Review Policy which sets out the framework for ensuring effective mortality review across the Trust.
- 1.3 These Procedural Guidelines should be read in conjunction with the Mortality Review Policy and set out the operational processes to be followed by staff for the review of individual deaths (as per section 5 of the Policy).
- 1.4 The purpose of these Procedural Guidelines is to ensure a consistent and coordinated approach for the review of deaths on an individual basis, to identify any areas of practice both specific to the individual case and beyond that could potentially be improved as well as good practice. This will enable the Trust to implement and share lessons learned and to ultimately ensure that services are as safe and effective as possible.
- 1.5 These Procedural Guidelines set out:
 - 1.5.1 The scope of the individual mortality review process (section 2);
 - 1.5.2 Definitions to be applied in the mortality review process (section 3);
 - 1.5.3 Protocols for notifying and recording patient deaths (attached at Annexe A);
 - 1.5.4 The processes the Trust will follow to ensure that appropriate family and carer liaison in the event of patient deaths takes place (attached at Annexe B).
 - 1.5.5 A diagrammatic representation of the process to be followed for the review / investigation of individual deaths (section 5);
 - 1.5.6 Processes to be followed for the review of individual deaths (section 6);
 - 1.5.7 A summary of national mortality review processes for certain types of death (attached at Annexe C);
 - 1.5.8 The processes to be followed by the Deceased Patients Review Group (section 7);
 - 1.5.9 The processes to be followed for Grade 2 Clinical Case Record Reviews (section 8) including mortality review pro-formas (attached at Annexes D – G); and
 - 1.5.10 The processes the Trust will follow to ensure that lessons are learnt and actions implemented (section 9).

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- 1.6 The Trust has a number of policies and procedural guidelines that have a direct impact on the mortality review process and these should be consulted and followed as appropriate. These include policies relating to the Duty of Candour and care of a deceased patient as well as the following specific policies:
- Adverse Incident (including SI) Policy and Procedure (CP3)
 - Notifying the Care Quality Commission of the Death of a Detained Patient (MHA1 / MHAPG1)
 - Whistleblowing Policy and Procedure (CP53)
- 1.7 In undertaking the investigation of a death, a large number of Trust policies may become relevant and should always be consulted. A full list of Trust policies is held on the Trust intranet.
- 1.8 The operational processes outlined in these Procedural Guidelines apply to anyone involved in the mortality review process – this includes all staff employed within the Trust either permanently or on a temporary basis and to volunteers. Specific staff responsibilities are set out in section 3 of the EPUT Mortality Review Policy.
- 1.9 As detailed above, there are nationally prescribed processes in respect of reporting and investigating certain types of deaths (e.g. homicides, child deaths and learning disability deaths). The Trust will therefore ensure that any deaths are handled through the appropriate nationally prescribed process where necessary. Guidance in such cases will be provided by the Serious Incident team.

2.0 SCOPE

- 2.1 These Procedural Guidelines for the review of individual deaths will apply to all deaths within scope for consideration of individual death review. Deaths within scope are outlined at paragraph 5.1.3 of the Trust's Mortality Review Policy.
- 2.2 The "level of scrutiny" (i.e. nature and extent of the review of each case) will be dependent on and proportionate to the circumstances of and factors relating to each specific death.
- 2.3 There are currently differences in the methods by which deaths of patients are notified and recorded within the Trust and across the NHS (a national issue recognised in the Care Quality Commission Report "Learning, Candour and Accountability – A review of the way NHS Trusts review and investigate the deaths of patients in England" December 2016). National work is now underway to address some of these challenges and the Trust will make local changes to processes in line with national work as and when required.

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- 2.4 At the current time, the Trust is using its incident reporting system (Datix) as the primary source of information for individual mortality review. Thus, all deaths within scope that have occurred within Trust provided services reported on the Trust's incident reporting system (Datix) will be subject to review at a minimum of Grade 1 (see section 6 below).

