This document has been reviewed in line with the Policy Alignment Process for Liverpool Community Health NHS Trust Services. It is a valid Mersey Care document, however due to organisational change this FRONT COVER has been added so the reader is aware of any changes to their role or to terminology which has now been superseded. When reading this document please take account of the changes highlighted in Part B and C of this form.

### Part A – Information about this Document

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Learning from Deaths Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Type</td>
<td>Board Approved (Trust-wide) [ ] Trust-wide [ ] Divisional / Team / Locality [x]</td>
</tr>
<tr>
<td>Action</td>
<td>No Change [ ] Minor Change [ ] Major Change [x] New Policy [ ] No Longer Needed [ ]</td>
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<tr>
<td>Approval</td>
<td>As Mersey Care’s Executive Director / Lead for this document, I confirm that this document: a) complies with the latest statutory / regulatory requirements, b) complies with the latest national guidance, c) has been updated to reflect the requirements of clinicians and officers, and d) has been updated to reflect any local contractual requirements</td>
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### Part B – Changes in Terminology (used with ‘Minor Change’, ‘Major Changes’ & ‘New Policy’ only)

<table>
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<td>Mersey Care NHS Foundation Trust- Community</td>
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### Part C – Additional Information Added (to be used with ‘Major Changes’ only)

<table>
<thead>
<tr>
<th>Section / Paragraph No</th>
<th>Outline of the information that has been added to this document – especially where it may change what staff need to do</th>
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### Part D – Rationale (to be used with ‘New Policy’ & ‘Policy No Longer Required’ only)

Please explain why this new document needs to be adopted or why this document is no longer required

### Part E – Oversight Arrangements (to be used with ‘New Policy’ only)

<table>
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<tr>
<td>Recommending Committee</td>
</tr>
<tr>
<td>Approving Committee</td>
</tr>
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<td>Next Review Date</td>
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LCH Policy Alignment Process – Form 1
**SUPPORTING STATEMENTS**

This document should be read in conjunction with the following statements:

---

### SAFEGUARDING IS EVERYBODY’S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / adult;
- knowing how to deal with a disclosure or allegation of child / adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child / adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust’s safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session.

---

### EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **Fairness**, **Respect**, **Equality Dignity**, and **Autonomy**.
Liverpool Community Health

Learning from Deaths Policy
<table>
<thead>
<tr>
<th><strong>Version Number:</strong></th>
<th>1.1</th>
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<tr>
<td><strong>Ratified by:</strong></td>
<td>Clinical Standards Group</td>
</tr>
<tr>
<td><strong>Date of Approval:</strong></td>
<td>26th September 2017</td>
</tr>
</tbody>
</table>
| **Name of originator/author:** | David Webster  
Associate Medical Director |
| **Approving Body / Committee:** | Clinical Standards Group |
| **Date issued: (Current Version)** | November 2017 |
| **Review date: (Current Version)** | November 2019 |
| **Target audience:**  | Organisation Wide |
| **Lead Director**     | Trish Bennett  
Executive Director of Nursing |
| **Changes / Alterations Made To Previous Version (including date of changes)** | |


1 Introduction

People die for a variety of reasons – both expectedly and unexpectedly. Not all deaths require an investigation and a death occurring while someone is under our care does not necessarily mean that the quality of care has been poor.

What is important though is that when someone does die unexpectedly this is identified so that the correct processes and appropriate levels of enquiry are made with a view to effective learning and taking preventative action in future.

Community Trusts do not collect Summary Hospital-Level Mortality Indicator (SHMI) or Hospital Standardised Mortality Ratio (HSMR) data as acute trusts are required to do. Liverpool Community Health (LCH) has implemented a process by which mortality within the Trust is managed and reviewed in a systematic way. In this way the organisation is following best practice.

2 Purpose

As the result of the Mazars Report into mental health and learning disability deaths in Southern Health NHS Foundation Trust in 2016, all NHS Trusts were requested to review systems and processes in place to identify, report, investigate and learn from deaths of people using their services. The review paid particular attention to how NHS trusts investigate and learn from deaths of people with a learning disability or mental health problem.

The purposes of reviewing the circumstances of or investigating a death are:

- to establish if there are any learning points for the Trust, the wider NHS and its partners around the circumstances of the death and the care provided leading up to a death;
- to learn from any care and delivery problems or system failures that need to be addressed to prevent future deaths and improve services;
- to identify if there is any untoward concern in the circumstances leading up to death; to be in a position to provide information to the Coroner if requested;
- to be able to work with and inform families, to help them understand the full circumstances and answer questions; and to have the full detail of the events available for any subsequent complaint or legal investigation.

