Leicestershire Partnership NHS Trust

Learning from Deaths Policy

This policy sets out the Trust's expectations against the expected requirements from NHSE National Quality Board 'National Guidance on learning from Deaths': A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (2017).

The purpose of this Policy is to set out how the Trust will ensure that it processes, responds to and shares learning from deaths of patients where the Trust is the main provider of healthcare. This includes the scope of review for deaths and how the Trust ensures that learning is identified and shared. This will also include looking at how the Trust improves upon and promotes learning when it comes to supporting the bereaved families and carers.

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Contents

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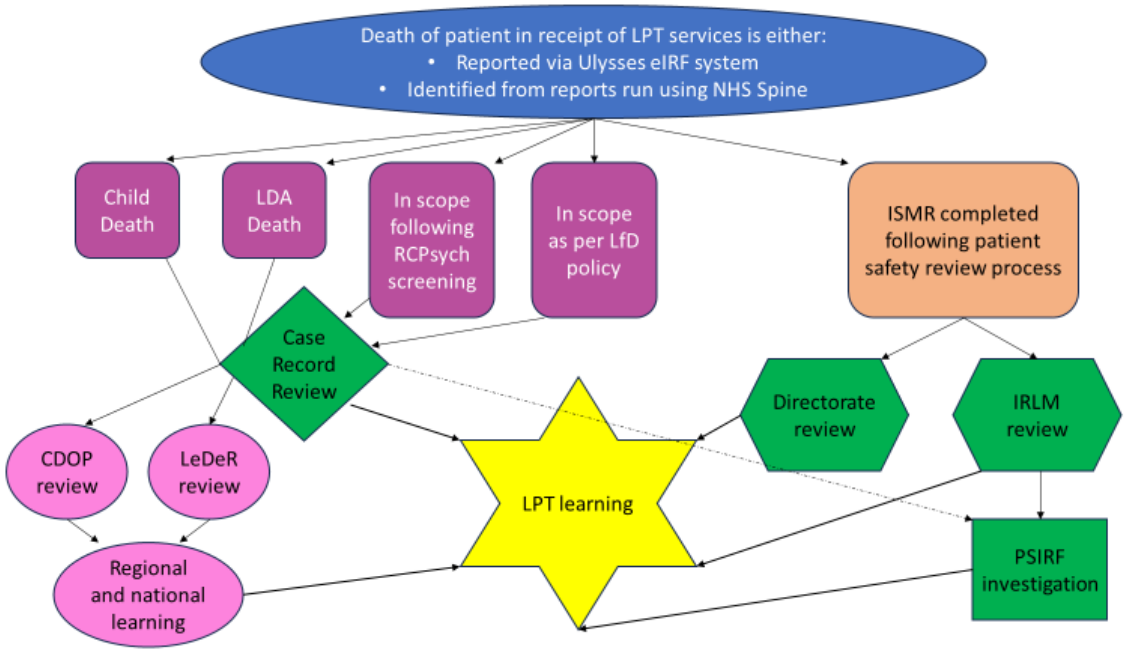
This policy has been written to help identify, share and spread learning across organisations to facilitate a culture of continuous learning and development based on *Implementing the Learning from Deaths framework: key requirements for trust boards, July 2017.*

The aim is to encourage learning, take on board opportunities for learning and improve on how the Trust collaborates with and involves families and carers of those who die in our care.

It is aimed at all healthcare professionals and staff involved with mortality reviews or learning from deaths and bereaved families and carers.

Staff involved in learning from deaths reviews will require training in completing Case Record Reviews.

The policy covers; the Trust's review of deaths process including which deaths are in scope for review; how the Trust compassionately engages with bereaved families and carers to support them to be involved in learning reviews; the changes with the Medical Examiner (ME) role that occurred in September 2024.



1. Introduction and Purpose

The Learning from Deaths Policy was first introduced in 2017, following the Mid-Staffordshire enquiry, whereby it was noted that when reviewing hospitals with the highest mortality, practical steps to help reduce avoidable deaths were being overlooked (National Quality Board, 2017).This was further reinforced through the findings in 2016 of the Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England, which demonstrated missed opportunities when learning from deaths, due to insufficient prioritisation from some organisations. Furthermore, there was a need to engage families and carers more, within the process, to help support further learning.

Following the recommendations made from this report, in a parliamentary statement from the Secretary of State, additional responsibilities were placed upon Trusts to ensure that they demonstrate learning when reviewing patients who have died within their care (Department of Health and Social Care and The Right Honourable Hunt MP, 2016). This consists of quarterly publications of specified information on deaths that were possibly avoidable and serious incidents alongside evidencing the learning and action that will ensue in response to this information. Alongside providing an annual report of this information within Quality Accounts, including actions taken during the preceding year, it's impact and actions intended for the year ahead.

A National Guidance on Learning from Deaths was therefore introduced to help provide a standardised approach (National Quality Board, 2017). To help determine which deaths to examine and how, as well as defining the various degrees of avoidable deaths, whilst allocating sufficient time and resources to allow for this and providing directorates within teams and Trust boards direction in how they must utilise their findings (National Quality Board, 2017). Trust boards were therefore accountable at ensuring they acted in accordance with this guidance alongside that of the Serious Incidents Framework (2015), which in August 2022 was replaced with Patient Safety Incident Response Framework (PSIRF), altering the way the NHS responds to patient safety incidents, by taking a more considered systems-based approach (NHS England, no date).

Each Trust was required to have a policy by September 2017, that sets out how they respond to the deaths of patients within their care, which is detailed within the next section.

This policy informs the organisation of staffs' roles and responsibilities relating to learning from deaths and promotes a culture of learning. The Trust requires all staff to be open, honest, and transparent about reporting deaths and for

engaging with families and carers, actively enabling them to ask questions about care and identify if care can be improved.

The Royal College of Psychiatrists (RCPsych), in November 2018, launched national guidance for NHS Mental Health Trusts to improve the way services learned from patient deaths. This guidance focuses on patients with a severe mental illness and includes four 'red flag' scenarios (Royal College of Psychiatrists, 2018). Part of this national guidance is made up of a Care Review Tool, which had been developed by the Colleges Centre for Quality Improvement, at the request of and funded by NHS England. This tool is based on the Structured Judgement Review (SJR) methodology, originally developed by the Royal College of Physicians, and is appropriate for use by mental health trusts to support mortality reviews for patients who had been under their care and can be adapted to use jointly by both mental health and community trusts (Royal College of Psychiatrists, no date).