3.0 DEFINITIONS

The definitions relating to the following elements of mortality review which have been agreed for use within EPUT are outlined at section 5.2 of the Trust's Mortality Review Policy:

- Type of death
- Death due to "problem in care"
- Critical incidents
- Serious incidents

4.0 NOTIFICATION AND REPORTING OF DEATHS

- 4.1 The Notification and Recording of Deaths Protocol (attached at Annexe A) should be followed by staff for all deaths of patients under the care of the Trust at the date of their death.
- 4.2 Any unexpected death of a patient (under the care of EPUT at the time of their death or who had been under the care of EPUT within the previous 6 month period) which potentially meets Serious Incident (SI) criteria, will be notified to the Serious Incident team via Datix (or via a telephone call) in accordance with the Adverse Incident Policy. They will be referred by the SI team to the Executive Medical Director and Executive Director with responsibility for SIs for consideration and determination as to whether the death meets the criteria to be designated as a "Serious Incident". In these cases, the "Adverse Incident Policy including Serious Incidents" CP3 will then be followed to investigate the death.
- 4.3 All those deaths reported on the Trust's incident management system (Datix) within scope which have not been deemed to meet SI criteria at the initial review stage will be subject to review / investigation in accordance with the processes outlined at section 6 below.

5.0 FAMILY AND CARER INVOLVEMENT

- 5.1 The Trust is committed to engaging meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death. The principles and processes to be followed in terms of family and carer involvement after a death are detailed in Annexe B to these Procedural Guidelines (awaiting finalisation).
- 5.2 The processes for liaison with and involvement of families / carers in the event of a death deemed to be a Serious Incident under the Serious Incident Framework are outlined in detail in the Adverse Incident Policy (CP3).

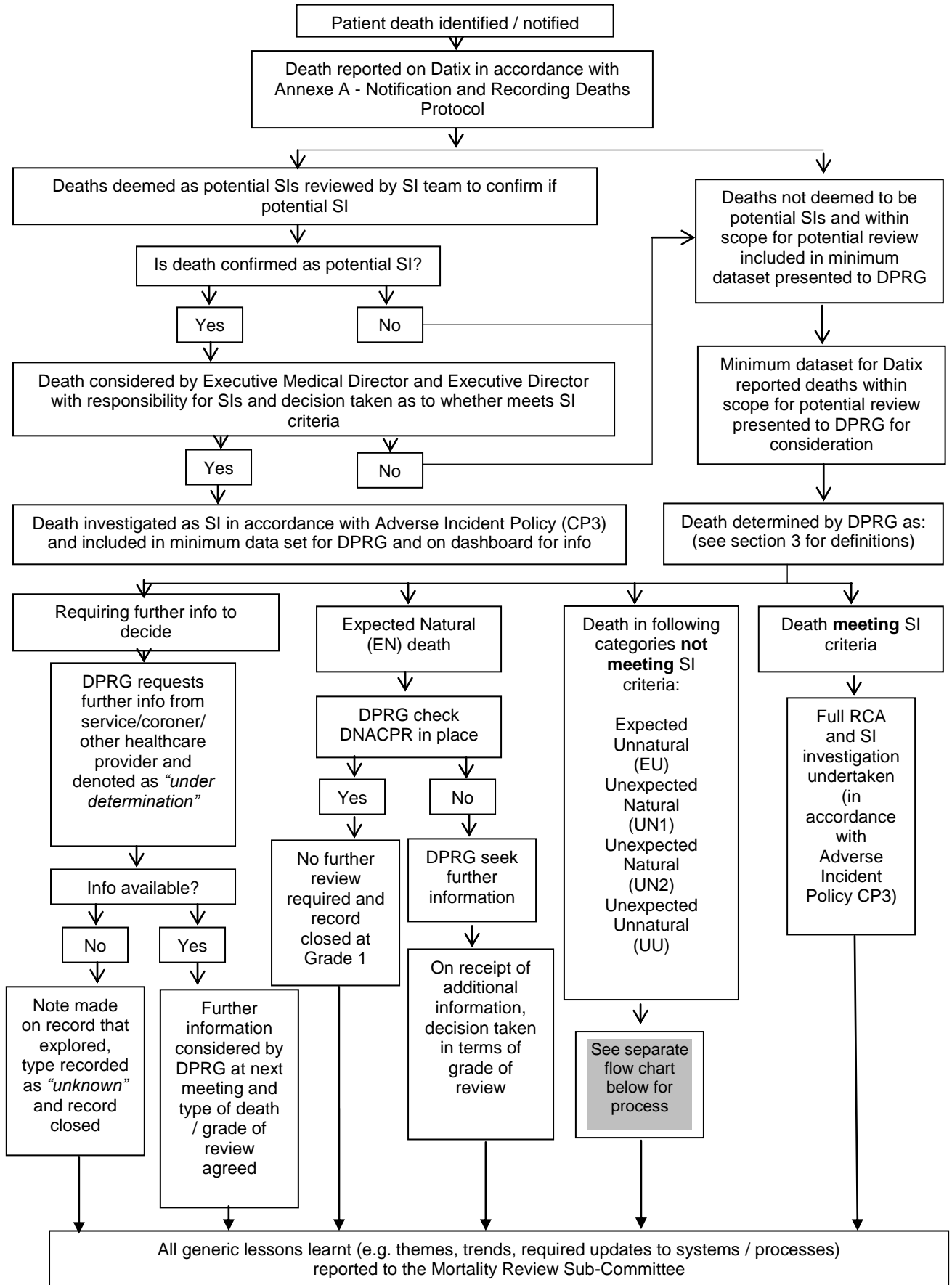
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6.0 PROCESS TO BE FOLLOWED FOR THE SCRUTINY (IE REVIEW / INVESTIGATION) OF INDIVIDUAL DEATHS

