Southern Health
NHS Foundation Trust

SH NCP 75

Policy and Procedure for Reporting and Investigating Deaths

Learning from Deaths

Version 6

Summary:	This document sets out the policy statement and procedure for reporting, reviewing and investigating deaths of people who have been in receipt of services from the Trust.	
Keywords (minimum of 5): *(To assist policy search engine)*	Death, unexpected death, mortality, incident, incident reporting, Ulysses, Safeguard, severity, serious incident, SI, managing incidents	
Target Audience:	All staff employed by Southern Health NHS Foundation Trust, subcontracts and partners delivering services on behalf of the Trust.	
Next Review Date:	February 2020	
Approved and ratified by:	Mortality and Serious Incident Forum	**Date of meeting:** 12 February 2019
Date issued:	February 2019	
Author:	Helen Ludford, Associate Director of Quality Governance Sarah Pearson, Head of Legal, Patient Safety and Risk	
Accountable Executive Lead:	Karl Marlowe, Medical Director Dr Mayura Deshpande , Deputy Medical Director (Quality)	

Version Control

Change Record

Date	Author	Version	Page	Reason for Change
June 2016 – Nov 2016	Tom Williams Fiona Richey	2	 5 16 5 5,18	Procedure review Amended the Figure on Page 5 around the criteria for each of the divisions on what deaths to report. Added Terms of Reference for Mortality Meetings Requirements to be confirmed for GP Partnerships. Changes requested by Helen Ludford now included in Figure 1, depicting additional detail. Changed description of Department of Psychological Medicine supporting UHS & OPMH Liaison Service supporting PHT. Also removed appendix 3 from page 18.
	Ryan Taylor	2	Through-out	General Updated • Target audience • Mortally Forum – TOR • Revised reporting for Psychiatric Liaison Services • Minor changes to impact descriptions • Added a section in regards to transfer of SHFT services • Added the application of the procedure in General Practice run by the Trust.
04.11.16	Ryan Taylor	2		Feedback from the Trust Medical Director • Strengthening reporting deaths within in-patients • Expanded on family engagement throughout • Clarity of importance when the 48 hour timeline starts and why it is essential to hold 48 hour panel within this time • Augmented the DoC sections and the distinction between being open, family engagement and DoC
21.11.16	Ryan Taylor		10	Mortality group requested minor changes to the Being Open section
17.01.17	Sarah Pearson	2	5	Change to reporting criteria for Community deaths in relation to Coroner involvement. Revert to previous position. Approved by Mayura Deshpande - chair of Mortality Panel
	Sarah Pearson	3		Correction of typing errors, and amendment to committee structures. Incorporation of Procedure for Department of Psychological Medicine at Appendix 4
02.02.2017	Mehreen Arshad Briony Cooper	3	3, 13, 16-24	Inclusion of Mortality Meeting Terms of Reference. Amendments approved by chair of Mortality Panel - Mayura Deshpande, Clinical Service Director, Adult MH
19.06.17	Helen Ludford	4	Through out	Change format to include a policy statement Change authors and sponsoring director Document changes to incorporate National Quality Board requirements – addition of Structured Judgement Review Document changed to acknowledge to role of the FLO Document changed to include the Quality Audit of Mortality / 48 hr Panels Name Change from Mortality Forum to Mortality and Serious Incident Forum
04.07.17	Helen Ludford	4.1	7	Following consultation further clarity around Hampshire and IOW MAPS Pathway and Pathfinder services.
12.07.17	Helen Ludford	4.2	Front Page &	Add Dr Sarah Constantine to ownership Add The Practice information from Rachel Anderson
18.07.17	Helen Ludford	4.3	13	Further update for LNFH following Mortality Forum
10.08.17	Helen Ludford	4.5		Further changes made to reference Safeguarding Rapid Response, Death in Detention and Clinical Record Keeping.
12.09.17	Helen Ludford	4.6	24	Changes to the Terms of Reference to the Mortality and Serious Incident Meeting Final approval given by the Group
8/2/18		4	34	Addition of appendix 9: Guiding Principles: Sharing Reports. Updated contents page. Approved at Families First Involvement Group 12.12.17
26/2/18				Review date extended from February to April 2018

Date	Author	Version	Page	Reason for Change
11/04/18	Sarah Pearson	5		Review of whole document. Amendment to referral of mesothelioma cases. Insertion of Appendix 10 – Criteria for deaths that must be reported to HM Coroner. Amendment to include mesothelioma/industrial disease as an additional field on the 48 hour death questionnaire
30/04/18	Helen Ludford	5		Revised TOR for mortality forums
17/12/18	Helen Ludford	6	1 6 6 9 12 13 & 21 13 14 18 28	Addition to title – Learning from Deaths New reference to NQB paper – July 2018 Change of Executive Leadership to Medical Director Reduction of reporting period after last contact or discharge from 12 months to 6 months to align with other NHS Trusts. Specify that concerns may come from the family or carers. Addition of Lead Investigating Officer (AMH) as panel Chair. Additional SJR tools for Mental Health added. Addition of reference to the Mental Health SJR tool. Further reference to Learning from Deaths. OPMH moved from ISD structure to MH.

Reviewers/contributors

Name	Position	Version Reviewed & Date
Quality and Governance Team		Version 1 10.11.15
Mortality Project Group		Version 1 09.11.15
Tom Williams	Ulysses System Developer	V2 – June 2016
Fiona Richey	Head of Risk	V2 – June 2016
John Stagg, Sarah Constantine, Deborah Moore, Debbie Robinson, Mortality Working Group, Governance Team		Version 2 20.06.16
Ryan Taylor	Interim Head of Incident Management & Patient Safety	Version 2 October 16
Gina Winter-Bates	Quality Governance Business Partner East ISD	Version 2 October 16
Sarah Pearson	Head of Legal, Patient Safety and Risk	Version 4 July 17
Helen Ludford	Associate Director of Quality Governance	Version 4 July 17
Sarah Constantine, Mayura Deshpande, Rachel Anderson, David Kingdon	Medical Directors and Associate Medical Directors.	Version 4 July 17
Sara Courtney	Director of Nursing and Allied Health Professionals Executive Lead for Mortality	Version 4 July 17
Mortality Forum Membership	Mortality Forum Membership	Version 4 July 17
Hants & IOW Pathway and Pathfinder services – secure services group	Service Clinical Leads	Version 4.1 July 17
Mortality Forum Membership Virtual Policy Approval Group	Mortality Forum Membership	Version 4.3 August 17
Mortality and Serious Incident Forum Membership	Mortality and Serious Incident Forum Membership	Version 4.6 September 17
Serious Incident and Mortality Forum Membership	Mortality and Serious Incident Forum Membership	Version 6 January 19

Quick Reference Guide

For quick reference, this page summarises the actions required by this policy. This does not negate the need to be aware of and to follow the further detail provided in this policy.

This policy and procedure demonstrates the Trusts' obligations to fulfil the national requirements of the National Quality Board, March 2017, 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, and how it does so. The Trust is obligated through its Duty of Care to report, investigate and learn from patient deaths.

The document provides clear guidance to staff on the following:

1. Which deaths to report
2. How to report
3. The process following reporting
4. Establishing the level of investigation to be undertaken
5. Involving Loved Ones, Families and Carers
6. The Role of the Family Liaison Officer
7. Learning through the Serious Incident and Mortality Forums

It also demonstrates how Southern Health NHS Foundation Trust will quality monitor the process and provide the Board with assurance that deaths are being review and learning / improvement is taking place to benefit future patients.

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Policy and Procedure for Reporting and Investigating Deaths

1. Policy Statement

1.1. Southern Health NHS Foundation Trust recognises the importance of reporting and investigating deaths to enable service wide learning and quality improvement for the benefit of current and future patients.

1.2. Southern Health NHS Foundation Trust recognises the importance of involving families in the care of patients, values the richness of information they are able to share and wishes to involve them in investigations of deaths where concerns have been raised about the care provided as an important of learning from deaths.

1.3. The Trust has reviewed the national publications and in the construction of this policy and procedure has considered the recommendations and findings within these documents:

- NHS England, December 2015, Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015.
- Care Quality Commission, December 2016, Learning, candour and accountability.

