Southern Health NHS
NHS Foundation Trust

SH NCP 75

Procedure for Reporting and Investigating Deaths

Version 1

Summary:	This document sets out the procedures for reporting, reviewing and investigating the deaths of people who have been in receipt of services from the Trust.	
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Version Control

Change Record

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Quality and Governance Team		Version 1 10.11.15
Mortality Project Group		Version 1 09.11.15

Contents

Procedure for Reporting and Investigating Deaths

1 Introduction

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

1.2 This procedure provides staff with information about which deaths should be reported internally on the Trust's risk management system (Ulysses) and the subsequent review and investigation that is required.

1.3 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.

1.4 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 or social care services provided by the Trust.

2 Background

2.1 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.

2.2 It is acknowledged that most deaths do not occur as a result of a 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 documented.

2.3 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.

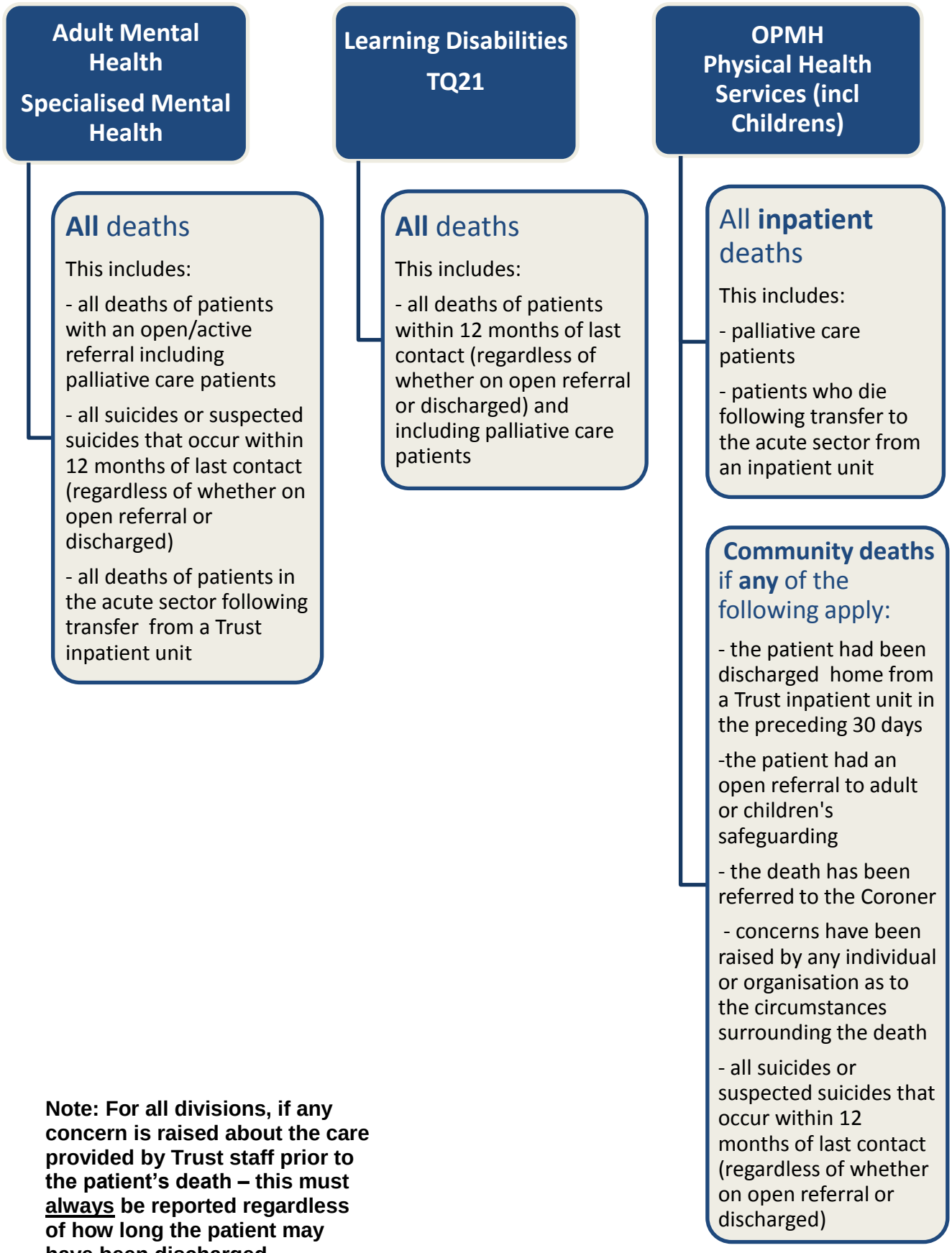
3 Process for reporting deaths

3.1 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.