- 6.1 The following flow charts are intended to provide a diagrammatic representation of the process to be followed for the review / investigation of individual deaths in scope once they have been reported onto Datix.
- 6.2 In summary, an initial review is undertaken by the Trust's Deceased Patient Review Group (processes outlined in Section 7 below). If the Deceased Patient Review Group/s determine that further detailed review is required, deaths can be referred for a Grade 2 Clinical Case Record Review (processes outlined in Section 8 below) or for individual investigation in accordance with the Adverse Incident (including SIs) Policy (CP3). Details of the level of scrutiny this represents are included in section 7 below.
- 6.3 There are nationally prescribed processes in respect of reporting and investigating certain types of deaths which may occur within the Trust (e.g. homicides, an individual with a Learning Disability or Mental Health Needs (Detained or Prison) and an infant or child death).
- 6.4 The Serious Incident Team will be responsible for identifying where a death reported on Datix falls within one of these categories and will ensure that the nationally prescribed processes applicable at that time are appropriately fulfilled by the Trust. Details of background information and nationally prescribed processes are appended as follows to the National Guidance on Learning from Deaths (link to national guidance at Section 9 of the Mortality Review Policy):
- Annexe D – Learning Disabilities
 - Annexe E – Mental Health
 - Annexe F – Children and Young People
- A summary of the requirements is attached at Annexe C to these Procedural Guidelines.
- 6.5 The fact that the death falls within the scope of one of the nationally prescribed processes will be recorded on Datix and thus reported to the Deceased Patient Review Group for consideration of internal actions and assurance to the Mortality Review Sub-Committee.