The principles behind these mortality reviews are to ensure that all deaths are appropriately reviewed to consider whether there is a capacity for further learning; to create an environment of openness and transparency, rather than blame, to aid learning when deaths are reviewed; that SJR are completed for deaths that require further review; and where possible, to involve families and those with whom the deceased was close to, within the review process. The Trust uses a locally designed template, the Learning from Deaths Quality Safety Review (LfD QSR) form, in place of the Royal College of Physicians SJR methodology. Please refer to Appendix Three to view this form. This tool is under review and may be adapted after this policy is published.

Directorate of Mental Health (DMH) follow the first stage of the RCPsych Care Review Tool, with the first stage including a form to complete as soon as possible after a patient's death, comprising of patient details and the four 'red flag' scenarios which would prompt further investigation. These 'red flags' include patients;

- where families, carers or staff have raised concerns about the care that had been provided;
- with a diagnosis of an eating disorder or psychosis who had been under the care of the services at the time of their death or had been discharged 6 months prior to their death;
- who were an in-patient within a mental health unit at the time of their death or had been discharged within the last month;
- who were under the care of the Crisis Resolution and Home Treatment Team at the time of their death.

If any of these 'red flags' apply, this would then be followed by a further review from an experienced clinician, rating the care received and concluding within 60 days of this patient's death having been reported. The aim of this tool is to help Trusts screen all patient deaths in mental health services which meet the essential criteria in addition to reviewing a sample of other deaths, through having completed forms, to analyse themes of areas where there has been good care that can be further

developed and areas which require further improvement. Another part of this guidance helps to inform trusts on how to respond to concerns raised by families and carers about the care received by their loved ones (Royal college of Psychiatrists, 2018).

Within LPT, learning from a review about the care provided to patients who die in our care is integral to the trust's governance and quality improvement work.

2. Policy Requirements and Objectives

When responding to deaths, the National standards which have been set, for Trusts to adhere to include how providers (National Quality Board, 2017):
3.1 - establish the review process within which patient deaths are regarded as being under their care and are to be included within case record review, referred to as 'in-scope' (whilst also stating which patients are to be excluded, referred to as 'out of scope')
3.2 - register deaths within their organisation as well as inform other interested organisations, including persons GP, and how this is determined.
3.3 - act in response to the deaths of those individuals with for example, mental health needs, learning disability, an infant or child aged under the age of 18 years, a stillbirth or maternal death, including the processes involved in supporting these deaths
3.4 - are to review the deaths of those patients which they do not consider having been under their care, but another organisation recommends that they review the care that had been provided for that patient in the past
3.5 - review the care that had been provided for patients whose death may have been expected, such as for those receiving end of life care for example
3.6 - document the outcome of their decision as to whether to examine or consider a death, which should have been informed by the views of bereaved families/carers
3.7- sympathetically and meaningfully engage with the bereaved families/carers by informing them if the care is to be reviewed/investigated, what this would include and how involved families/carers would want to be within this process, including space for them to raise any concerns with regards to the care that had been provided and where appropriate, guidance on how to seek support, such as legal advice for example

3. Process

Case Record Review

The Governance & Quality Assurance Coordinator LfD identifies the number of deaths that have occurred each month for patients who had an open referral to LPT services or had an open referral within the previous 6 months. This data is collected from SystmOne reports that use information from the Spine to ensure all deaths are captured. Some deaths will also have an Electronic Incident Reporting Form (eIRF) completed on Ulysses, but this does not reliably capture all the deaths.

This report then goes through a filtering or screening process for each directorate, depending on the in-scope criteria.

According to national guidance, Trusts are expected to, at a minimum, include all inpatient deaths as in scope, for review, and if possible, those who die within 30 days of being discharged from inpatient services (NHS Improvement, 2017). However, all those considered in scope for review, do not necessarily need to be reviewed unless they fall into categories, which includes (NHS Improvement, 2017):

- Deaths where bereaved families/carers, healthcare staff for example, have raised concerns about care.
- Deaths of those with severe mental illness or learning disabilities.
- Death occurring where the patient was not expected to die.
- Deaths which occur within a specialty, diagnosis or treatment group where an 'alarm' has been raised (for example, when there have been concerns from Care Quality Commissioners, concerns from an audit, increased mortality rate).
- Deaths where learning will help provide quality improvement.
- In addition, a sample of other deaths should be reviewed to help clarify where there is learning, and improvement needed most (NHS Improvement, 2017).

Community Health Services (CHS) in-scope criteria

- All inpatient deaths or deaths which occurred within 30 days of discharge if there is a concern raised by the Medical Examiner or by family, carers, members of staff or 3rd party i.e., Local Authority or Safeguarding Team.
- Community deaths if there is a concern raised by the Medical Examiner or by family, carers, members of staff or 3rd party i.e., Local Authority.
- Deceased patients who have a diagnosis of Learning Disability (LD) or Autism as well as referral into the Learning from Lives and Deaths of people with a LD and autistic people (LeDeR) process.
- 5 deaths each month will be identified for review by the directorate LfD group, according to any areas where "alarms" or concerns have been raised, death has occurred within 48 hours of deterioration and admission to University Hospitals of Leicester NHS Trust (UHL) or randomly.

In all 3 directorates, some unexpected deaths are initially reviewed using an Initial Service Management Review (ISMR) form that is discussed at the weekly directorate incident review meeting or sent for review at the Trust wide Incident Review Learning Meeting (IRLM) and from there the decision is made to review as a patient safety incident or remain as an ISMR, the outcome of all of these reviews will be heard and discussed at the relevant directorate's LfD meeting.

DMH in-scope criteria

Any patient who is currently open to DMH, or has been open in the previous 6 months, who also:

- has a diagnosis of learning disability and/or Autism OR
- meets one or more of the four Royal College of Psychiatrists red flag criteria this includes:

- Being open to Crisis Resolution Home Treatment Team at the time of death.
- were recently admitted to a psychiatric ward or recently discharged from inpatients in the previous 30 days.
- have a diagnosis of psychosis or eating disorder.
- concerns by staff, family, carers or 3rd party (i.e., Local Authority) regarding care within LPT.

Families, Young People and Children's and Learning Disability and Autism (FYPC/LDA) in-scope criteria

Any patient who is currently open to FYPC/LDA, or has been open in the previous 6 months, who also:

- has a diagnosis of learning disability and/or Autism OR
- any child under the age of 18 years OR
- has a diagnosis of Eating Disorder
- any inpatient deaths

For deaths of children under the age of 18 years, this needs to also be reported to the Designated Doctor via Electronic Child Death Overview Panel (eCDOP), a secure web-based platform (Leicestershire and Rutland Safeguarding Children Partnership, 2024). Any professional who becomes aware of a child death has a statutory duty to notify and can report this by completing an online notification (Leicestershire and Rutland Safeguarding Children Partnership, 2024).