1.4. It is a priority of the Trust Board to be assured that there is an evidence based procedure and methodology to support the reporting and investigation of deaths of patients using Trust services and that the Trust meets the requirements of:

- National Quality Board, March 2017, 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.
- National Quality Board, July 2018, National Guidance on Learning from Deaths: Guidance for NHS Trusts on working with Bereaved Families and Carers.

1.5. Executive leadership for this policy and procedure sits with the Medical Director and the Non-Executive Director responsible for Quality. The document changes are approved by the Mortality and Serious Incident Forum and shared with the Quality and Safety Committee.

1.6. Divisional Clinical Directors and Associate Directors of Nursing and Allied Health Professionals are responsible assuring that the policy and procedure are used with the divisions as the standard mortality management for Southern Health NHS Foundation Trust.

1.7. The corporate Quality Governance team are responsible for updating the document based on national guidance.

2. Introduction

2.1. This procedure supports the Trust's Policy for Managing Incidents & Serious Incidents (SI), (SH NCP 16) and should be read in conjunction with this. It outlines the specific requirements for reporting, reviewing and investigating deaths.

2.2. This procedure provides staff with information in relation to which deaths should be reported internally on the Trust's incident management system (Ulysses), subsequent review and the level of investigation that is required.

2.3. This procedure is applicable to all staff whether they are employed by the Trust permanently, temporarily, through an agency or bank arrangement, are students on

placement, are party to joint working arrangements or are contractors delivering services on behalf of the Trust.

2.4. For ease of reference, the term 'patient' is used throughout this procedure document. This is intended to refer to all people who make use of any of the health care services provided by the Trust.

3. Background

3.1. Previously, deaths were reported on Ulysses if they were deemed to be 'unexpected' and reporting practice varied among divisions. The distinction between 'expected' and 'unexpected' deaths is not straightforward and in many cases this classification proved unhelpful. The new criteria for reporting deaths on Ulysses are provided in Section 3 below.

3.2. It is acknowledged that most deaths do not occur as a result of a direct patient safety incident. Nonetheless, it is important that opportunities for learning from deaths are not missed and that when deaths are deemed not to require any further investigation the rationale and justification for this is clearly documented.

3.3. Deaths are to be reported using a specific *Death Notification Form* on Ulysses. This information feeds into the incident database. This does not mean that the Trust considers every reported death to constitute a patient safety incident and there are mechanisms to differentiate between these.

4. Process for reporting deaths

4.1. Any member of staff can report a death on Ulysses, although it is preferable for this to be someone who was involved in a patient's care at the time of death. Alternatively this can be the member of staff who was informed of the death, if, for example, the patient had not accessed services for some time. All staff, particularly within the community setting, will ensure that any information they may receive on a death of a patient is raised to their team management.

4.2. In order to report a death, Ulysses should be accessed by following the link below or by using links on the intranet. All staff with network access can log in to Ulysses using their network log in and password details at https://risk.southernhealth.nhs.uk/. Staff should then click "Report a Death" on the Ulysses home page.

4.3. When reporting a death the associated incident number should be entered into the clinical record for future reference. It is not necessary to enter the full details of the incident including whether an further investigation was required as this will be embedded within the Ulysses System. Please refer to SH IG Procedure for the Notification and Electronic and Manual Recording of Service Users Deaths for information regarding the clinical records.

4.4. The table below shows which deaths should be reported to Ulysses for each division:

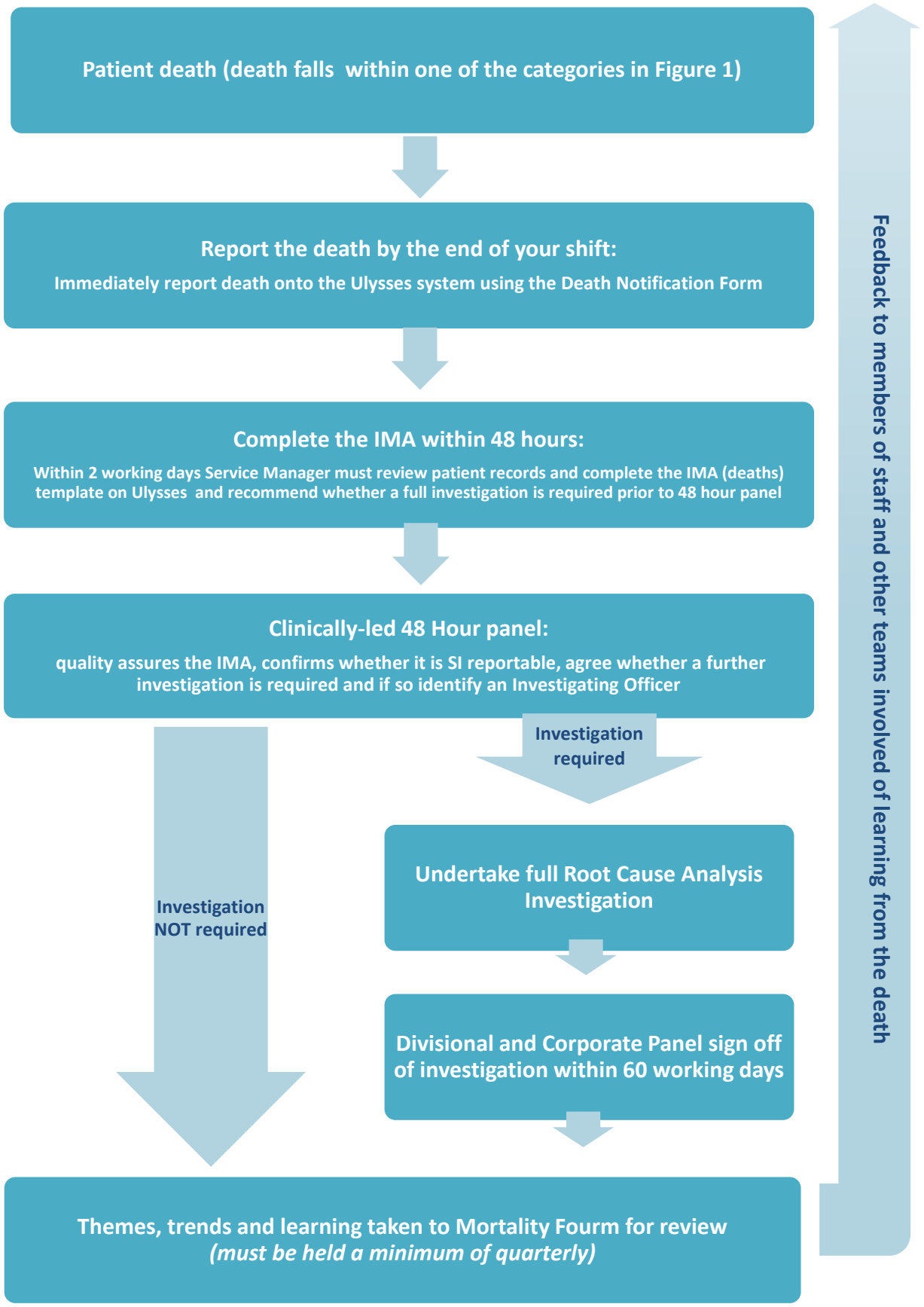
Figure 1: Deaths which must be reported on Ulysses within the Trust