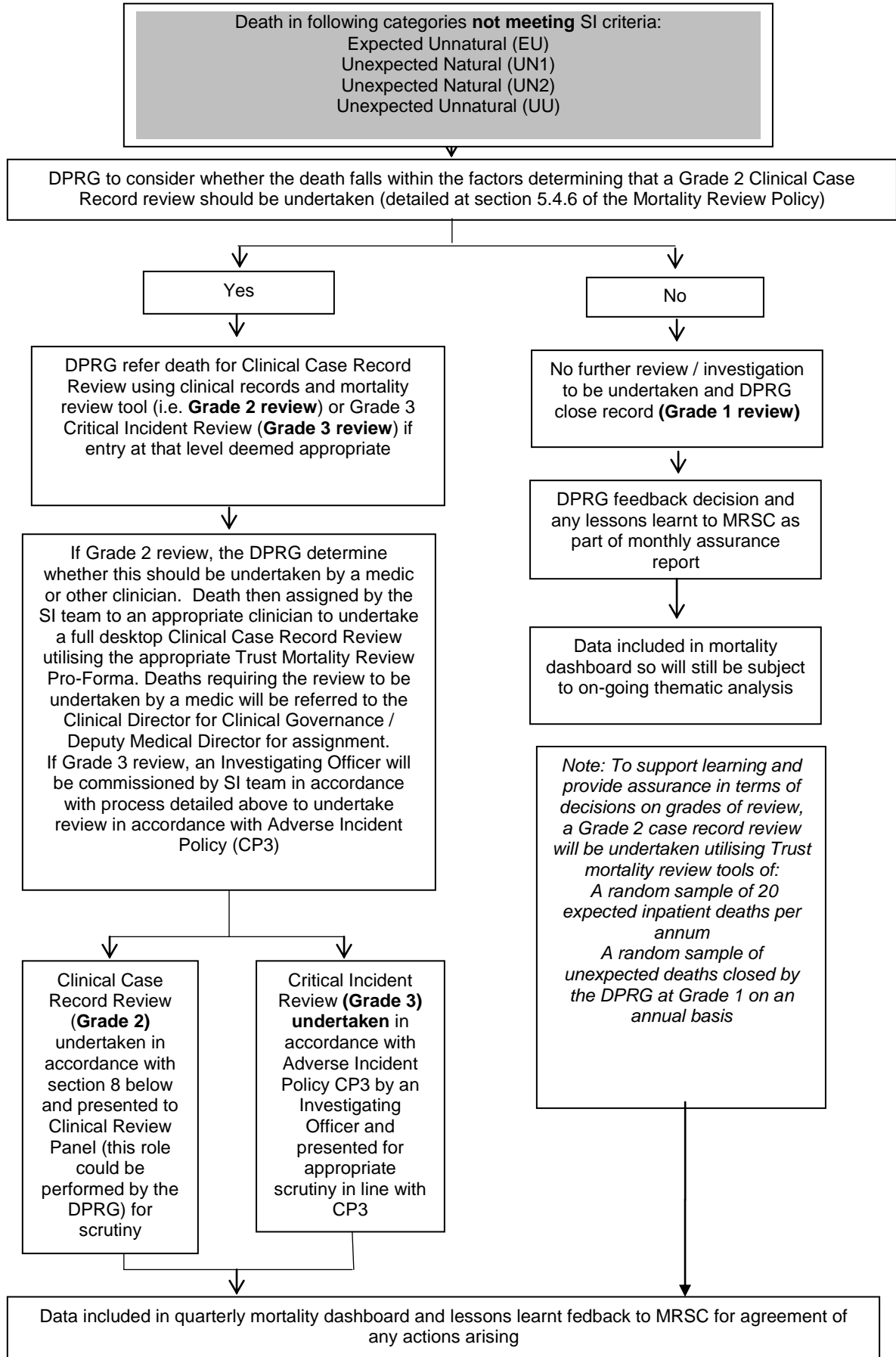
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FLOWCHART 1 – SUMMARY OF PROCESSES TO BE FOLLOWED FOR THE REVIEW OF INDIVIDUAL DEATHS REPORTED ON DATIX



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FLOWCHART 2 – PROCESSES TO BE FOLLOWED FOR THE REVIEW OF INDIVIDUAL DEATHS REPORTED ON DATIX WITHIN SCOPE FOR POTENTIAL INDIVIDUAL REVIEW



7.0 PROCESSES TO BE FOLLOWED BY DECEASED PATIENTS REVIEW GROUP

7.1 Section 5.4 of the Mortality Review Policy sets out the process to be followed to provide the Deceased Patient Review Group (DPRG) with information for review in terms of deaths. A minimum dataset will be provided to the DPRG for each death falling within the scope for individual review (scope detailed at section 5.1.3 of the Mortality Review Policy).