For all directorates, any deaths where the patient has a diagnosis of Learning Disability or Autism will have a Case Record Review (CRR) completed by the directorate while also being referred into the LeDeR process by the clinician involved in the care of the patient.

In each directorate, the relevant Clinical Director or Associate Medical Director, assisted by the Governance & Quality Assurance Coordinator LfD, will nominate reviewers to carry out the case record reviews. Appropriate training should be available for these reviewers, who should use the agreed review form to capture the information. The patient's family or carers should be given an opportunity to engage in the review process.

The Trust's Bereavement Support Service (BSS) will contact the bereaved families/carers where the patient dies in hospital, acknowledging loss of a loved one and where concerns have been raised via the Medical Examiner (ME) or family, informing them that services will be undertaking a review of care. This contact is to help ensure they know that they may share concerns, positive feedback and may contribute to the review. If a patient dies in the community, their deaths are reviewed by the ME through the ME process, and the bereaved families/carers are signposted to bereavement services in the community. If concerns are raised during this process, the ME would forward any concerns to the BSS, who would then pass these concerns over to LPT. If the BSS has the capacity, they will contact the bereaved family/carer.

Deaths should be reviewed within 3 months. The Directorates are required to provide a list of all those deaths not reviewed within the timescale to the Trust wide Learning from Death Group where applicable. At times, the Trust may not become aware of

the death immediately and in those cases, they will be reviewed within 3 months of it being reported.

The National Medical Examiner System

As part of the changes from the Department of Health and Social Care's Death Certification Reforms, as of 9th September 2024, ALL deaths, within England and Wales, which occur within any healthcare setting or the community, that is not to be investigated by the coroner should be proportionately reviewed by an NHS Medical Examiner (ME) (NHS England, no date). This means, that prior to the registration of any non-coronial death, there is a statutory requirement for a ME to independently proportionately review/screen them. This Reform introduced a new Medical Certification of Cause of Death (MCCD), whereby medical practitioners could complete this MCCD if they had attended to the deceased within their lifetime, as opposed to the previous 28-day rule (NHS England, no date). For further details of this process, please refer to Appendix Four for the Overview Process for Death Certification.

Within any LPT inpatient setting, the Advanced Nurse Practitioner/doctor is to complete and email across the ME referral proforma (available on SystmOne) to the Leicester, Leicestershire & Rutland Medical Examiner NHS Net mailbox at medical.examinersllr@nhs.net , or alternatively call: 07815 028098 or 07815 457565, if they have any questions, to begin this referral process.

Any deaths occurring in an inpatient setting (including community hospitals) or when patient was discharged from hospital within 30 days are all reviewed by the ME through the ME process which was established 1st April 2022. Any concerns/issues with care are then brought to the attention of the Trust via the BSS and the LfD email: lpt.learningfromdeaths@nhs.net to be presented at the LfD meetings.

Out of scope Patient Deaths

- Patient deaths investigated as part of the Internal Investigation PSIRF process.
- Deaths scrutinised by the ME where no concerns are raised with LPT
- Stillbirths and perinatal deaths (see Appendix Five for full description)
- Neonatal deaths with no involvement from LPT services

Reporting Patient Deaths

All inpatient deaths will require a routine referral to the ME, by completing the ME referral proforma, including completion of the Notification of Death Form and Bereavement Checklist. Please refer to the LPT Care of the Deceased Policy to see a copy of this form, and the Care of Deceased Process Map within LPT In-patient areas. Appendix Six contains the Medical Examiner (ME) Bereavement Support Service (BSS) Process Map, for further details regarding ME process.

Where clinical services receive notification of a death of a patient (where the Trust is the main care provider), an eIRF form is completed on Ulysses Incident reporting system.

For patients who are in-scope and have died within the community, the same process noted above, is to be followed.

CHS Community: For Community Nursing and Therapy patient deaths these only need reporting if LPT staff arrive at a patient's home and find them deceased or if the patient dies at the time of LPT staff carrying out care.

For patients who are out-of-scope and have died within the community, the ME will assess and review the cause of death alongside the Certified doctor to agree or not agree upon issuing the Medical Certificate of Cause of Death (MCCD). If concerns regarding care are raised during this process, the ME office will forward any concerns to the BSS and the BSS will complete an eIRF, if one has not been completed already. The BSS will then relay concerns to the appropriate directorate.

There are three causes when reporting patient deaths on Ulysses, they include:

- Expected Death
- Sudden / Unexpected Death
- Suspected suicide (Actual)

Expected Death

Expected deaths follow the ME process and any concerns are escalated to relevant bodies.

When there is an in-patient death of a patient that is expected and not detained, the ME referral proforma is to be completed by a registered health professional and sent to the ME Office alongside any additional relevant forms. The ME Officer will then contact the LPT referrer if further information is required. The ME will then discuss the cause of death with the Certifying Doctor and either agree for a MCCD to be issued by the Certifying Doctor or where it cannot be issued a referral is sent to the coroner by the appropriate service depending on the circumstances. If the MCCD is completed at LPT, this is then to be sent over to the LLR ME mailbox, medical.examinersllr@nhs.net or the clinician can call: 07815 028098 or 07815 457565 to start the referral process. The ME or Clinical Medical Examiner Officer (CMEO) will then make contact with the family and inform them of the cause of death, if there are no concerns raised the CMEO or ME will inform the bereaved family as to the BSS. The BSS will then make contact with the family within 6-8 weeks, or earlier if needed. The MCCD is then countersigned by the ME and the ME Officer completes the ME Proforma and sends this across to LPT, including the LPT LfD team, BSS and LeDeR if the deceased had LD or Autism. If, however, concerns are raised by the family, the ME Officer will inform the Certifying Doctor, who will then refer to the coroner. The ME Officer will then complete the ME proforma confirming that the MCCD cannot be issued, sending this across to the Doctor completing the referral to coroner, LPT LfD team, BSS and LeDeR if the deceased had LD or Autism. When a referral to the coroner is required, the BSS will contact the bereaved family within 2 weeks.

Expected deaths will have a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form/Advanced Care Planning (ACP) in place and have a clear end of life/management plan in place.