Deaths which must be reported on Ulysses by Division	Including
For All Services	- *All deaths of patients where any concern is raised about the care provided by Southern Health NHS Foundation Trust to staff prior to a patient's death, by family or others. This must always be reported regardless of how long the patient may have been discharged.* - *Where the death has been reported to the Coroner*, or concerns have been raised by any individual or organisation as to the circumstances surrounding the death* - *Patients / Service Users who die detained under a Section of the Mental Health Act.*
Adult Mental Health & Specialised Services	- *All deaths of patients with an open/active referral including palliative care patients* - *All suicides or suspected suicides that occur within 6 months of last contact (regardless of whether on open referral or discharged)* - *Patients who die following transfer to an acute/general hospital from a Trust inpatient unit (including those who are under a Section of the Mental Health Act)*
Learning Disabilities	- *All deaths of patients within 6 months of last contact (regardless of whether an open referral or discharged) and including palliative care patients*
OPMH, Physical Health, & Children's (In-patient)	- *All deaths of in-patients, including;* - *Palliative care patients* - *Patients who die following transfer to an acute/general hospital from a Trust inpatient unit (including those who are under a Section of the Mental Health Act)* - *Child deaths may also be subject to a Rapid Response Process through Safeguarding.*
OPMH, Physical Health, & Children's (Community)	- *The patient had been discharged home from a Southern Health inpatient unit in the preceding 30 days* - *The patient was known to have an open referral to adult or children's safeguarding* - *If any acts, omissions or concerns in care provided by Southern Health services have been identified* - *All suicides or suspected suicides that occur within 6 months of last contact (regardless of whether on open referral or discharged)*
OPMH Liaison Service Services	- *OPMH – All deaths by suicide/related to self-harm should be reported.* - *Patients who die following transfer to an acute/general hospital from a SHFT service under active mental health act section.*
Psychological Medicine – Liaison Services	- *The patient was known to have an open referral to adult or children's safeguarding* - *If any acts, omissions or concerns in care provided by Southern Health services have been identified* - *All suicides or suspected suicides that occur within 6 months of last contact (regardless of whether on open referral or discharged)*
Hampshire and IOW MAPS Pathway and	**Pathway** - The service users within this service are managed by the National Probation Service, some of whom may be registered with a general practitioner. The primary focus of this service is to support the professional (Offender Managers) in working with the service user group (personality

Pathfinder	disordered offenders posing a high risk of harm to others and a high risk of recidivism) and therefore SHFT care is only time limited joint work sessions with the Offender Manager and service user. All outcomes are reported on the National Probation Service electronic recording system 'Delius'. **Pathfinder** – As above although RiO records are kept and a caseload exists however the care coordination (for health referrals) or risk management (for criminal justice referrals) remains the responsibility of another party. Only report if: - *If any acts, omissions or concerns in care provided by Southern Health services have been identified* - *Concerns have been raised by any family member* - *The service user was under SHFT care coordination / mental health services within the previous 6 months* The service will be involved in any investigation undertaken by the National Probation Service, the general practitioner or mental health service provider (Solent or IOW) as requested.
General Practice (operated by the Trust)	Established processes for reporting and reviewing deaths to NHS England and commissioners are in place. This process includes establishing whether there are any concerns that may need further investigation, where this is the case, this procedure would be instigated. **In addition SHFT procedure will be instigated where;** - *Any death requiring reporting to the Coroner * (includes suicides, industrial deaths, RTAs and other unexplained deaths)* - *Any complaints or concerns raised to the GP in relation to a death* ***For 'The Practice' based at LNFH:*** *The death of any patients seen by The Practice at LNFH within the previous 30 days.*

***** Details of deaths which must be reported to HM Coroner are detailed in Appendix 10.

This flow chart outlines the process for reporting and investigating deaths. Each step is explained in more detail on the following pages.



5. Transfer of services from Southern Health NHS Foundation Trust

5.1. As per the requirement of the standardised contract, the responsibility to investigate a death following the transfer of a service will be assumed by the new provider.

5.2. Southern Health will be happy to participate in any multi-provider serious incident investigation, should the requirement arise and contact should be made through the Southern Health central serious incident management team.

6. Death Notification Form

6.1. The Death Notification Form is found in Ulysses as described in 3.2 above. This form should be completed as soon as possible within the same shift. Certain fields on the electronic form are necessary to be mandatory as failure to complete will slow down the next stage of the process. The form will only be able to be submitted once these are completed.

6.2. On reporting the death using the Death Notification Form, the cause of the person's death may not yet be known. The reporter will therefore be asked to select from the following broad categories:

- **Probable Suicide - inpatient**
- **Probable Suicide - outpatient**
- **Other inpatient death** (includes deaths in the acute sector following transfer from a Southern Health inpatient unit)
- **Other outpatient or community death**

6.3. If the cause of death is known, this should be included in the relevant field of the form. If the death has been referred to the coroner to establish cause of death (i.e. for post-mortem examination), this information should also be included.

6.4. Consideration of whether the incident requires referral to adult or children safeguarding is to be undertaken. This should be noted on the form.

6.5. If the person was in receipt of palliative/end of life care this should also be recorded (if known).

6.6. Once completed and submitted, the Death Notification Form will then trigger the established 'notification rules' where the relevant manager listed within the system will be notified automatically and they will then be prompted to complete an electronic IMA on Ulysses. If a staff member feels that the manager notification may not be correct or where the named manager may be on annual leave of other absence, the reporter must ensure that another suitable manager is made aware and notified through the system.

7. Initial Management Assessment (IMA)

7.1. Any death which meets the criteria (outlined in Figure 1 above) for reporting onto Ulysses will require initial review by the service manager. This is the same approach taken when completing an IMA for patient safety incidents inclusive of serious incidents.

7.2. The IMA will need to be reviewed by a clinically-led panel (see Section 6) within 48 hours **from when we knew of the death** so every attempt should be made to complete the IMA as quickly as possible and must be completed prior to the 48 hour panel review.

7.3. The IMA must be completed on Ulysses using the IMA template that is triggered when a Death Notification Form is completed. The IMA template is similar to that used for patient

safety incidents (often referred to as the 'manager's form'), but contains additional questions specific to deaths.

7.4. Deaths that meet the Serious Incident criteria **must** be reported to commissioners (or where applicable NHS England) with 48 hours. This is a critical contractual performance indicator and therefore it is imperative that the clinical 48 hour panel meets and concludes within this period. **Please refer to the Procedure for the Management of Serious Incidents that Require Investigation (SH NCP 60)**

7.5. The purpose of the IMA is to:

- capture any potential concerns about the care or service provided prior to the death including those raised by the family and / or carers
- identify key issues or safety risks that require immediate action
- identify any initial third party agency factors and considerations
- determine whether further investigation is required and whether the death meets the criteria to be deemed and declared as a 'Serious Incident' (SI). This will be formally agreed as part of the 48 Hour Panel Review (see below)
- Any reasons why a death may need to be potentially reported externally, including the police. In these cases, advice should be sought from the central legal team or a director.

7.6. The IMA report may be shared with commissioners, the family, the Coroner and other external agencies and must of a suitable quality for this purpose.

7.7. The patient's clinical/support records must always be reviewed as part of the IMA process and it is likely that provisional discussions with staff will be required and consideration should also be given to contact with the family of the deceased (see Section 10 below).

7.8. One of the key functions of an IMA is to determine if further investigation maybe required and if this **is** the case, this will then proceed to a root cause analysis investigation (RCA).The IMA will also confirm whether the death meets the national framework for reporting as a serious incident. A death can still be subject to and benefit from a root cause analysis investigation, even if it is not reportable as a serious incident. If the person completing the IMA feels that it would benefit from a more detailed investigation this should be made clear.

7.9. The key criterion to determine whether an investigation is required is not the possible cause of the person's death, but whether it appears adverse acts or omissions in care or service delivery may have been identified.

7.10. If the cause of death is not yet known, and further investigation is not deemed to be required, every effort should be made to discover the cause of death following the completion of the IMA beyond the initial 48 hour period. When the cause of death is discovered, the IMA must be re-visited to ensure the recommendations and actions taken remain appropriate. Confirmation of cause of death could offer further information that could trigger a full review of the initial IMA and potentially a further 48 Hour Review Panel may be required.

7.11. Where the death appears to meet the requirements of a Serious Incident, refer to section 8.

7.12. Where it is determined at IMA stage that a death does **not** require further investigation by the Trust, the service manager should also consider whether:

- the death should be notified to commissioners because of concerns about the care provided by a third party which might need investigating outside of the Trust. This should be undertaken via the central Quality & Governance Team

- there is any learning to be obtained from the IMA process (even if this is minor and does not in itself warrant further investigation)
- there is good practice that has been identified that should be shared

It should be noted that it is the responsibility of the 48 hour Panel to review the IMA, completed the structured judgement review and formally conclude if a further investigation is required or not.

7.13 For child deaths if there is a Rapid Response Process instigated by the police this should be documented in the IMA and reviewed by the 48 hour panel.