7.2 The DPRG will review the information provided to it for each death in scope and initially determine the type of death in accordance with the definitions in section 5.2 of the Trust's Mortality Review Policy. Dependent on the type of death, they will then take action as follows:

7.3 Type of death – EXPECTED NATURAL (EN)

7.3.1 The DPRG will check that the patient was on an end of life care pathway and that there is a DNACPR in place (part of the minimum dataset).

7.3.2 If there is, no further investigation will be undertaken and the record will be closed on Datix. This will be referred to as a *Grade 1* review.

7.3.3 If there is no DNACPR in place, the DPRG will seek further information prior to making a decision in terms of the appropriate grade of investigation required. The relevant paragraphs below will then be followed.

7.4 Type of death – EXPECTED UNNATURAL (EU), UNEXPECTED NATURAL (UN1), UNEXPECTED NATURAL (UN2), UNEXPECTED UNNATURAL (UU)

7.4.1 Any deaths in the above categories deemed as potentially meeting the criteria for a Serious Incident (SI) should already have been referred to the Executive Medical Director / Executive Director with responsibility for SIs for determination as to whether a full Root Cause Analysis and SI Investigation should be undertaken in accordance with the Adverse Incident Policy (CP3). This will be denoted on the dataset provided to the DPRG. All deaths of detained patients will be automatically subject to a full Root Cause Analysis and SI Investigation in accordance with the Adverse Incident Policy (CP3). An SI investigation will be recorded as a *Grade 4* review.

7.4.2 The DPRG will determine the grade of review / investigation required for all remaining deaths based on a number of agreed factors as detailed in section 5.4 of the Mortality Review Policy.

7.4.3 If the DPRG considers that (based on the circumstances of the death) there is no requirement for further investigation, they will close the record on Datix. This will be referred to as a *Grade 1* review.

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7.4.4 If the DPRG considers that there is a requirement of further review/investigation, the DPRG will refer the death for an appropriate level of review (which will be dependent on the circumstances of each individual case) in line with the Mortality Review Policy. The grades of review/investigation available for consideration are as follows:

Grade 1: Desktop review by DPRG and decision taken to close (as detailed above).

Grade 2: Detailed desktop clinical case record review undertaken by an appropriate clinician using the appropriate Trust mortality review tool and clinical records. Please see section 8 below for details of this process.

Grade 3: Full Critical Incident Review by an Investigating Officer (as per the Adverse Incident Policy CP3).

Grade 4: Full Root Cause Analysis and SI investigation by an Investigating Officer (as per the Adverse Incident Policy CP3).

7.4.5 If the DPRG determines that a Grade 2 review is required, the DPRG determine whether this should be undertaken by a medic or other clinician. The death will then assigned by the SI team to an appropriate clinician to undertake a full desktop Clinical Case Record Review utilising the appropriate Trust Mortality Review Pro-Forma. Deaths requiring the review to be undertaken by a medic will be referred to the Clinical Director for Clinical Governance / Deputy Medical Director for assignment. If the DPRG determines that a Grade 3 review is required, an Investigating Officer will be commissioned by SI team (in accordance with the process detailed above) to undertake review in accordance with Adverse Incident Policy (CP3). The record on Datix will be updated accordingly.

7.4.6 A monthly assurance report will be provided from the DPRG to the Mortality Review Sub-Committee informing members of the number of deaths that have been closed each month at Grade 1 or referred for Grade 2 or 3 review.