3 Definitions

3.1 Expected Death

An expected death can be defined as “a death where a patient's demise is anticipated in the near future and the doctor will be able to issue a medical certificate as to the cause of death (i.e. the doctor has seen the patient within the last 14 days before the death)”. (Home Office 1971)

When someone is dying they should be cared for with an end of life care plan. This is a multidisciplinary decision and when a death occurs whilst on such a care plan we can be assured that this was an expected death. Deaths which occur outside of such a care plan will need to be reported and reviewed to decide if they are unexpected and require further investigation.
End of life care plans include Advanced Care Plans, ACPs, for patients who are residents in care homes and palliative end of life care plans.

3.2 Unexpected Death

An unexpected death is: “Any death not due to terminal illness or, a death the family was not expecting”.

It may also apply to patients

- Where the GP has not attended within the preceding 14 days.
- Where there is any suggestion of suspicious circumstances, trauma or neglect.
- Patients who die within 30 days of discharge from secondary care.
- Patients without an end of life care plan

4 Duties

4.1 Trust Board

The Trust Board is responsible for ensuring that LCH:

- has an existing Board-level leader acting as Patient Safety Director (the Executive Director of Nursing) to take responsibility for the learning from deaths agenda;

- pays particular attention to the care of patients with a learning disability or mental health needs;

- has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;

- adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with The LeDeR Programme relating to The Learning Disabilities Mortality Review Programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;

- ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;

- ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the Board in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the Board level with data suitably anonymised;

- ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts;

- shares relevant learning across the organisation and with other services where the insight gained could be useful;
• ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths;

• offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death;

• acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and

• works with Commissioners to review and improve their respective local approaches following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.

4.2 Executive Director of Nursing
The Executive Director of Nursing has overall responsibility for ensuring that mortality is monitored, reviewed and any actions required identified and acted upon.

4.3 The Associate Medical Director will act as Chair of the Mortality Group.

4.4 Mortality Group
The aim of the group is to provide assurance to the Clinical Effectiveness Sub Committee that the Trust has robust internal quality assurance processes. This is to ensure that patient safety, clinical effectiveness and user experience form the core practice and principles of services through the regular monitoring and reviewing of mortality related issues. The group will undertake reviews of all deaths and report findings and recommendations to the Patient Safety Sub Committee (PSSC).

Findings and recommendations will be reported to the Quality Committee and the Trust Board as part of the assurance around management of risk within the Trust. Additionally, findings will be disseminated to the Locality Clinical Leads and Wards Managers for further dissemination to medical and healthcare staff within each Ward.

4.5 Governance and Quality Practitioners.
The Governance and Quality Practitioners are experienced clinicians working within the locality governance teams and they will review the Datix entries and make an initial decision as to whether to escalate immediately or to refer to the Being Open weekly locality meeting. Any uncertainties may be discussed with the Associate Medical Director.

4.6 All Medical and Healthcare Staff
All medical and healthcare staff are to be aware of the requirements of the mortality review process and should enter all unexpected deaths onto Datix. They should feedback any relevant observations or concerns to the relevant Care Managers. Expected deaths should be coded as such through the EMIS electronic records system, available for future search and audit purposes. The Read codes for recording on EMIS are:

1. Has End of Life Advanced Care Plan : 8CME

4.7 Being Open weekly locality meeting
This meeting occurs in each locality and is a group of key clinical team members. Initially the Being Open meeting should carry out a review to be conducted within seven working days of the death of a patient using their own checklist. The key purpose of this review is to ensure all appropriate care was delivered in a timely manner. The patient’s records (including the medical record, patient assessment and plan of care and acute hospital record where appropriate) should be reviewed as part of this process.

All unexpected deaths should then be reported to the Associate Medical Director for a structured case note review.

5 Any Unexpected Death requiring immediate escalation

5.1 Process following the unexpected death of a Patient.
The following should be notified as soon as is possible, for deaths which are considered to be Serious Incidents Requiring Investigation (SIRI).

- Medical Director
- Director of Nursing
- Associate Medical Director
- Deputy Director of Nursing
- Locality Associate Director
- Locality Clinical Lead

This urgent mortality group review process will then be initiated by the Medical Director or Associate. The review should be led by the Medical Director or nominated deputy and include the medical and healthcare staff involved in the patient’s care. Deaths that are assessed as avoidable will be classed as a SIRI, placed on the Strategic Executive Information System, StEIS, and reported to both the CCG and CQC. This is then followed by the commissioning of a full Root Cause Analysis (RCA), which will be completed within 60 days. All other unexpected deaths should be reported to the Mortality Group following discussion at the locality Being Open meeting, so that any further investigations or actions can be taken locally.

Duty of Candour as per the Being Open Policy should be considered. The Governance and Quality Practitioner will liaise with the appropriate colleagues.
5.2 **Unexpected Death Review using Structured Review**

If the death is an unexpected death this should be reported through the Trust’s incident reporting system (Datix). If on initial investigation there is any evidence of service care or delivery problems or concerns that were considered to be a significant contributory factor then the Datix Incident should be escalated as a SIRI as outlined above, as per the Serious Incident process.