8. 48 Hour Panel Review

8.1. Terms of Reference for the 48 hour panel are attached as Appendix 1.

8.2. Each completed IMA is required to be quality assured by a clinically-led 48 hour panel to ensure that the findings and recommendations made in the IMA are appropriate and sufficient. In particular, the recommendation as to whether to proceed to a full RCA investigation or not and whether the death is reportable as a serious incident.

8.3. The panel is also responsible for undertaking the structured judgement review and to enable this to happen the completed IMA and clinical records must be available. A minimum of 30 minutes per case should be allowed.

8.4. The panel can be convened by remote access such as Lync or conference calling and divisions can make their own decisions on a case by case basis as to who is most appropriate to attend. It must, however, be chaired by a senior clinical lead within the Division (for eg. Clinical Director, Clinical Service Director, Associate Director of Nursing, Lead Investigating Officer AMH) and 'attended' by the IMA author. If the IMA author is not able to attend then a member of the panel must be nominated to feed back any comments and changes that need to be actioned. In Learning Disabilities the panel must be attended by an individual trained in the LeDeR methodology to meet the requirement of the National Quality Board.

8.5. The Structured Judgement Review (SJR) tool is available as a 'questionnaire' to be selected by the panel administrator and these must be completed as part of the panel process. The options available are;

Structured Judgement Review tool – Physical Health Community Patients and Physical Health In-patients; both based on the Royal College of Physicians tool.

Structured Judgement Review tool – Mental Health all services; based on the Royal College of Psychiatrists tool.

8.6. If the cause of the person's death is not known at the time of the 48 hour panel, the panel members and chair must agree, based on what information is known and understood whether any acts or omissions of care were identified or suspected from the IMA. They must jointly agree if an investigation is required or not.

8.7. If an investigation is required, the panel should ensure a commissioning manager is assigned and also take steps to nominate an investigating officer where possible. The panel should agree a process for drafting the Terms of Reference for the investigation; see SH NCP 60 Procedure for Serious Incidents Requiring Investigation for further information about roles of Investigating Officers and Commissioning Managers.

8.8. If the panel agree that the death does not require further investigation and this is in effect the end of the formal process, they must grade the impact of any act or omission on the

person's outcome (see section 8 "grading the actual impact of the incident" below). If the death is going to proceed to further investigation this grading will take place once the investigation is complete.

8.9. The Chair's name is recorded in the 48 hour panel questionnaire to sign off the IMA. IMAs must be returned to the author if the quality is not satisfactory and a note should be entered on the 'questionnaire' to provide the reasons for the form being returned. Further actions required should be added to the IMA on Ulysses by adding an action in the relevant section; this can then be allocated out to the relevant person, such as the IMA author.

8.10. A further panel can be held if required to review the further information requested – an additional questionnaire should then be added to record the second panel decision making. However the initial panel must be conducted within 48 hours, this is particularly important as where a death is deemed to be a SI, the Trust must report this to the commissioners within 48 hours (2 working days).

9. Structured Judgement Review

9.1. The structured judgement review is a requirement of the National Quality Board, March 2017, 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.

9.2. Southern Health NHS Foundation Trust uses a modified tool from the Royal College of Physicians for use in the physical health services both In-patients and Community. And has adopted the tool launched by the Royal College of Psychiatrists published in December 2018.

9.3. Southern Health NHS Foundation Trust has decided to use the NCEPOD scale, Avoidability scale and Quality of Care Tool as part of the structured judgement review questionnaire.

9.4. For those patients with a Learning Disability the LeDeR methodology should be used and the panel must consist of an individual trained in the methodology. This should be recorded as part of the panel function.

9.5. The review tool is available as a questionnaire within Ulysses system and it should be completed as a function of the panel or within five days following the panel if not enough information is available.

9.6. Lymington New Forest Hospital have an established process in place where the Structured Judgement Review is completed as part a review undertaken by a Consultant rota in 100% of cases and is recorded on a separate electronic tool. NCEPOD grade is established and recorded as part of this process.

9.7. The use of the Structured Judgement Review will be audited as part of the 25% of all reported deaths audited per month.

9.8. The Trust must publish data on the amount of Structured Judgement Reviews undertaken quarterly as from quarter three 2017 and report this to Board in a 'stand-alone' report. The year-end position will be published within the annual Quality Account.

10. Full Investigation – Root Cause Analysis (RCA)

10.1 Every death which is reportable as a Serious Incident under the national framework must have a full RCA investigation undertaken in line with SH NCP 60 Procedure for Serious Incidents Requiring Investigation.

10.2 A RCA investigation can also be carried out for deaths which are not reportable as a serious incident under the national framework if it is felt that the case would benefit from a more thorough review.

10.3 If the person's cause of death is not yet known, the investigation should still be commenced, however further amendment and revision should be made to the terms of reference and investigation report as more information becomes available.

10.4 During the investigation, if a Police investigation is also being undertaken then advice MUST be sought from the detective responsible to seek approval to continue to a full investigation. This is to ensure Police investigations are not compromised. This must be formally recorded on the IMA form under "police involvement".

10.5 RCA investigations must be carried out on the Ulysses system to ensure all of the information relevant to that patient is kept on one single record. All associated documentation must also be attached to Ulysses.

10.6 The Investigation report must follow the Divisional Panel and Corporate Panel processes for review within the 60 working day timeframe required by Commissioners. This means that such investigations need to be internally completed by 45 working days. The Corporate Panel will agree the actual impact grading for any death subject to full investigation as per section 8 below.

10.7 For further guidance and procedures around undertaking an investigation, please refer to SH NCP 60 Procedure for Serious Incidents Requiring Investigation.

11. Grading the Actual Impact of the incident

11.1 The impact of any failings on the part of the Trust that has contributed to the patient's outcome needs to be assessed and graded. This is for both internal reporting purposes but is also needed in order to report to the National Reporting and Learning System (NRLS) and the Care Quality Commission.

11.2 Grading the impact requires consideration of any gaps, omissions or acts during the care or service provided that may have caused or contributed to the patient's death.

11.3 The following table gives definitions for the impact grading of a death:

Actual Impact Grading	
Actual Impact	**Definition**
No Harm	▪ No care or service delivery problems identified. Trust could not have prevented the death. ▪ No root cause (material factors) or contributory factors relating to SHFT care were established.
Low Harm	▪ Some care or service delivery problems identified, but only impact on quality of service, not on patient outcome. Trust could not have prevented the death. ▪ No root cause (material factors), some minor contributory factors relating to

	SHFT care were established.
Moderate Harm	▪ Contributory factors identified may have had a minor impact on the actual outcome for the person. Trust could not have prevented the death. ▪ No root cause relating to SHFT care was established.
Major Harm	▪ Contributory factors identified that may have an impact on the outcome for the patient. Not clear, although possible we could have prevented the death. ▪ Potential for a contributory factor to be possible root cause relating to SHFT care provided.
Catastrophic Harm	▪ Material care or service delivery gaps established. ▪ Preventable death. ▪ Root cause directly linked to SHFT care provided.

12. Involvement and support of the deceased's family, Duty of Candour (Being Open) and the Family Liaison Officer

12.1 Every healthcare professional must be open and honest with patients and their families. The Being Open principles and ethical duty of openness and engagement apply to all incidents and any potential failure in care or treatment.

12.2 The statutory requirement of Duty of Candour (DoC) applies to specific incidents whereby moderate harm, significant harm or death has occurred or may in the future. This refers to harm that the organisation either by act or omission could have caused. Where it is suspected that this has occurred, the requirements under DoC apply.

12.3 Every NHS Trust, since November 2014, has a statutory responsibility in relation to Duty of Candour and the associated requirements.

12.4 Candour is defined by Robert Francis as: *'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made'.*

12.5 In the event of a death under this procedure where it is decided that further investigation is required the Duty of Candour Policy (SH NCP 12) and the Being Open Procedure (SH NCP 13) must be followed. This will ensure communication is effective within a structured manner with families and others. It is important to follow these polices to ensure that staff understand the difference in the context of the legal requirement (and actions) required under Duty of Candour legislation, opposed to undertaking patient engagement and being open.