7.4.7 Any recommendations for an investigation under Grade 4 (SI) will require the approval of the Executive Medical Director and Executive Director with responsibility for SIs in accordance with the SI framework. The record on Datix will be updated accordingly.

7.5 Type of death – UNKNOWN (unable to obtain information from coroner / other health care provider to determine type of death)

7.5.1 In some cases, the DPRG may determine that they are unable to make a decision based on the information available and that further information is required from within the Trust, another healthcare provider or the coroner.

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- 7.5.2 Where this is the case, the DPRG will request the information required and make a record on Datix that further information is awaited.
- 7.5.3 Any further information received will be considered at the next available meeting of the DPRG and consideration given to the appropriate grade of review, as detailed above.
- 7.5.4 Where no further information is forthcoming and all avenues exhausted in the view of the DPRG, the type of death will be recorded as "Unknown" on Datix. A note will also be made on the Datix record by the DPRG that information has been requested but not secured, no further investigation will be undertaken and the record will be closed.
- 7.6 Whilst the paragraphs above detail the grade of review / investigation usually undertaken in given circumstances, the DPRG or Mortality Review Sub-Committee may legitimately decide to undertake a review / investigation at a different grade if considered appropriate.
- 7.7 The grade of review / investigation undertaken for each death will be included in the summary dashboards analysed by the Mortality Review Sub-Committee to ensure that an overview can be maintained of grades of review / investigation undertaken and assurance provided that all deaths are appropriately investigated.
- 7.8 To this end, the Datix records will be updated as quickly as possible after the meeting of the DPRG in order to ensure timely update of the mortality data dashboard.

8.0 PROCESSES TO BE FOLLOWED FOR GRADE 2 CLINICAL CASE RECORD REVIEWS

- 8.1 Where the DPRG considers that a more detailed review is required of a death, with access to clinical records, they may decide to refer a death to an appropriate clinician to undertake a Grade 2 clinical case record review under the above framework. This clinician will ideally be an individual with appropriate knowledge of the clinical area but who was not involved in the care of the deceased patient.
- 8.2 The clinician undertaking the Grade 2 review will have access to the full EPUT clinical records (electronic and paper) of the deceased patient for reference during the review.
- 8.3 The reviewer will review the clinical records and complete the appropriate Mortality Review Form (see paragraphs below) attached at Annexe D, Annexe E, Annexe F and Annexe G.
- 8.4 The Mortality Review Form at **Annexe D** should be used for any deaths that occur whilst the individual is an **in-patient within EPUT Mental Health / Learning Disability Services**.
- 8.5 The Mortality Review Form at **Annexe E** should be used for any deaths that occur in the community of patients under the care of **EPUT Community Mental Health Services or Learning Disabilities** at the date of death.

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- 8.6 The Mortality Review Form at **Annexe F** should be used for any deaths that occur whilst the individual is an **in-patient within EPUT Community Health Services**.
- 8.7 The Mortality Review Form at **Annexe G** should be used for any deaths that occur in the community of patients under the care of **EPUT Community Health Services** at the date of death.
- 8.8 The reviewer will make a judgement based on their review of the clinical records in terms of the following:
- Any lessons learnt;
 - The extent to which the death was due to “problems in care” provided by EPUT – see paragraph 8.9 below; and
 - Whether the case should be closed or referred for further investigation under Grade 3 or Grade 4 (refer to section 7 above for the definitions of the Grade).
- 8.9 The reviewer will use the mortality review tool structured questions to assist them in making a decision in terms of the extent to which the death was due to “problems in care” provided by EPUT on the scale of 1 – 6. There is a section of the mortality review tool dedicated to this decision. The scale used by the Trust is:
- 1 - Death **definitely more likely than not** to be due to problems in care provided by EPUT.
 - 2 - **Strong evidence** – i.e. significantly more than 50:50 – that death more likely than not to be due to problems in care provided by EPUT.
 - 3 - **Probably likely** – i.e. more than 50:50 – that death due to problems in care provided by EPUT.
 - 4 - **Not very likely** – i.e. less than 50:50 – that death due to problems in care provided by EPUT.
 - 5 - **Slight evidence** – i.e. significantly less than 50:50 – that death could be due to problems in care provided by EPUT.
 - 6 - Death **definitely less likely than not** to be due to problems in care provided by EPUT.
- 8.10 The reviewer will usually aim to complete their review within 6 weeks of the request to undertake. The outcomes of the Grade 2 review, in the form of the completed Mortality Review Form, will be presented by the reviewer to a Clinical Review Panel. The role of the Clinical Review Panel is to subject the review to scrutiny in terms of robustness and assess whether they concur with the conclusions and recommendations made by the reviewer.