When there is an in-patient death of a patient that is expected and they are detained, the coronial process is followed, and learning is carried out via the ISMR or PSIRF route.

Sudden/Unexpected Death

When there is an unexpected death an eIRF is completed. If this occurs in the community, in-scope, the clinical team will complete an eIRF. If this unexpected death is out-of-scope but becomes in-scope due to concerns being raised, this e-IRF would be completed by the BSS, if one has not already been completed.

Suspected Suicide (Actual)

When the Coroner gives a Suicide verdict, this category is then completed as the cause of the patient's death. In the event of a narrative verdict the cause will remain 'Sudden/Unexpected Death'.

When notifying other interested organizations of a patient's death, including Primary Care, this can be done via SystmOne. The Trust themselves, may become aware of a patient death via several different sources, including notifications provided by UHL where patients have also been known to LPT services and SystmOne when Primary care notify the Trust.

Death of individuals within certain groups

Learning Disabilities

For all deaths of adult patients with or suspected Learning Disability and/or a clinical diagnosis of Autism, an Adult Learning Disability Deaths Review (ALDDR) Learning from Deaths form is to be completed by the service treating the patient. This form is then to be submitted to the LeDeR programme (NHS LeDeR 2022).

The LeDeR programme has been live since 01 October 2017 with trained and active reviewers in place across LLR. From 01 February 2019 all deaths of people with a learning disability were to be subject to a LeDeR review. Following on from this, the LeDeR programme included the death of people with a clinical diagnosis of Autism on or after February 2022. From July 2023, the LeDeR programme no longer reviews the deaths of children under the age of 18 years. All child deaths, including those with a learning disability and/or autism are to be reviewed through the child death review process, However, the results following their review are to then be shared with the LeDeR programme, working alongside Child Death Overview Panel (CDOP) to progress and support the learning from the deaths of children (NHS England, 2021).

The death of patients within this group is to be reported by the ward or service manager, via the online LeDeR website, including as much information as possible. Once this has been completed, LeDeR will begin the review process, which they aim to complete within 6 months, unless there are other processes or investigations taking place, such as a coroner's inquest. If this occurs, the LeDeR review will be on hold until these are completed.

The directorates will still complete a Case Record Review for deaths with Learning Disability and Autism.

Child Death

All child deaths (under 18) are subject to statutory Child Death Review (CDR) to understand causes and prevent future deaths. This is governed by the Children Act 2004 and detailed in Working Together to Safeguard Children 2023 and CDR Statutory & Operational Guidance 2018.

Immediate decision-making must begin within 1–2 hours of death; professionals notify others within 24 hours.

A Joint Agency Response (JAR) is triggered for deaths due to external causes, sudden unexplained deaths, custody/Mental Health Act cases, suspicious circumstances, or unattended stillbirths.

A Child Death Review Meeting (CDRM) is held within 3 months, involving all relevant professionals.

Bereaved families receive support and a guide; a Keyworker is assigned to liaise and signpost services.

All cases are reviewed anonymously by the CDOP, with findings submitted to the National Child Mortality Database.

In Leicester, Leicestershire & Rutland (LLR), deaths are reported via eCDOP; local area conducts the review.

Expected deaths follow the Medical Examiner (ME) process; concerns are escalated to relevant bodies. After proportionate review of the clinical records speaking with the certified doctor and talking with the designated bereaved family member, the ME will decide whether a further review of care is needed. The ME office will then feed this back to the relevant team/Directorate, copying in the BSS and LfD team.

The directorates will still complete a Case Record Review for all child deaths.

Reviewing deaths following other services recommendations

As a Trust, if concerns are raised by another Service, of the care received by the deceased, the BSS would be informed. They would then pass on any concerns to the Governance systems in the appropriate Directorate who complete an eIRF and will then act in accordance with the processes as noted above.

Engaging with bereaved families/carers

When informing family, it is important for an appropriately trained member of staff to contact the patients next of kin, sensitively notifying them that they have died and inviting them to visit, informing them if visiting restrictions apply, providing them with the contact details for the Bereavement Support Service (BSS). If there is no family, lead nurse/team leader for the service is to be informed, and an e-mail sent to the Bereavement Support Nurse.

It is important for family to be informed of what happens next.

For patient deaths not directly being referred to the coroner, family need to be informed that they should expect a call for the ME Office, within the next 1-3 working days, to discuss the proposed cause of death and certification process. During this contact, they will have space to raise any concerns with regards to the care that had been provided and will be informed if the death can be registered or whether it is to be referred to the coroner.

For deaths directly referred to the coroner, the family will not be contacted by the ME Office and should be informed to expect a call from the Coroner’s Office over the following days.

For child deaths, a Child Death Review Nurse (allocated Key Worker) would also help to signpost bereaved families/carers to bereavement support organisations and assist family in raising questions / concerns as part of the CDOP process.

For all other inpatient deaths, the Bereavement Support Service Nurse (BSSN), will make contact with the bereaved family, to hear from the family, identify if there are any unmet bereavement needs, to signpost/refer to appropriate support organisations as required, invite families to provide feedback about the standard of End-of-Life care and sends feedback/compliments to the team (Appendix Seven).

If family raise any questions or concerns which cannot be resolved by the BSSN, the BSSN will act as an advocate for the family and provide feedback to the clinical team and request reviews of the care provided or arrange a meeting with the clinical team

via an appropriate pathway. The BSSN can escalate to the Patient Safety Team, as required and is able to share clinical team responses/ review feedback with the family via their preferred method and where requested by the family, signpost or assist in raising a formal concern/complaint.

In addition to the BSS, the Patient and Family Liaison Officer, within LPT, would be able to support bereaved carers/families.

For community deaths, the ME will assess and examine cause of death and signpost the bereaved family to bereavements services in the community. If concerns are raised by the bereaved family and/or the ME, the ME will forward these to the BSS alongside additional feedback provided by the family. If the BSS have capacity, the BSSN will then contact family, as noted above.

Corporate Patient Safety Team (CPST)

The CPST is responsible for supporting the Medical Director and non-executive Director to ensure there is a transparent mortality monitoring and review process within the Trust, meeting the requirements of the Learning from Deaths national guidance. All mortalities within the Directorates are discussed, and these are reported Quarterly to CPST via the Learning from Deaths Coordinator. If at any point, it is known that the criteria of a Patient Safety Incident have been met, CPST in conjunction with local clinical governance teams initiates further review. Data is collected, shared and published to monitor trends in deaths with Trust Board level oversight. In accordance with Trust policy, the Ulysses reporting system is to be used to record ALL in scope deaths (expected and unexpected and community and inpatient), to help ensure that the information processed is consistent and precise to maintain high standards in mortality governance.