12.6 Liaison and communication with the patient's family should be co-ordinated with all services or teams involved in delivering care and should be based on the preferences of the family in terms of method and amount of involvement/communication.

12.7 Families should be contacted to offer condolences and give the family contact details of someone they can discuss concerns with should they have any, and details of how to make a complaint should they wish to. It should be remembered that the fact the event has been recorded as a formal incident, often gives confidence to the family that a thorough and open investigation will take place.

12.8 It is important to remember when communicating with families that often when it is decided an investigation is required under this procedure, this does not automatically mean we have failed to provide adequate care or treatment, however we need to undertake a further review to ensure this and establish whether there are any lessons that could be learnt. Some families might not be aware of any issues associated with a

death of a family member, particularly for an end of life patient. Therefore learning that an 'investigation' into the death is being undertaken may cause additional anxieties if this is not handled well.

12.9 Every review of a patient's death must be undertaken in liaison with the person's family wherever possible. Families should be given the opportunity to provide feedback about the service regardless of whether the death meets legal obligations for following Duty of Candour.

12.10 If the family would like the person's death to be investigated or if they have any concerns, these must then inform the level of review and the terms of reference of any investigation into the person's care. Families must be invited to share concerns they may have and be offered input into the terms of reference for the investigation.

12.11 Families should have the opportunity to receive information on findings from IMAs and investigations. Involvement can be face-to-face, via telephone or in writing/email. Regular updates on the investigation progress should be discussed and agreed with the families.

12.12 The investigation Commissioning Manager (if an investigation is undertaken) or Service Manager is responsible for ensuring that family members and carers or others who may have been affected by the death are offered information and guidance about counselling and support available via their GP, voluntary sector or local Mental Health services.

12.13 Southern Health NHS Foundation Trust has a Family Liaison Officer (FLO) in post and staff are able to refer cases directly to her for support at any time within the process. She is able to offer sign posting to other services as well as providing initial support. The FLO will also attend meetings with families alongside the Investigating Officer or the Commissioning Manager to share reports and investigation findings. Referral form can be found at Appendix 7.

12.14 Any death that is reported as a probable suicide or as a result of self-harm should automatically include a referral to the FLO as part of the 48 hour panel process.

12.15 The Duty of Candour activities must be recorded on Ulysses and any communication letters / e mail attached to the system.

12.16 Within Being Open activities, it must be recognised that some families wish to see change evidence and be provided assurance that action plans for improvement have been managed properly to prevent reoccurrence. This should be offered.

12.17 Further guidance can be found in SH NCP 12 Duty of Candour Policy and SH NCP 13 The Being Open Procedure (incorporating Duty of Candour).

13. Supporting Staff

13.1 The service manager is responsible for ensuring that staff who may have been affected by the death are offered the opportunity of counselling, support or debriefing. They should be made aware of all the internal and external support available (and assistance with making referrals and/or seeking support as appropriate). These include:

- Human Resources and Occupational Health Services
- Critical Incident Stress Management (CISM) services
- Independent Employee Assistance Programme

- Trade Unions, including Staff side/Union reps, other Professional bodies or other managers or colleagues

13.2 It is also important for staff to be kept aware of the progress of an investigation with which they have had clear associations. This will be the responsibility of the commissioning manager of the investigation and the line manager of the member(s) of staff. In particular, staff involved should be kept informed of when the investigation report has been completed and the findings and recommendations. They should be involved in coming up with actions to address the recommendations.

14. Learning from Deaths - Mortality and Serious Incident Forum, Mortality Meetings and Thematic Reviews

14.1 The Trust has a Mortality and Serious Incident Forum in place is to oversee and assure the Effective Work Stream and Quality & Safety Committee (QSC) that:

- Mortality Meetings are occurring in each of the Divisions to a high standard receiving formal feedback from the Chairs of those meetings
- The Serious Incident and Mortality Action Plan is reviewed and those actions which are red are discussed and either remedial recovery plans put in place or escalation to Director level to resolve with the accountable action owner
- Thematic reviews related to mortality are received and reviewed by the group.
- Learning from Deaths is shared throughout the Trust for improvement.

14.2 To ensure that processes in place within the Trust for the monitoring of mortality are correct and lead to improved outcomes for service users.

14.3 At divisional level Mortality Meetings should be held at least quarterly in each Division, although it is up to the division to decide whether this will be a single meeting for the whole division or whether there will be a number of locality or speciality based meetings.

14.4 Terms of reference for Mortality Meetings are attached at Appendix 2 and provide further guidance.

14.5 In summary, Mortality Meetings are the forum through which thematic reviews into emerging themes and trends are commissioned and reviewed with recommendations being made and disseminated. These will be overseen by the Mortality and Serious Incident Forum.

14.6 Chairs of divisional Mortality Meetings are required to provide formal feedback to the Trust wide Mortality and Serious Incident Forum.

15. Quality Assurance and Process Audit

15.1 It is important the Trust has the ability to monitor the compliance to and the quality elements of this policy and procedure therefore a formalised approach has been adopted.

15.2 Compliance to completing the IMA, structure judgement review and 48 hour panel is monitored through daily Tableau business intelligence system with monthly results reported through to the Mortality and Serious Incident Forum as a standard agenda item.

15.3 The quality of the components listed at 15.2 are assessed by a structured audit process. This process is undertaken monthly, by schedule, by the clinical membership of the Mortality and Serious Incident Forum.

15.4 The structured audit is conducted on 25% of all cases and the findings reported back for learning and improvement to the Mortality and Serious Incident Forum as a standard agenda item. The divisional representative in attendance feeds this information back to the 48 hour panel Chairs.

15.5 The percentage result related to the question – 'is there evidence of decision making as to the level of investigation and is this correct?' is reported to the Quality and Safety Committee as a sub-committee of the Board.

16. Associated Documents

This procedure supports the following policy and associated procedures:

SH NCP 16 Policy for Managing Incidents and Serious Incidents
SH NCP 60 Procedure for Reporting and the Management of Serious Incidents

Please also refer to the following policies and procedures as required:

SH CP 15.2 Safeguarding Adults Policy
SH CP 56 Safeguarding Children Policy
SH NCP 12 Duty of Candour Policy
SH NCP 13 The Being Open Procedure (incorporating Duty of Candour).
SH IG Procedure for the Notification and Electronic and Manual Recording of Service Users Deaths.

Appendix 1: Terms of Reference for 48 Hour Panels

1. Constitution

1.1 The Trust Executive Committee (TEC) resolves to establish 48 hour Panel Meetings which function as part of the incident process.

1.2

1.3 The 48 hr panel meetings are authorised by the Quality & Safety Committee (QSC) via the Patient Safety Group to take action in respect of any activity within their Terms of Reference. They are authorised to seek any information they require from any employee and all employees are directed to co-operate with any request made by the panel Chair.

1.4 The definition of 48 hours is within 2 working days of the incident or death occurring or the Trust being made aware that it had occurred.

2. Purpose, Duties and Responsibilities

2.1 The purpose of the 48 hour Panel Meeting is to review information pertaining to the occurrence of a death or incident. The panel is responsible for reviewing IMAs linked to patient deaths and those incidents with significant patient harm graded as major or catastrophic and completing the structure judgement review tool.

2.2 The panel's duties include the following:

- Determine if the information contained within the IMA form is adequate
- Determine whether the recommendations made by the IMA author are appropriate with regards to:
    - Immediate actions required to prevent harm to others
    - Requirement to contact the police
    - Referrals to Safeguarding
    - Level of investigation required (including whether the incident is reportable as a 'Serious Incident')
    - Steps taken in relation to duty of candour
    - Support for the staff involved in the incident
    - Requirement to notify commissioners of any concerns identified with 3rd party organisations
- Determine the Investigation Commissioning Manager (usually the panel Chair) and Investigating Officer. (Whilst the commissioning manager does not need to be the panel chair, the panel chair is responsible for ensuring the Terms of Reference (TOR) are provided to the investigating officer within 5 days of the panel convening.)
- Make an accurate record of the panel meeting including its membership and its conclusions on the Ulysses system
- Communicate the outcome with regards to SI reporting to the Governance Team (Incident and Investigation Team) to ensure that the external reporting to STEIS (Strategic Executive Information System) is completed. This must occur on the same day as the panel as national external reporting must be undertaken in 48 hours (2 working days).
- Develop a plan for internal executive communication if required
- Develop a plan for external media communications if required
- Ensuring completion of the Structured Judgement Review embedded within the Ulysses system.

