

**ANNEXE C – SUMMARY OF NATIONALLY DEFINED  
MORTALITY REVIEW PROCESSES**

**1.0 INTRODUCTION**

- 1.1 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).
- 1.2 The SI 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: <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>):
- Annex D – Learning Disabilities  
Annex E – Mental Health  
Annex F – Children and Young People
- 1.3 The following sections provide a brief summary of the national processes, as taken from the national guidance.
- 1.4 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.

**2.0 LEARNING DISABILITIES (ANNEX D OF NATIONAL GUIDANCE)**

- 2.1 The lives of people with learning disabilities often involve a complex array of service provision with multiple care and support staff. If the NHS is to improve service provision for people with learning disabilities and their families, and reduce premature deaths, we need to look wider than NHS-related circumstances leading to a person's death, in order to identify the wider range of potentially avoidable contributory factors to their death. A cross-sector approach to reviewing deaths of people with learning disabilities is imperative: one that includes families, primary and secondary healthcare, and social and third sector care providers. Such a balanced approach across acute and other settings is needed from the outset of a review process, in order to accurately determine if there are any concerns about the death, or to identify examples of best practice that could lead to service improvement.

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- 2.2 The national Learning Disabilities Mortality Review (LeDeR) programme has therefore been put in place, commissioned by Healthcare Quality Improvement Partnership (HQUIP) for NHS England. Once fully rolled out, the programme will receive notification of all deaths of people with learning disabilities and support local areas to conduct standardised independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age. These will be undertaken by trained reviewers.
- 2.3 The purpose of the local reviews of death is to identify any potentially avoidable factors that may have contributed to the person's death and to develop plans of action that individually or in combination will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.
- 2.4 The Trust has in place systems to identify the death of any patient with recorded learning disabilities. These deaths are automatically included within the Trust's mortality data dashboard and are referred to the Deceased Patient Review Group for consideration.
- 2.5 All deaths of patients with recorded learning disabilities, whether they be in-patient or community based, will be automatically referred by the Deceased Patient Review Group for review utilising the LeDeR initial review process documentation and referral to the national programme.
- 2.6 All deaths of people with recorded learning disabilities are notified to the national programme. The process for referral will be managed by the SI team.
- 2.7 Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer.
- 2.8 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 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.
- 2.9 A full multi-agency review is required if the criteria for the current themed priority review are met (death of a person from a Black and Minority Ethnic background or aged 18 – 24), or where an assessment of the care received by the person indicates deficiencies in one or more significant areas.
- 2.10 A full-multi agency review is recommended if there have been any concerns raised about the death, if any "red flag alerts" have been identified in the initial review or if the reviewer thinks that a full multi-agency review would be appropriate.

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- 2.11 The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.
- 2.12 Governance structures that can support the cross-agency implementation of recommendations from mortality reviews are required at all levels but in particular for the reviews of deaths of people with learning disabilities. Such structures exist in the form of regional steering groups for the LeDeR programme.
- 2.13 In summary, key points for providers to note are:
- All deaths of people with learning disabilities aged four years and older are subject to review using LeDeR methodology;
  - The LeDeR programme is being rolled out across England. It has been rolled out in the region covering EPUT.
  - If there is a death of a person with learning disabilities in an acute setting in an area that is not yet covered by the LeDeR programme, Trusts are recommended to use the Structured Judgement Review (SJR) process or a methodology of equivalent quality that meets the requirements for the data that must be collected as an interim measure.
  - Trusts wishing to complete their own internal mortality review are recommended to use the LeDeR initial review process and documentation; and then submit this as an attachment to the LeDeR notification web-based platform once their internal review is completed.
  - Once the LeDeR review has been completed, a copy will be sent to the relevant governance body at the Trust where the death occurred.
  - Trusts have been encouraged to identify appropriate personnel to undertake LeDeR training and review processes. Reviewers are expected to conduct reviews independent of the Trust in which they work.

### **3.0 MENTAL HEALTH (ANNEX E OF NATIONAL GUIDANCE)**

#### **Inpatients detained under the Mental Health Act**

- 3.1 Regulation 17 of the Care Quality Commission (Registration) Regulations 2009 requires 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. The Trust has the following processes in place to ensure this requirement is fulfilled:

The Mental Health Act Department inform the CQC.

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- 3.2 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. The Trust has the following processes in place to ensure this requirement is fulfilled:

Contact is made with the coroner's office in regards to relevant patients and liaison is undertaken through the SI office to supply reports and witnesses as required. Support is given to staff who are requested to attend Coroner's inquest via the SI team.

Trusts 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). The Trust has the following processes in place to ensure this requirement is fulfilled:

A Root Cause Analysis investigation is undertaken in accordance with the Adverse Incident Policy and Procedure.

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

The Trust has the following processes in place to ensure this requirement is fulfilled:

This is undertaken in accordance with the Adverse Incident Policy and Procedure in line with the national Serious Incident Framework.