All unexpected deaths will be reviewed by the Mortality Group. In order to assist in this process an Unexpected Death Investigation Review, using a structured review process should be carried out by the Mortality Group to identify any care and service delivery issues associated with the unexpected death and a subsequent decision made as to whether the death was avoidable.

(Structured Judgment Review is one such process being developed by the Royal College of Physicians, to formalise case note review, enabling a more objective approach to decision making. We await this being applied to community services.)

This review should be led by the Associate Medical Director and may include speaking with any medical and healthcare staff involved in the patient’s care. This investigation should be carried out within **ten working days**. A report of this review, including initial findings, lessons learnt and actions proposed, will then be submitted to the Mortality Group to assist in the review and investigation process.

At this stage, the death may be found to be more serious than originally thought, and a full RCA will be commissioned.

**Structured Case Review**

The patient’s records (including the medical record, patient assessment and plan of care and acute hospital record where appropriate) should be reviewed including transfer of care/ admission, medical management, care plans, observation charts, evaluation and communication sheets and a chronology of events.

On reviewing unexpected deaths any contributory factors should be identified, as per the unexpected death review template.

These could include:

a) **Initial Assessment:**
   - Referral / Transfer of Care Information
   - Admission Assessment
   - Communication
   - Facilities
   - Spirituality
   - Medication
   - Current Interventions
   - Mental health / Learning
Disability
• Nutrition
• Hydration
• Skin Care
• Explanation of Care plan
b) Ongoing Assessments and Day to Day Care
• Review of current management plan (incl. reviews of Do Not Attempt Resuscitation (DNAR) and appropriate Care Plan reviews)
• Delivery of care
c) Care after Death
• Verification of Death (persons present, relatives, coroner likely to be involved…)
• Certification of Death (cause of death)
• Patient Care
• Dignity
• Relative /Carer
• Information
• Organisational Information (notified GP, Healthcare / Multi-disciplinary (MDT) Teams and other appropriate services

5.3 Duty of Candour

Central to Liverpool Community Health’s strategy to improve patient safety is its commitment to improving communication between healthcare professionals and patients and families / or carers when a patient is harmed as a result of a patient safety incident. This communication is known as Being Open. Being Open involves apologising and explaining what has happened. The process seeks to ensure that communication is open, honest and occurs in a timely manner following an incident.

Since October 2014 NHS providers are required to comply with the Duty of Candour (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20). Meaning providers must be open and transparent with service users about their care and treatment, including when it goes wrong.

Being Open about what happened and discussing incidents promptly, fully and compassionately can help families cope better with the after effects. Being Open when things go wrong is clearly fundamental to the partnership between patients, their families and those who provide care.

The patient /relative is informed within 10 working days of the incident being recorded on local systems.
□ The initial information must be verbal unless the patient cannot be contacted in
person or declines notification.

☐ An apology must be provided which contains a sincere expression of sorrow or regret for harm caused.

☐ Verbal notification must be accompanied by an offer of a written notification.
☐ Any incident investigation report must be shared within 10 days of being signed off as complete and the incident being closed (including action plans).
☐ The whole Duty of Candour process (outlined above) has to be auditable.

5.4 Patients with Long term Mental Health and Learning Difficulties.

Since the report from Mazar (see References), there is special consideration to those patients with the above difficulties. The policy of LCH is to highlight on the report on Datix any deaths in patients with these difficulties. These deaths will be case note reviewed even though the death may be expected.

It is appreciated that the life expectancy of these groups of patients is lower than expected in the general population and lessons need to be learnt across the NHS regarding this significant discrepancy.

5.5 Unexpected Death Review Recommendations and Findings

Recommendations, findings and suggested action plan of the Unexpected Death Review will be reviewed and agreed by the Mortality Group. These will also be reported to the Medical Director and the Patient Safety Subcommittee, PSSC. As required, additional reporting will be made to the Quality Committee and Trust Board. Recommended actions and lessons learnt from the Unexpected Death Review and the Datix Investigation will be discussed at the Locality Governance meeting and disseminated to appropriate staff by individual / team briefings or staff awareness events.

6 Mortality Reporting

6.1 Monthly Reporting

The Locality Governance and Quality Facilitator will co-ordinate the monthly reporting of mortality related information distributing relevant reports to the Mortality Group members and the PSSC. Expected and Unexpected Death related data will be included in monthly performance management reporting and available to those who need to refer to the mortality data. See Appendix 4 for a flowchart of the mortality reporting process.

6.2 Mortality Report

The Chair of the Mortality Group will provide a quarterly report to the Patient Safety Sub Committee and an annual mortality report to the Quality Committee.