Sharing Learning

Learning is shared with individuals and teams identified within each Directorates LfD Group as well as wider through sharing of highlight reports from the Directorate Learning from Death Groups meetings with:

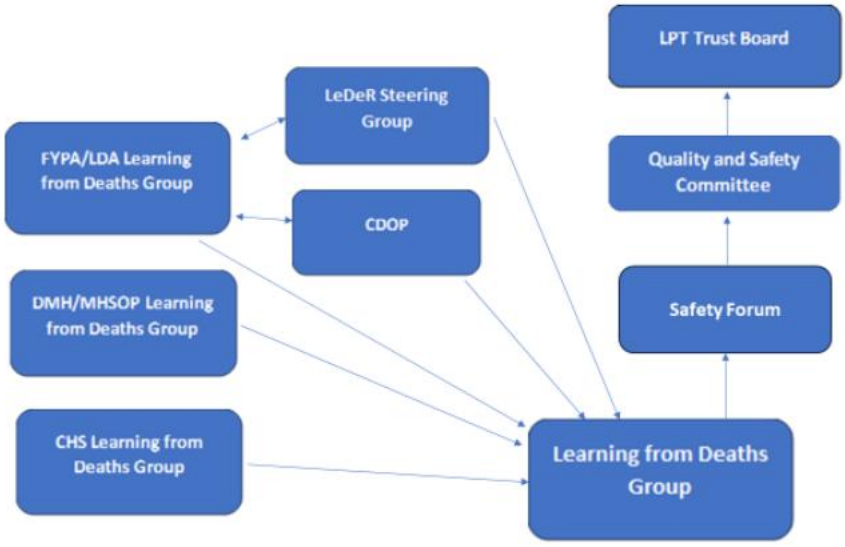
- CHS – Quality & Safety Directorate Management Team Meeting
- DMH – DMT Quality & Safety Meetings
- MHSOP – Quality & Safety Meetings
- FYPC/LDA - Clinical Leadership Forum and Quality & Safety Meetings

Cases where there is wider learning are shared within the Directorate and directly with the clinical team. These are recorded on the LfD form presented to the LfD Group for sharing across the Directorates.

The Trust-Wide Learning from Deaths Group is where overall learning is highlighted and shared across the directorates.

4. Roles and Responsibilities

The governance structure within the Trust allows for the reporting of deaths from ward to board, in a consistent, comprehensive and timely manner. It also supports the capturing and sharing of learning from mortality review within the Directorates and across the Trust.



Lead Executive Director

The Medical Director is the Lead Executive Director for Learning from Deaths and has overall responsibility for the learning from deaths process which sits with the Medical Director. Roles and responsibilities include:

- Overall oversight and regular review of the learning from deaths process
- Ensuring case record reviews are carried out to a high quality.
- Ensuring that any risks identified during the review process are escalated accordingly to the Trust Risk Register.

Corporate Patient Safety Team

The Corporate Patient Safety Team is responsible for ensuring that:

- Data is collected and published to monitor trends in all deaths, with Board level oversight of this process.
- Ensuring that the Ulysses reporting system is used to its full potential to record deaths and the circumstances of individual deaths.
- Information is processed consistently, precisely and in a meaningful way to fulfil the governance processes required to ensure high standards in mortality governance are maintained.

It is the responsibility of the above staff:

- To foster a culture of responding to the deaths of patients who die under our care and ensure staff reporting deaths have the skills and training to support the review process.
- To participate in the review and investigation of patient deaths.
- Support staff that are to review and investigate the deaths ensuring they have the time to carry this process out in skilled way to a high standard.
- To promote learning from deaths through facilitating and giving focus to the review, investigation and reporting of deaths.

- To ensure that all learning from the process of review and investigation is shared and learning is acted upon.

All staff

All Healthcare professionals need to acquaint themselves with this policy and understand the process for learning from deaths.

Clinical Staff

Clinical staff must ensure that deaths are reported in a timely manner with all relevant details in the incident description.

Governance Group level 1 and 2

The Trust Wide Learning from Deaths Group (Level 3 will be held quarterly and is chaired by the Deputy Medical Director for Quality and Safety. The Group is overseen by the Safety Forum (level 2).

The Group will ensure learning from deaths takes place in line with national guidance to enhance care provided for our service users. It will provide assurance that robust system and reliable data are in place to facilitate effective review of deaths of patients under the care of the Trust.

All three Directorate Learning from Deaths Sub-Groups will develop their Terms of Reference following guidance from the Trust Wide Learning from Deaths Group and the Trust wide LfD Group Terms of Reference.

Each Directorate is required to provide a quarterly report, which goes to the Trust Wide LfD Group before being seen at the Safety Forum, the Quality and Safety Committee and finally Public Trust Board. Within this report, they are expected to include the number of patient deaths on their list, identify any themes, and comment on the learning that has transpired from this information.

Once every 3 months, each Directorate is expected to provide a Triple A Report (replacing the Highlight Report) which is to go to the Trust wide LfD Group. The responsibility of this report is for the chairs of the directorate meetings. Within this report they are expected to identify the number of deaths, if there are any backlogs in relation to this, they need to include what is being done to reduce this and identify if there are any gaps. Any concerns are required to be highlighted including what is being done to mitigate these concerns and the work that is being done to address these.

The Groups will provide the following standards of operation:

- Minutes which include how learning will be shared.
- Quoracy to be documented.
- Action log for recommendations emerging from mortality reviews.
- Uptake of role specific training if available.
- Completion of the Case Record Review and appropriate forms.
- Incident numbers will be used to cross check with list of all deaths in scope to ensure that all relevant mortality reviews have been completed.
- Learning and actions to be included in minutes.

Policy Team

The Key individuals involved in developing and consulting on the revised document are:

- Dr Neelofar Bargir – Consultant Psychiatrist and Undergraduate Clinical Tutor
- Dr Samantha Hamer – Deputy Medical Director for Quality and Safety
- Dr Rohit Gumber – Associate Medical Director FYPC/LDA
- Dr Graham Johnson – Associate Medical Director CHS
- Sarah Latham – Head of Nursing CHS
- Dr Charlotte Messer – Clinical Director MHSOP and chair of DMH LfD group
- Learning from Deaths Committee
- Tracy Ward- Head of Patient Safety
- Trust Policy experts

Policy Authors

- Dr Neelofar Bargir – Consultant Psychiatrist and Undergraduate Clinical Tutor
- Dr Samantha Hamer – Deputy Medical Director for Quality and Safety

5. Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered.