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- 8.11 Clinical Review Panels will be established on an “as and when required” basis and may if appropriate form part of regular DPRG meetings. There will usually be a minimum of three core members of a Clinical Review Panel ideally as follows:
- Chair (from Quality / SI team)
 - Appropriate Consultant (ideally not involved directly in the care of the deceased patient/s under review but with an understanding of the service area/s in which the death/s occurred)
 - Pharmacy representative

For reviews in Community Health Services, a Senior Nurse (usually a Matron) will also usually be a member of the Clinical Review Panel.

Others expert members may be co-opted onto Clinical Review Panels as required dependent on the circumstances of the patient death/s under consideration.

- 8.12 The Clinical Review Panel will complete the final section of the Mortality Review Form to record their conclusions and will, via the Chair, make their recommendations to the MRSC in terms of lessons learnt, extent of any “problems in care” and recommended action through presentation of the findings and recommendations of the completed Mortality Review Form (not detailed clinical information) to the next available MRSC meeting. The agreement in terms of an appropriate “problems in care” score to assign can be made via a Panel meeting or virtually by a Panel using email where necessary.
- 8.13 The Quality / SI team member on the Clinical Review Panel will provide the appropriate information to the SI team to enable them to update Datix accordingly and a copy of the completed Mortality Review Form will be attached to the Datix report of the death. The Quality / SI team will also retain the completed Mortality Review Forms for all cases.
- 8.14 Should the Grade 2 review determine that the overall quality of care was “poor” or “very poor” or assign a “problems in care” score of 1- 3, the death will automatically be referred for a Critical Incident Review (Grade 3) or Serious Incident investigation (Grade 4) as appropriate.
- 8.15 It should be noted that work is still on-going nationally to agree a national methodology and approach to case note reviews for mental health and community health deaths which it is hoped will be launched in late 2018. The Trust will therefore keep abreast of national developments and adapt processes accordingly.

9.0 LESSONS LEARNT

- 9.1 The CQC Report “Learning, Candour and Accountability” (December 2016) identified that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvement were not being identified.
- 9.2 To encourage a culture of continuous learning and service improvement, opportunities should be provided (irrespective of any formal review or investigation) by managers for staff within Ward / Team meetings and individually in 1:1 meetings to reflect on the care provided to people who have died and any learning from this to inform their practice and the way that care is organised.
- 9.3 As detailed in the sections above, the purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. This will include what may need to change in service provision in order to reduce the risk of future occurrence of similar events.
- 9.4 Research has shown that, when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems none of which would be likely to have caused the death in isolation but which in combination can contribute to the death of a patient. Some of these elements of care may have occurred prior to admission and Trusts are therefore required to support other organisations (for example in primary care) to understand and act on areas where care could be improved in the future.
- 9.5 Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon. The Chair of the DPRG and of Clinical Review Panels will ensure that all learning from mortality reviews undertaken by the DRPG and by Clinical Review Panels will be feedback to the clinical lead in the service area in which the death occurred (including sharing a copy of the completed Mortality Review Form for the death). The outcomes and learning should be shared by the clinical lead at relevant team meeting/s as soon as possible to ensure local learning and agreement of any local actions required.
- 9.6 Themes of any lessons learnt from individual mortality reviews will be feedback to the Mortality Review Sub-Committee as part of the monthly assurance report from the DPRG and reports from Clinical Review Panels as detailed above. Any thematic learning from Critical and Serious Incident Reviews related to deaths will also be reported to the Mortality Review Sub-Committee, as well as learning from thematic reviews commissioned by the Mortality Review Sub-Committee.
- 9.7 Recommendations within any “Regulation 28 Report on Action to Prevent Future Deaths” from the Coroner will also be reported to the Mortality Review Sub-Committee in order to ensure that these are integral to the Trust’s systems to support learning within and across the organisation and with local system partners.