3. Membership

3.1 The Divisional Clinical Director, Clinical Service Director, Associate Director of Nursing, Head of Nursing or Lead Investigating Officer (AMH) should chair the panel which can

take place either face to face or via Lync conference call facilities. If none of these members of staff are available, the panel can be chaired by a nominated senior clinician.

3.2 Those invited and expected to attend as a minimum would be:

- The manager of the service in which the incident occurred
- The individual completing the IMA (if different to the above)

3.3 Further invited members to be considered dependent on the incident type;

- Service senior managers
- Clinicians involved
- Safeguarding representative
- Corporate Serious Incident Manager and incident officer
- Business manager
- Human Resources expert
- Subject matter experts dependent on the incident.

4. Accountability

4.1 The Divisional Clinical Directors are accountable for ensuring that 48 hour panels are held to review IMAs involving a patient / service user death or those incidents with significant patient harm graded as major or catastrophic, and to ensure the Structured Judgement Review is completed.

5. Review

5.1 These Terms of Reference shall be reviewed within 12 months of the date previously approved.

Appendix 2: Terms of Reference for and Mortality Meeting and Serious Incident (divisional)

Mortality and Serious Incident Meeting (Divisional)

Terms of Reference

1. Constitution

1.1. The Trust Senior Management Committee (SMC) resolves to establish a divisional based forum known as the Serious Incident and Mortality meeting.

1.2. The Mortality and Serious Incident Forum is authorised by the Quality and Safety Committee (QSC) via the Effective workstream to take action in respect of any activity within its Terms of Reference.

1.3. The meetings will be overseen in the first instance by the Mortality and Serious Incident Forum (MSIF). It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the meeting Chair

2. Purpose

2.1. The purpose of the Mortality and Serious Incident meeting is to derive knowledge and insight from adverse events which may have resulted in patient / service user death or serious harm. The knowledge regarding the death or event should be openly discussed and critiqued regarding contributory factors.

2.2. Where contributory factors are the primary responsibility of the Trust, improvement should be discussed and where feasible should be implemented.

2.3. Where contributory factors are not the primary responsibility of the Trust findings should be shared across multiple providers as part of a health service improvement plan which will be led by the commissioners.

2.4. The Mortality and Serious Incident meeting is linked into the Trust governance framework reporting both to Divisional and Trust Boards. Through this mechanism the meeting provides assurance to the Trust Board that patient and services users are not dying or coming to serious harm as a direct result of the Trust not learning from previous incidents.

3. Membership

3.1. The Clinical Service Director will chair and in their absence, the nominated deputy will preside over the meeting. (For Childrens Division the meeting will be chaired by the Associate Director of Nursing and Allied Health Professionals).

3.2. A quorum will be 50% of core members in addition to the Chair or Vice Chair.

3.3. Members will attend at least 75% of meetings annually, meetings will occur quarterly (as a minimum) but division may opt to hold these monthly.

3.4. **Core Members**

- Clinical Service Director (Chair)
- Nominated Deputy (Vice Chair)
- Medical Representative from each locality (minimum 2)
- Nursing Representative from each locality (minimum 2)

- Therapies Representative from each locality (if appropriate)
- Senior Divisions Manager with responsibility for Governance
- Lead Investigator

An agreed consistent secretary will provide secretarial support to the meeting. Functions to be undertaken;

- agenda construction
- meeting booking
- circulation of papers
- minute taking

3.5 **Co-opted Members**

Any other member of staff from across the Trust or externally, may be invited to attend the meeting on a periodic or ad-hoc basis. These may include;

- Corporate SI and Incident Officer
- Corporate Safeguarding team member
- Quality Governance Business Partner
- External Stakeholders – Commissioners, GP representative and 3rd sector organisations

The corporate Deputy Medical Director for Patient Safety or Director of Performance, Quality and Patient Safety must attend each divisional meeting once per annum.

4. Duties & Responsibilities

Data review

4.1. To review the data and the themes surrounding all deaths and serious harm incidents within the Division. This must include numeric data plus qualitative data, for example, cause of death / serious harm and the locality where it occurred.

Improvement & Development

4.2. Undertake periodic review of a sample of deaths reported which did not require investigation to review and validate decision making.

4.3. Through case study review the attendees should establish;

- What happened?
- Why did it occur?
- Whether the Trust by act or omission contributed to the patient harm?
- Could it have been prevented or better managed?
- What are the lessons for learning and sharing?

4.4. Where treatment plans could be viewed as contributory factors consider involving other forums to lead the quality improvement activities, examples;

- Mental or Physical Health drug and therapeutics committees with oversight from the Medicines Management Committee
- Clinical Effectiveness forum
- Resuscitation committee
- Falls group

4.5. To promote a culture of learning from deaths Trust-wide amongst health professionals.

4.6. To provide case studies for organisational learning via the Trust-wide quality conferences.

Assurance

4.7. To provide assurance to the Divisional Board and Trust Board that service / care activities provided are safe and that patients / service users are not dying as a direct consequence of service failure or malpractice.

4.8. To provide a quarterly report monitoring mortality rates, types and service improvements to the Trust Board via the Quality and Safety Committee as the requirement of the National Quality Board.

Risks

4.9. To monitor the risk specific to treatment pathways and associated therapies that from thematic analysis have an increased risk of unexpected death occurring. Ensure these risks are captured and actively monitored on the divisional Ulysses risk register.

5. Accountability

5.1. The Mortality meeting shall be accountable to the Divisional and Trust Board via Mortality and Serious Incident Forum and the Quality and Safety Committee.

5.2. Appendix 4 shows the reporting structure of the meeting.

6. Review

6.1. The Terms of Reference of the meeting shall be reviewed annually.

6.2. This will include a review of its effectiveness to ensure it has performed in accordance with these terms of reference, specifically that:

- The Mortality meeting has occurred and been quorate
- The Mortality meeting has reported to the Divisional and Trust Board via QSC
- Has provided service quality improvement and is able to evidence this?

7. Reporting Structure

7.1. Refer to Appendix 4

Appendix 3: Terms of Reference for Mortality and Serious Incident Forum (Trust Wide)

Mortality and Serious Incident Forum

Terms of Reference

1. Constitution

1.1. The Trust Senior Management Committee (SMC) resolve to establish a divisional based forum known as the Mortality and Serious Incident Forum (formally known as the Mortality Working Group and Mortality Forum).

1.2. The Mortality and Serious Incident Forum is authorised by the Quality and Safety Committee (QSC) via the Effective work stream to take action in respect of any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the meeting Chair.

2. Purpose

2.1. The purpose of the Mortality and Serious Incident Forum is to oversee and assure the Effective work stream and the Quality and Safety Committee (QSC) that:

- Mortality Meetings are occurring in each of the Divisions to a high standard receiving formal feedback from the Chairs of those meetings
- The Serious Incident and Mortality Action Plan is reviewed and those actions which are red are discussed and either remedial recovery plans put in place or escalation to Director level to resolve with the accountable action owner
- Thematic reviews related to mortality and serious incidents are received and reviewed by the group
- Trust-wide learning occurs as a result of mortality and serious incident investigations.

2.2. To ensure that processes in place within the Trust for the monitoring of mortality are correct, lead to improved outcomes for service users and meet the requirements of the National Quality Board and NHS Improvement – Quality Account.

3. Membership

3.1. The Associate Medical Director - Quality will chair and in their absence, the nominated deputy will preside over the meeting from the attending senior medical staff. In a circumstance where parties are not available the Associate Director of Quality Governance will chair.