Appendix One Definitions

Terminology:

ALDDR form	Adult Learning Disability Deaths Review Form
BSS	Bereavement Support Service
BSSN	Bereavement Support Service Nurse
Case Record Review (CRR)	This is sometimes referred to as a Structured Judgement Review, which is a review of case records using a template to identify themes and support learning. The Trust uses a locally designed template, referred to as a Learning from Deaths Quality Safety Review form (LfD QSR) or in FYPC/LDA an Adult Learning Disability Deaths Review (ALDDR) form for LD/ASD patients. These are carried out by clinicians to identify if there were any concerns in the care provided to a patient prior to their death.
CDR	Child Death Review
CDRM	Child Death Review Meeting- Stage of the review process that precedes the CDOP arranged by CDRP
CDRP	Child Death Review Partners- The local authority and any CCG for an area which falls within the local authority area
CDOP	Child Death Overview Panel reviews all child deaths who reside within Leicester, Leicestershire and Rutland. All deaths are to be notified via secure platform eCDOP.
CHS	Community Health Services
DMH	Directorate of Mental Health
Expected death	An expected death is the result of an acute or gradual deterioration in a patient's health status, usually due to advanced progressive incurable disease. The death is anticipated, expected, and predicted.
FYPCLDA	Families, Young People and Children's and Learning Disabilities and Autism
ISMR	Initial Service Management Review. This is a form of Case Record Review.
LeDeR	Learning from Lives and Deaths of people with a Learning Disability and Autistic people aged over 18 years (LeDeR programme). All deaths are to be notified to this programme.
LfD	Learning from Deaths
LfD QSR form	Learning from Deaths Quality and Safety Review form is a modified Structured Judgement Review form.
LLR	Leicester, Leicestershire, and Rutland

Mazars	Independent review of deaths of people with a Learning Disability or Mental Health problem
MHSOP	Mental Health Services for Older People (part of DMH)
Patient Safety Incident	Patient safety incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
Patient Safety Incident Response Framework (PSIRF)	PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety (NHS England, no date).
ReSPECT	ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Such emergencies may include death or cardiac arrest but are not limited to those events. The process is intended to respect both patient preferences and clinical judgement. The agreed realistic clinical recommendations that are recorded include a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop. https://www.resus.org.uk/respect/respect-healthcare-professionals
Structured Judgement Review (SJR)	Structured Judgement Review- Referred to as Case Record Review, see above.
Sudden or Unexpected Death	A death that occurs suddenly or earlier than anticipated.
Ulysses	The Risk Management Software used at Leicestershire Partnership Trust that includes the reporting of patient safety incidents.

Appendix Two Governance

Version control and summary of changes

Version number	Date	Description of key change
7	14/10/2025	Updated with ME process, in-scope deaths and new policy template

Responsibilities

Responsibility	Title
Executive Lead	*Medical Director*
Policy Author	*Deputy Medical Director Quality and Safety Consultant Psychiatrist and Undergraduate Clinical Tutor*
Advisors	*Associate Medical Directors, Heads of Nursing, Clinical Directors and Head of Patient Safety*
Policy Expert Group	

Governance

Governance Level	Name
Level 1 Assurance Oversight	*Quality and Safety Committee*
Level 2 Delivery Group for policy approval and compliance monitoring	*Safety Forum*

Compliance Measures

KPI (only need 1-2 KPI's per policy)	Where will this be reported and how often
Directorate reports are provided on a quarterly basis and contain the information listed on pages 16 and 17 of the policy	*Quarterly reporting to the Trustwide LfD group with review of contents.*
Compliance with policy and reviews of in-scope deaths	*Quarterly review at Trustwide LfD group.*
Training for Case Record Reviews is developed, available and staff are compliant with the training	*Annual review at Trustwide LfD group.*

Training Requirements

Training
Training for staff completing Case Record Reviews needs to be developed and rolled out to all staff completing CRRs.

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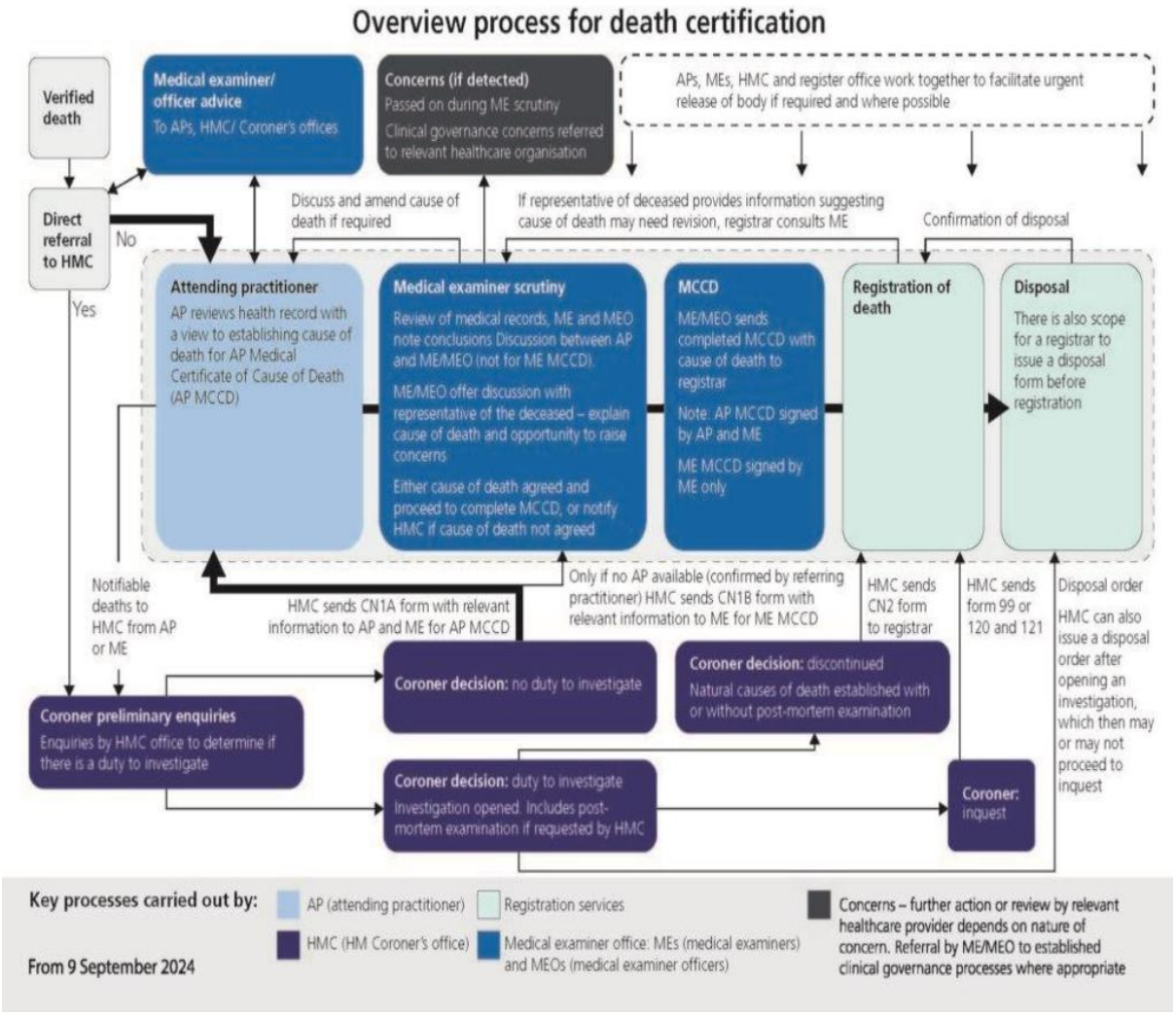
Appendix Three LfD Quality Safety Review Form