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- 9.8 Any organisational lessons learnt arising from any of the above will be considered by the Mortality Review Sub-Committee and appropriate actions agreed. The Mortality Review Sub-Committee will, where appropriate, provide a report of lessons learnt to the Learning Lessons Oversight Sub-Committee for consideration.
- 9.9 Established organisational processes for onward sharing and acting on organisational lessons learnt within the Trust will be followed for mortality review. These are outlined in detail in Section 15 of the Trust's Adverse Incident Policy and Procedural Guidelines (CP3). This will include publication in Trust written communications, discussion at team meetings etc.
- 9.10 Any potential local system learning identified (included as at paragraph 9.4) will be reported to appropriate links in the other organisations concerned by the Mortality Review lead and will also be reported to the CCG for system wide learning.

10.0 IMPLEMENTATION

- 10.1 These procedural guidelines will be implemented and reinforced by the following means:
- Formal induction of new staff at corporate and local level.
 - Appropriate training and exercise of duties of staff, team leaders and managers to support effective mortality review.
 - Ongoing review of death reporting, investigation, action and learning at local, directorate and Trust level through normal governance and risk management processes.
 - Resources on the Trust intranet.
 - Trust communications such as Team Brief and Trust Today.
 - Advice and support from the Quality and Governance Team, Serious Incidents Team and Risk Management Team.
 - Oversight by the CCG and where appropriate regional groups of the Trust's mortality review process and reporting.

11.0 MONITORING AND REVIEW

- 11.1 The Mortality Review Sub-Committee is responsible for ensuring that these Procedural Guidelines are appropriately implemented and for monitoring their effectiveness.
- 11.2 To support the Mortality Review Sub-Committee in their monitoring of effectiveness of the processes in place, a random audit of an appropriate sample size of deaths designated as "Unexpected deaths" which are closed by the DPRG at Grade 1 review will be undertaken on an annual basis to assess the appropriateness of the definitions and associated levels (grades) of investigation assigned. The relevant Mortality Review Form will be completed for the cases with a view to determining whether it was appropriate to close the case without further review. The outcomes of these audits will be presented to the Mortality Review Sub-Committee.

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- 11.3 An independent assessment of the quality of SI investigations within EPUT will also continue to be commissioned on an annual basis by the Executive Medical Director.
- 11.4 These Procedural Guidelines will be kept under regular review by the Mortality Review Sub-Committee. They will be formally reviewed on an annual basis by the Mortality Review Sub-Committee (or earlier if required).
- 11.5 Any amendments to these Procedural Guidelines will be presented to and approved by the Mortality Review Sub-Committee.

ATTACHMENTS:

- ANNEXE A:** Notification and Recording of Deaths Protocol
- ANNEXE B:** Family and Carer Involvement Protocol
- ANNEXE C:** Summary of national processes for mortality review of certain types of death
- ANNEXE D:** Mortality Review Tool – MHS/LD In-patient Death
- ANNEXE E:** Mortality Review Tool – MHS/LD Community Death
- ANNEXE F:** Mortality Review Tool – CHS In-patient Death
- ANNEXE G:** Mortality Review Tool – CHS Community Death

DATE APPROVED BY MORTALITY REVIEW SUB-COMMITTEE FOR IMPLEMENTATION: October 2018

END