3.2. A quorum will be 50% of core members in addition to the Chair.

3.3. Members will attend at least 75% of meetings annually, meetings will occur monthly.

3.4. <u>Core Members</u>

- Chairs of the Divisional Serious Incident and Mortality Meetings
- Associate Director of Quality Governance
- Associate Medical Director – Quality
- Head of Legal, Patient Safety and Risk
- Ulysses System Developer or Risk Manager

- Lay Person / Patient Partner

An agreed consistent secretary will provide secretarial support to the meeting.
Functions to be undertaken;

- agenda construction
- meeting booking
- circulation of papers
- minute taking

3.5 Co-opted Members

Any other member of staff from across the Trust or externally, may be invited to attend the meeting on a periodic or ad-hoc basis. These may include;

- Associate Directors of Nursing
- Serious Incident Investigating Officers
- Corporate Serious Incident Manager
- Corporate Safeguarding team member
- External stakeholders – commissioners, GP representative, 3rd sector organisations, NHS England and NHS Improvement

4. Duties & Responsibilities

4.1. To review and oversee the Reporting and Investigating Deaths policy and procedure, Serious Incident policy and procedure, and amend accordingly through a process of review and revisions, minimum every two years.

4.2. To review the electronic developments in the Ulysses Safeguard system to support reporting of deaths, initial management assessments (IMAs) and 48 hour panel questionnaires.

4.3. To review Trust-wide compliance to the policies and procedures list at 4.1., through review of the monthly audit results and active discussion with the Divisional Chairs.

4.4. To review the tableau data in relation to mortality and serious incident compliance and actively seek assurance from the Divisional Chairs of compliance from the Divisions.

4.5. Oversight and monitoring of the Serious Incident and Mortality action plan (Mazars) – actions specific to Mortality Meetings and the reporting procedure.

4.6. To promote a culture of learning from deaths and serious incidents Trust-wide amongst health professionals.

4.7. Receive reports from the Divisions on a minimum bi-annual basis monitoring mortality rates, types and service improvements.

4.8. Receive and review thematic analysis which has been commissioned by the Divisional meetings, requesting sight of related action plans and progress.

4.9. To commission investigations or thematic reviews into areas of concern highlighted within the data.

4.10. To provide assurance to the Trust Board that service / care activities provided are safe and that patients / service users are not dying as a direct consequence of service failure or malpractice.

5. Accountability

5.1. The Mortality and Serious Incident Forum meeting shall be accountable to the Quality and Safety Committee via the Effective work stream. The Chair will also report to the Trust Executive Committee by exception.

5.2. Appendix 4 shows the reporting structure of the meeting.

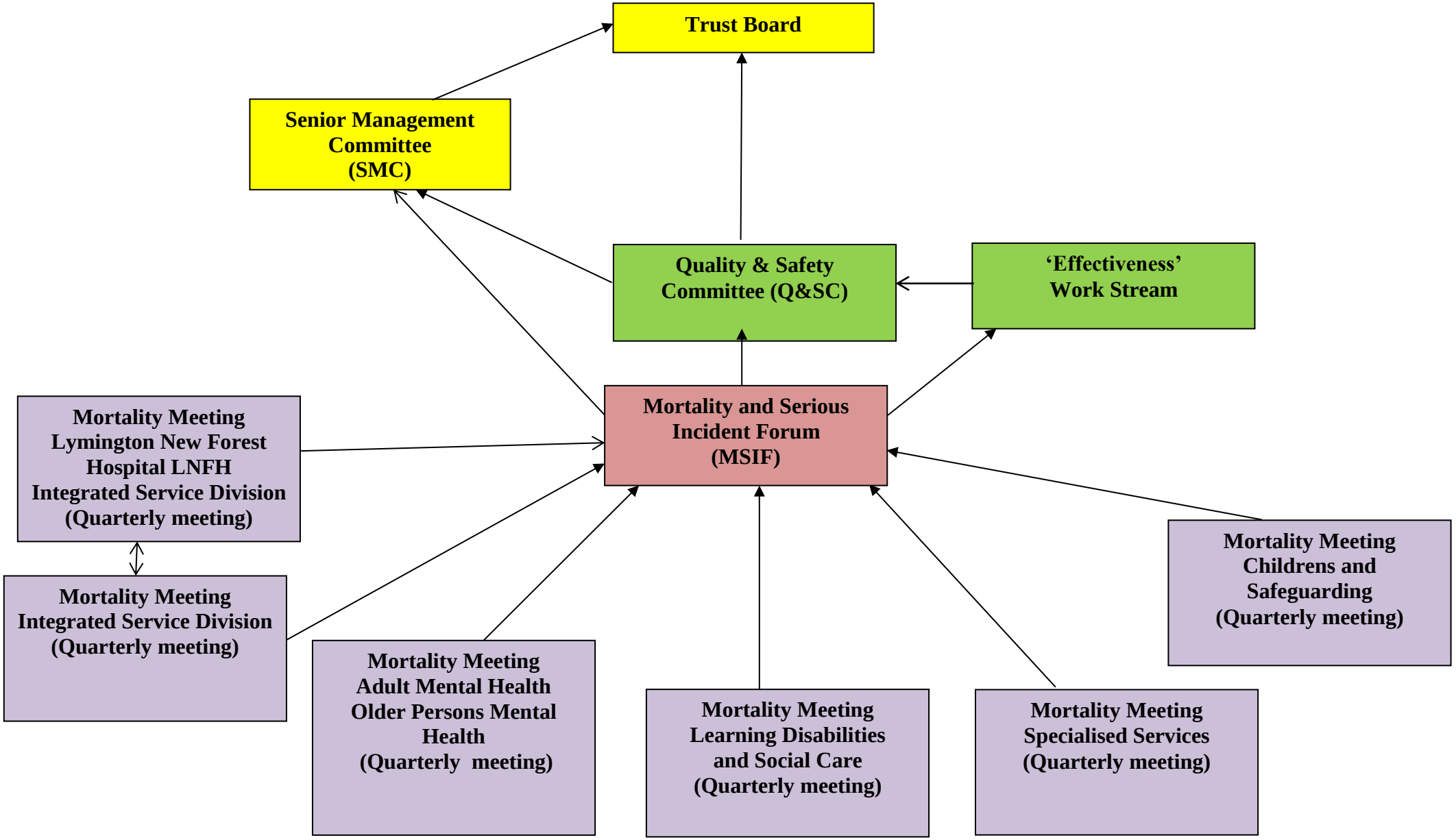
6. Review

6.1. The Terms of Reference of the meeting shall be reviewed annually.

6.2. This will include a review of its effectiveness to ensure it has performed in accordance with these terms of reference, specifically that:

- The Mortality and Serious Incident Forum meeting has occurred and been quorate
- The Mortality and Serious Incident Forum meeting has reported to Trust Board via Quality & Safety Committee and Effective work stream.
- Has provided service quality improvement and is able to evidence this.

Appendix 4: Reporting Structure



Appendix 5

Procedure for reporting deaths within Department of Psychological Medicine

Inpatient deaths
All inpatient deaths are reported or reviewed within UHS. It will be highlighted on the referral form to IMEG if a team within DPM is involved in the patient's care.

A death will also be reported within SHFT via Ulysses if:

- It was a suicide or a suspected suicide
- The IMEG panel judges that there was a concern around care provided and the DPM involvement may be connected to these concerns.
- If there were specific concerns around the patients care connected to the service provided by DPM.

Community deaths
The majority of deaths will continue to be reviewed by the person's GP who will have information that the DPM were involved in the person's care via letters.

As with the OPMH and Physical Health Services a death will be reported within SHFT if:

- It is a suspected suicide or suicide that occurs within 6 months of the last contact (regardless of whether it is an open referral or discharged).
- Concerns have been raised by any individual or organisation as to the circumstances surrounding a death
- The death has been referred to a coroner
- The patient had an open referral to adult or children's safeguarding

Appendix 6
Structured Judgement Review Tools

SHFT has Structured Judgement Tool built into the Safeguard Ulysses incident reporting system.

Physical Health tools are based on the Royal College of Physicians tool and adopt all three scoring methodologies.

Mental Health tools are based on the Royal College of Psychiatrists tools and adopt the Quality of Care Score.