NHS
Leicestershire Partnership
NHS Trust

Learning from Deaths Quality and Safety Review Form							
Name of person(s) completing review:				Date of review:			
NHS Number:		eIRF Number:		DOB:		Age:	
Sex:		Ethnicity:		Religion:		Sexual orientation:	
Post Code:		Ward/Team/Service:		Date/Time of death:		Expected / Unexpected death:	
In-Patients				Date/Time of Admission:			
Community Patient				Date of Referral:		Date Last Seen:	
Diagnosis on last contact:							
No of days between admission/last seen and death:							
Family Contacted to offer condolences		Method	Choose an item.	Family comments/feedback			
		Rationale for non-contact					
Timeline of key events (Summary): Please include Date and Time							
Poor Communication Identified:				Explanation of poor communication:			
Delay in treatment:				Explanation of Delay in Treatment:			
Unidentified Deterioration:				Explanation of Unidentified Deterioration:			
Contributing Iatrogenic event:				Explanation of contributing Iactogenic event:			
Was the death considered more likely than not to be due to Problems in care:				Explanation of problems identified			
Did the quality of care meet standards of good practice in the domains below (Yes/No/Not Applicable)? Please provide a brief explanation in each phase of care:							
Allocation and assessment	Choose an item.						
Care during admission	Choose an item.						
Ongoing care (physical and mental)	Choose an item.						
Care during specific procedure	Choose an item.						
Discharge planning	Choose an item.						
Overall LPT care	Choose an item.						
Outside LPT care	Choose an item.						
Does the overall quality of care reflect good practice?				Professional standards the care is assessed against:	Choose an item.		
Is further review needed?	Choose an item.			If further review is needed, please state reasons why:			
Please consider how any learning or good practice from this death can be themed and subthemed.							
Learning identified:							
Theme & Subtheme				Explanation			
Choose an item.							
Choose an item.							
Recommended actions resulting from the learning identified:							
Good practice identified:							
Theme & Subtheme				Explanation			
Choose an item.							
Choose an item.							

V6 Electronic Learning from Deaths Quality and Safety Review Form 22/9/2023

Appendix Four Overview Process for Death Certification



Appendix Five Stillbirths and Maternal Deaths

Stillbirths and early neonatal deaths (0–6 days) or severe brain injuries diagnosed within 7 days must be reported by Acute Hospitals to the Maternity and Newborn Safety Investigations (MNSI) programme but are out of scope for LfD reviews.

A Joint Agency Response (JAR) is required if no healthcare professional was present at birth.

Healthcare Safety Investigation Branch (HSIB) must be informed of safety concerns to ensure learning and family involvement.

In Leicester Hospitals, deaths within 28 days are logged, discussed with the Medical Examiner (ME), and may be referred to the coroner.

Rapid Review within 72 hours is triggered if care concerns arise; followed by Perinatal Mortality Review and CDOP notification.

Maternal deaths (during or within 1 year of pregnancy) are reported to MNSI, which investigates direct (obstetric) and indirect (pre-existing or pregnancy-exacerbated) causes.

Suicide-related maternal deaths are investigated by the NHS Trust, not MNSI.

Confidential Enquiry into Maternal Deaths (CEMD) and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) provide national learning from maternal deaths.