### **People with Mental Health Disorders in Prisons**

- 3.4 The national Serious Incident Framework states that in prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations.
- 3.5 Healthcare providers must fully support these investigations where required to do so. The PPO has clear expectations in relation to health involvement in PPO investigations into death in custody. Guidance published by the PPO – <https://www.ppo.gov.uk/news/updated-guidance-for-clinical-reviews/> - must be followed by those involved in the delivery (and commissioning) of NHS funded care within settings covered by the PPO. The Trust, via operational team and SI team, would undertake a Root Cause Analysis investigation and support the PPO, ensuring that the Trust complies with the requirements of this guidance and any related investigation.

<b>4.0 CHILDREN AND YOUNG PEOPLE (ANNEXE F OF NATIONAL GUIDANCE)</b>
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- 4.1 In child mortality review, professionals have moved away from defining “avoidability” to instead using the language of “a preventable death” where the latter is defined as a death in which “modifiable factors may have contributed to the death and which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths”.
- 4.2 Since 1<sup>st</sup> April 2008, Local Safeguarding Children’s Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The relevant legislation underpinning such responsibility is enshrined in the Children’s Act 2004 and applies to all children under 18 years of age.
- 4.3 The processes to be followed when a child dies are described in Chapter 5 of the statutory guidance document “Working Together to Safeguard Children”.
- 4.4 The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children and to prevent future deaths.
- 4.5 “Working Together to Safeguard Children” describes two interrelated processes which are undertaken on a local basis:
- i. a “Rapid Response” multi-professional investigation of an individual unexpected death; and
  - ii. a Child Death Overview Panel (CDOP) review of all deaths in a defined geographical area. The purpose of the CDOP is to establish the exact cause of death, identify patterns of death in community and remedial factors, and to contribute to improved forensic intelligence in suspicious deaths. The family should be kept central to the process.
- 4.6 The actions taken by the Trust to contribute to these local processes are outlined in the Safeguarding Children Procedures (CLPG 37) Appendix 10. *Please note: at the time of updating this Annex C, CLPG 37 Appendix 10 is being updated to reflect newly released Child Death Review Statutory and Operational Guidance published in October 2018.*
- 4.7 **National Child Mortality Programme**
- 4.7.1 NHS England is undertaking a national review of child mortality review processes both in the hospital and community. A key aim is to make the process easier for families to navigate at a very difficult time in their life. Central to the programme is the creation of a National Child Mortality Database which was, at the time of writing the national guidance on Learning from Deaths, being commissioned. The Child Death Review Statutory and Operational Guidance published in October 2018 indicates that the database is due to go live on 1<sup>st</sup> April 2019.

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4.7.2 The goals of the NHS England's child mortality review programme are to:

- Establish, as far as possible, the cause or causes of each child's death;
- Identify any potentially contributory or modifiable factors;
- Provide on-going support to the family;
- Ensure that all statutory obligations are met;
- Learnt lessons in order to reduce the risk of future child deaths;
- Establish a robust evidence base to inform national policy across government to reduce avoidable child mortality across the UK nations.

4.7.3 Since publication of the National Guidance on Learning from Deaths, Child Death Review Statutory and Operational Guidance has been published by the Cabinet Office (October 2018). Trust processes are being adapted to ensure implementation of this guidance. A full copy of the guidance can be found at [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/747995/Child\\_death\\_review\\_statutory\\_and\\_operational\\_guidance\\_England.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/747995/Child_death_review_statutory_and_operational_guidance_England.pdf). The SI team and Safeguarding team will provide advice and guidance on implementation of the guidance within EPUT.

4.8 Trust Boards should ensure that learning is derived from the care provided to children who die, by the appropriate application of the child mortality review process, and that learning is shared and acted on.

4.9 Particular attention should be paid to the deaths of children and young people with learning disabilities or mental health conditions as these present with frequent co-morbidities and are often a more vulnerable group. The National Child Mortality Review Programme is working close with the Learning Disabilities Mortality Review (LeDeR) programme and also aims to align itself with the Children and Young People's (CYP) Mental Health Programme and Specialised Commissioning particularly with regard to deaths in Tier 4 inpatient CAMHS units. It will also work closely with the National Programme on Suicide in Young People.

4.10 The processes followed by the Trust in terms of child deaths are outlined in Safeguarding Children Policy CLPG 37 Appendix 10 – Procedure for Unexpected Child Death Review process. This sets out staff responsibilities, feedback to relatives and identifying and implementing lessons learned.

*Please note: at the time of updating this Annexe C, CLPG 37 Appendix 10 is being updated to reflect newly released Child Death Review Statutory and Operational Guidance published in October 2018.*

### **5.0 HOMICIDES**

5.1 In the event of a homicide, the Trust will report as a Serious Incident and complete a Root Cause Analysis, linking with NHS East of England. The Trust must await police confirmation that it is allowed to investigate.

5.2 The Trust's Adverse Incident Policy and Procedure and national Serious Incident Framework will be followed.

**6.0 GUIDANCE AND ADVICE**

6.1 Guidance and advice in terms of the learning disabilities, mental health and homicide deaths can be obtained from:

Trust Serious incident team – [REDACTED]  
[REDACTED]

Trust Safeguarding team – [REDACTED]

**7.0 PROTOCOL REVIEW**

7.1 Any amendments to this protocol will be submitted to the Mortality Review Sub-Committee for approval.

**APPROVED BY THE MORTALITY REVIEW SUB-COMMITTEE: October 2018**

**REVIEW: October 2020**

**END**