7 Dissemination and Implementation

This process will be disseminated to the Medical Director, Associate Medical Director, Director of Nursing, Deputy Director of Nursing, Locality Management, The Mortality Group will monitor compliance with this process by:

1. Reviewing any related reported incidents
2. Feedback from staff involved in the process.

8 Audit
Clinical staff will make judgments as to whether the death is expected or otherwise. To ensure that there is a robust check on the quality of those judgments, there will be an audit process on a selection of those deaths. This audit will look at a sample of the deaths judged to be expected and review the case notes, through Structured Casenote Review.
This will be presented to the Clinical Effectiveness Sub-Committee and will be included in the Annual Mortality Report.

9 Related Documents

10 References
Appendix 1: Mortality Review Flowchart

Mortality Review Flowchart

Was the patient’s death expected and End of Life Care Plan in?

Yes

Recorded on EMIS as Expected death

Quarterly gathering of Mortality figures.
Annual Audit of Expected deaths.
Assurance that decisions made are correct.
Assurance of the quality of care.
Assurance that patients are on End of Life care plans.

Presentation of Audit at Patient Effectiveness sub-committee and to Quality Committee.
Incorporated into Annual Mortality report.

The Case Manager and Clinical Lead will ensure that all relevant staff are made aware of all lessons learnt and actions identified. Locality Governance and Quality will support this process. Completion of Actions will be monitored by the Mortality Group.

No

Reported on Datix immediately as Unexpected Death

Risk and Governance Practitioner Unexpected Death to be reported on STEIS

Being Open Review of Datix

Unexpected Death Investigation
• Carry out Unexpected Death Investigation.
• Utilise Unexpected Death Investigation template, structured case note review.
• Review to be led by the Associate Medical Director.
• All medical and healthcare staff involved in patients are to participate.
• Findings, recommendations, lessons learnt, action will be identified and action plan developed.
• Investigation to be completed with ten working days of the patients death.
• Once investigation completed, Mortality Group to convene and review.
• Mortality Group will escalate any issues to the Medical Director and/or the Quality Committee if necessary.

Reporting
• The Associate Medical Director to submit and present completed report to the Mortality Group.
Any issues requiring escalation to be reported to the Patient Safety Sub Committee by exception.

Reported on EMIS as Expected death

Flowchart
# Unexpected Death Investigation Review

## Situation

<table>
<thead>
<tr>
<th>Patient Ref:</th>
<th>Datix Ref No:</th>
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<td>(Patient initials and last four of NHS Number):</td>
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<table>
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<th>Date of Birth:</th>
<th>Date and Time of Death:</th>
<th>Age:</th>
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**Cause of Death:** (to be complete when known)

## Locality and Team

**Detection of incident:**

**Involvement and support of patient relatives:**

## Background

**Admitted / Transferred From:**

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<th>Length of Stay:</th>
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**Reason for Referral:**

**Significant Medical History:**

**Medication:**

## Chronology (timeline) of events

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**Assessment**

Review the patient’s medical records including, Medical Assessments, Mental Health, Daily Charts, Rounding Tool, Evaluation and Communication Sheets and Care Plans to assess the care delivered.

Findings Summary:

---

**Recommendations**

Using the information above and any additional information found, what are the Care and Service Delivery problems associated with this incident?

What are the identified Contributory Factors? These could include: Patient Factors; Staff Factors; Team Factors; Communication Factors; Equipment Factors; Work Environment: Organisational; Education and Training:

Root Causes (the contributory factors that had the greatest impact, and which addressed will minimise the likelihood of re-occurrence):

Lessons Learned:

Conclusions / Recommendations:

Arrangements for Shared Learning:

---

| Author: |
| Role / Designation: |
| Report Date: |
Unexpected Death Investigation Review Action Plan:

Action plan:

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<td>Green</td>
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<tr>
<td>Amber</td>
<td>On track; risks identified</td>
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<tr>
<td>Red</td>
<td>Off Track</td>
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<th>Issue</th>
<th>Action</th>
<th>Accountable Person</th>
<th>Reporting Committee</th>
<th>Outcome - end result that addresses the issue</th>
<th>Time Scale - Due Date</th>
<th>RAG Status</th>
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Appendix 4: Mortality Reporting Flowchart

Trust Board
Unexpected/expected deaths to be reported via the Serious Incident Report on a monthly basis

Quality Committee
Quality Committee to receive summary via Serious Incident Report and exception reporting when required.

Patient Safety Sub-Committee
Associate Medical Director to provide summary of Expected/Unexpected Deaths and required actions

Mortality/Resus Group
- To review and ratify all Unexpected Death Investigation Review reports and Mortality Group Review Checklist for Expected Deaths.
- Group responsible for the implementation of review/checklist recommendations

Mortality Group
- To ensure that the Mortality Policy is followed following a death