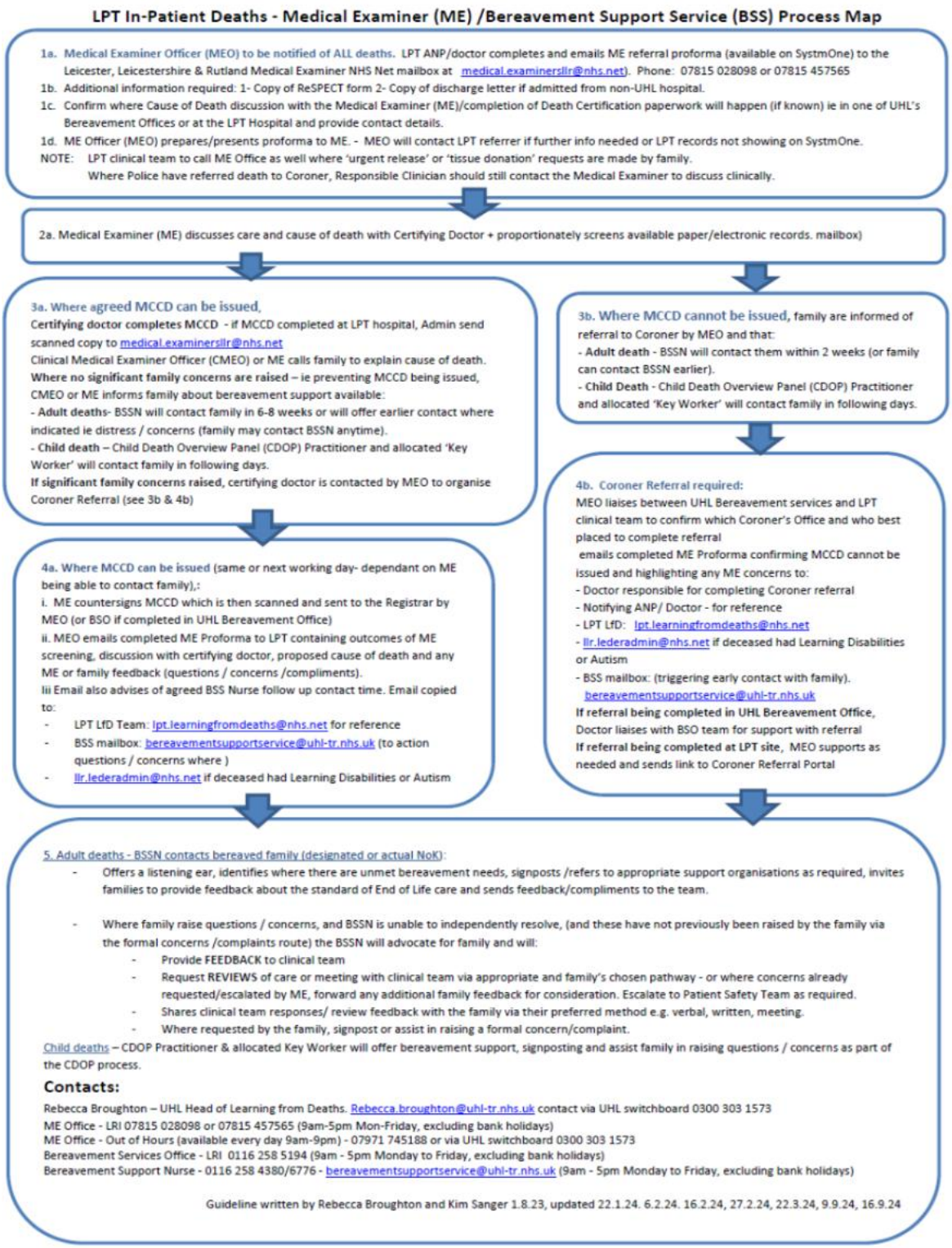
Leicester Hospitals conduct Structured Judgement Reviews, with ME involvement and coroner referrals as needed.

LPT undertakes proportionate reviews for maternal deaths under its care.

Bereavement support is provided to bereaved families/carers by the Bereavement Support Service and/or the Bereavement Midwife.

All these deaths, including maternal deaths, which have occurred within 1 year of pregnancy are reported to MBRRACE-UK by the University Hospitals of Leicester Women and Children’s Patient Safety and Complaints Team.

Appendix Six Medical Examiner (ME) Bereavement Support Service (BSS) Process Map



Appendix Seven ME and BSSN EoL Feedback Process Map

V9

Medical Examiner (ME) & Bereavement Support Service Nurse (BSSN) End of Life (EoL) Feedback Process Map

(For District Nursing or Palliative Care feedback: BSSN logs, themes, & forwards ME +/- family feedback to lpt.chsgovernance@nhs.net cc CHS Head of Nursing, Head of Patient Safety (& Matron for Integrated Community Specialist Palliative Care where team involved). If patient died in community, BSSN does not routinely contact family, but will if concerns have been raised & has capacity. Review outcomes are discussed/shared at CHS EoL Delivery Group & workstreams, & CHS Governance outcomes report is presented to CHS Senior Clinical Team meeting & Trust EoL Steering Group by Matron for Integrated Community Specialist Palliative Care.) NB. If evidence of 'Patient Safety Incident', escalate through Patient Safety Route.

'Inpatient death' LPT feedback - ME office returns completed referral template to LPT referrer, certifying doctor & lpt.learningfromdeaths@nhs.net providing ME & family feedback. Cc BSSN, who contacts family for further information / offers support within 2 weeks.
'Non LPT death' – ME / family questions or feedback for LPT are forwarded to BSSN to follow this pathway.

Family QUESTIONS (e-irf required)

Or concerns about 'experience' of EoL care.

Where BSSN unable to answer, request email response from clinicians ie. Consultant / ANP / Matron, and 'copy in' directorate mailbox:

LPT - lpt.chsgovernance@nhs.net

DMH - lpt.dmhinvestigations@nhs.net

FYPCLDA - lpt.fypcldgovernance@nhs.net

ME / Family CONCERNS (e-irf required)

'Management' of care that may have affected patient's outcome – potential learning.

BSSN captures and themes feedback/concerns raised & forwards to directorate:

CHS - lpt.chsgovernance@nhs.net

DMH - lpt.dmhinvestigations@nhs.net – to be triaged at sign off meeting.

FYPCLDA – lpt.fypcldgovernance@nhs.net

Feedback discussed at weekly 'sign off meeting' & triaged for A, B, or D as appropriate.

A - BSS feedback pathway

1. Verbal response requested: Agree BSSN /clinical team to provide.

2. Meeting with clinical team requested: BSSN coordinates meeting & drafts meeting summary. (Send to attendees for comment, then to directorate mailbox (as above) for 'sign off' before sharing with family:

3. Written response requested: BSSN drafts response from information provided by team –directorate sign off prior to sending to family.

Where response only requires information copied from ME template/coroner referral (+/- minor BSSN amendment e.g., simplified jargon), directorate governance team will require copy but no pre sign off is required.

(BSSN also sends final summary to: lpt.learningfromdeaths.nhs.net for adding to Ulysses EiRF.)

BSSN captures any themed concerns, learning and actions taken for 1-3.

Learning shared via BSSN quarterly report at EoL Steering Group.

Consider writing and circulating 'Patient Story.' – 'Permission & inclusion with family must be sought before this is undertaken.'

B - Incident Review & Learning Meeting IRLM (AM Fridays)

Corporate Patient Safety Team (CPST) request clinical team present Initial Service Management Review (ISMR - usually within 2 weeks)

Reviewer (+/- BSSN where requested) updates family with outcomes / next steps. Update BSSN and agree level of further BSSN involvement.

Further reviews may /may not be requested via routes C and D.

C - Local Directorate Review – Round table (SEIPS model- target 60 working days response time + 31-day sign off process). Reviewers update family +/- BSS input/support. Outcomes themed by governance team / shared with BSSN.

D - CPST Investigation – PSII (identified by PSIRF priorities. Target 60 working days response time + 31 day sign off process (extends in complex cases). Reviewers update family. Outcomes themed by PST.

Future Aims - to share themes.

E - Learning from Deaths (LfD)

Review outcomes presented and discussed during directorate LfD meeting to capture theming.

Family may have requested review summary / outcomes (verbal/written/meeting).