Scoring Methodology

NCEPOD scale

NCEPOD Grade	Descriptor	Please Tick
1	Good Practice	
2	Room for improvement in clinical care	
3	Room for improvement in organisational care	
4	Room for improvement in clinical care and organisational care	
5	Less than satisfactory	

Avoidability Scale

Avoidability Scale	Descriptor	Please Tick
1	Definitely avoidable	
2	Stronger evidence of avoidability	
3	Probably avoidable (more than 50/50)	
4	Possibly avoidable (less than 50/50)	
5	Slight evidence of avoidability	
6	Definitely not avoidable	

Quality of Care Score

Quality of Care Score	Descriptor	Please Tick
A	Excellent	
B	Good	
C	Adequate	
D	Poor	
E	Very Poor	

Southern Health
NHS Foundation Trust

Appendix 7

Referral to Family Liaison Officer for Serious Incidents and Complaints

Date of referral:	Name of referrer and contact no:
Incident number:	Investigating Officer: (name/location/contact number)
Date of incident:	
Division:	Service involved:
PLEASE STATE REASON BELOW IF YOU <u>DO NOT</u> WANT FLO INPUT:	
Brief details of the incident/complaint:	
Contact details for patient or Next of kin details for deceased: (name/address/relationship & telephone no)	
Contact with patient or NOK so far:	
Below sections for completion by FLO:	
Referral received date:	Contact made with patient/NOK (date):
FLO notes:	
Inquest date: (if applicable)	Support at inquest provided? Y/N

Please send this form via nhs.net to: shft.familyliaison@nhs.net
Elaine Ridley, Family Liaison Officer (from 05.12.16 – 07747 766947**)**
Email elaine.ridley@southernhealth.nhs.uk – Not for PID

Appendix 8: Equality Impact Assessment

The Equality Analysis is a written record that demonstrates that you have shown *due regard* to the need to **eliminate unlawful discrimination**, **advance equality of opportunity** and **foster good relations** with respect to the characteristics protected by the Equality Act 2010.

Stage 1: Screening

Name of policy/procedure	**Policy for Procedure for Reporting and Investigating Deaths**
Name and job title of person completing the assessment:	Ricky Somal. Head of Engagement and Wellbeing
Date of assessment:	July 2017
Responsible department:	
Intended equality outcomes:	This document sets out the policy statement and procedure for reporting, reviewing and investigating deaths of people who have been in receipt of services from the Trust. The policy aims to promote parity of esteem for people with learning disability or mental health issues.

Who was involved in the consultation of this document?	

Please describe the positive and any potential negative impact of the policy on service users or staff.

In the case of negative impact, please indicate any measures planned to mitigate against this by completing stage 2. Supporting Information can be found be following the link: www.legislation.gov.uk/ukpga/2010/15/contents

Protected Characteristic	Impact
Age	The policy aims to promote parity of esteem for people with learning disability or mental health issues.
Disability	The Trust has reviewed the national publications and in the construction of this policy and procedure has considered the recommendations and findings within these documents: NHS England, December 2015, Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015. Care Quality Commission, December 2016, Learning, candour and accountability. The trust has established an equality standard to meet the requirements of the EDS2 and WRES. The Trust is actively working towards the Accessible Information Standard (AIS) and will respond positively to Article 2 and 14 of the ECHR.
Gender reassignment	The policy aims to promote parity of esteem for people with learning disability or mental health issues.
Marriage & civil partnership	The policy aims to promote parity of esteem for people with learning disability or mental health issues.

Pregnancy & maternity	The policy aims to promote parity of esteem for people with learning disability or mental health issues.
Race	The policy aims to promote parity of esteem for people with learning disability or mental health issues. The trust will respond positively to reasonable adjustments and offers interpreting and translation services.
Religion/Belief	The policy aims to promote parity of esteem for people with learning disability or mental health issues. The trust has a Lead Chaplain (Head of Spirituality and Chaplaincy) and established links with local diverse faith groups.
Sex	The policy aims to promote parity of esteem for people with learning disability or mental health issues.
Sexual orientation	The policy aims to promote parity of esteem for people with learning disability or mental health issues.

Stage 2: Full impact assessment

What is the impact?	Mitigating actions	Monitoring of actions

Appendix 9

Guiding Principles: Sharing a Draft Report with **patients, service users, family and carers who are involved in the Investigation.**

There is presently no mandatory or statutory requirement for serious incident investigation reports to be shared in draft with patients, service users, family and carers who are involved in the Investigation. However it is considered best practice. It is hoped that clearer guidance will be provided from NHS England and the National Quality Board in early 2018.

Southern Health NHS Foundation Trust follows these guiding principles:

Whilst conducting an investigation it is vital that a positive relationship is built with **patients, service users, family and carers** and they are supported to become involved in the investigation. This includes establishing a communication agreement and this work can be supported by the **Family Liaison Officer**.

Towards the end of the investigation, the investigator should share a copy of the draft report with **patients, service users, family and carers**, the organisation, and any person included in the report. This gives everyone mentioned in the report a chance to comment on the draft findings. It is advisable that the investigator arrange to meet with the family and others to go through the details of the report in person.

The rare exception to this is if the Investigating Officer is told by Police not to share information. More usually, the Trust's investigation would be delayed until the Police investigation was completed.

The draft report should not be shared until all of the avenues of investigation have been completed as missing lines of enquiry will cause distress and incorrectly suggest that the investigation has been completed.

The report will contain all the information that has been gathered and **patients, service users, family and carers** who are involved in the investigation should be supported to **challenge the factual accuracy** of the report and **highlight any avenues which have not been explored**. They should also be allowed **to make comment on the findings and recommendations**, which the investigator and commissioning manager should take into consideration when finalising the report.

Patients, service users, family and carers who are involved in the Investigation should be respectfully reminded that the draft report is confidential and should not be shared until finalised. This is because it may include a factual inaccuracy which has not been corrected or question that has not been answered and may cause distress if it became public.

Once finalised a final report should be shared with **patients, service users, family and carers**, and other organisations who are involved in the Investigation. This should occur within ten days of the final sign off and be documented on Ulysses.

References:
https://www.hsib.org.uk
https://www.ombudsman.org.uk/about-us/corporate-information/freedom-information-and-data-protection/our-publication-scheme/our-privacy-policy

Appendix 10 - Criteria for Deaths that MUST be reported to HM Coroner

- All unexpected deaths.
- Where the death may be linked to an accident (whenever it occurred) or trauma of any kind.
- Death, which cannot be attributed to natural causes.
- Where the deceased was not examined by a doctor within the fourteen days prior to their death.
- If the death is as a result of violence, or there is a history of violence, neglect or suspicious circumstances.
- The death has occurred during, or shortly after, detention in prison or police custody, including voluntary attendance at a Police Station.
- The deceased was detained under the Mental Health Act.
- The death is linked to an abortion.
- Patients with any industrial disease e.g. mesothelioma, asbestos related, or where the deceased was pursuing a claim for damages or compensation for an industrial disease or accident even if only a contributory factor.
- The actions of the deceased person might have contributed to the death, e.g. self harm, overdose and history of drug addiction, excessive alcohol (see below) or solvent abuse and also self neglect or neglect by others. The deceased was receiving any form of war pension or industrial disability pension.
- The death may be related to a medical procedure whether invasive or not.
- Where there is an allegation of a lack of medical or clinical care.
- The deceased has been in hospital less than 24 hours.
- The death occurred within 24 hours of an operation.
- Death whilst in the operating theatre.
- Death related to an operation or anaesthesia.
- All deaths related to alcoholic liver disease. Please Note: Any death where alcohol is mentioned on the death certificate, or is a contributory factor in the death, e.g. cirrhosis of the liver, must be reported to the Coroner. H. M. Coroner has indicated that he is very unlikely to take such a case and will only inquest if alcohol was a major contributory factor (e.g. following a fall whilst intoxicated or aspiration pneumonia due to decreased level of consciousness due to alcohol). However many Crematoria Referees will require the Coroner to have

been informed to protect the Referee from any future developments. Therefore the Coroner must be informed in all cases where alcohol is a factor and the Cremation form noted to this effect.

- Unidentified persons.
- Deaths from hypothermia.
- Deaths from food poisoning.
- Unexpected stillbirths if there is any doubt about the child being born alive.

If in any doubt always contact the Coroner to discuss the matter.