3.2 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.

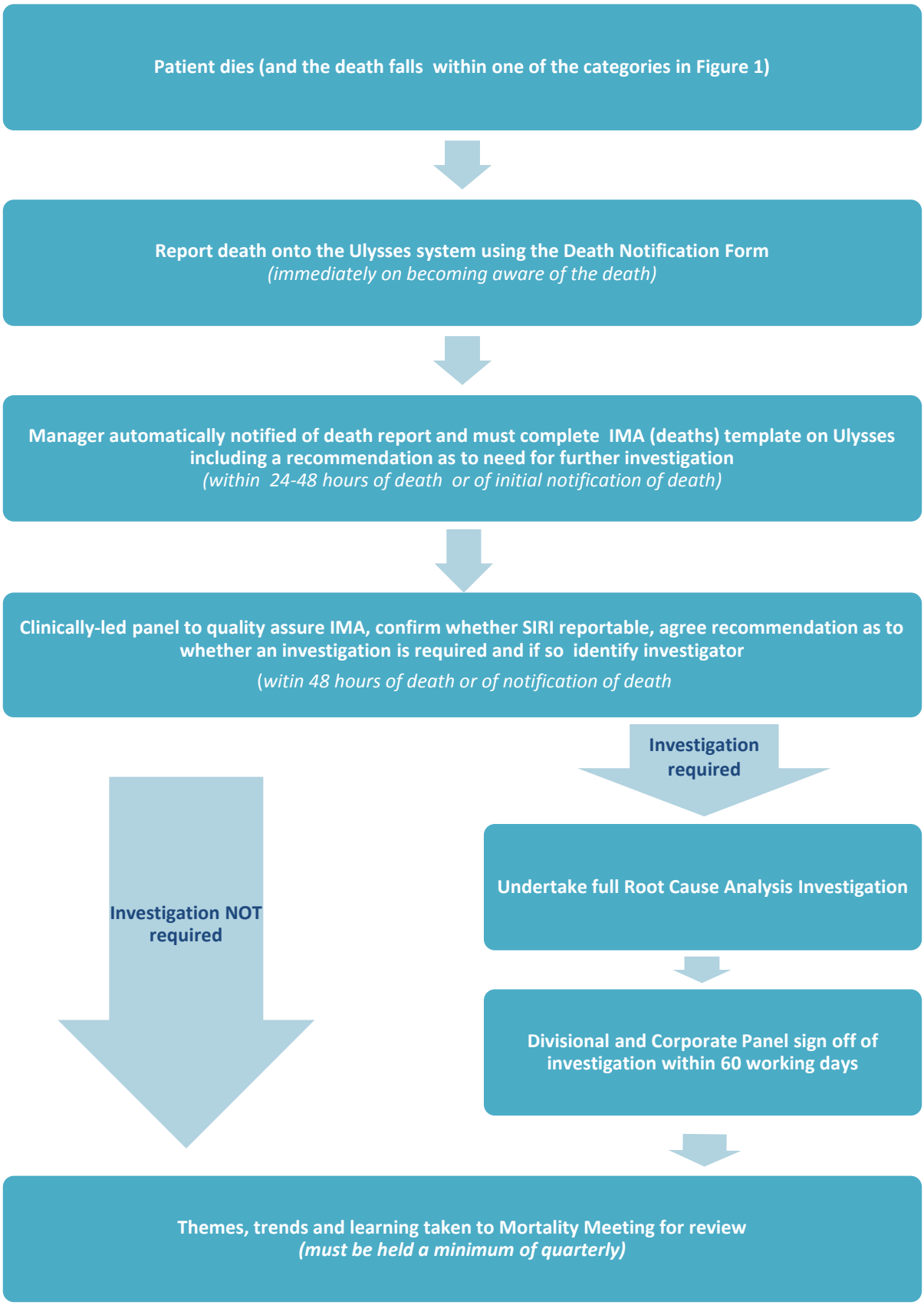
3.3 The figure overleaf shows which deaths should be reported to Ulysses for each division:

Figure 1: Deaths which must be reported on Ulysses by division



Note: For all divisions, if any concern is raised about the care provided by Trust staff prior to the patient's death – this must always be reported regardless of how long the patient may have been discharged.

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



4 Death Notification Form

4.1 The Death Notification Form is found on 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 mandatory as failure to fill them in will slow down the next stage of the process. The form will only be able to be submitted once these are completed.

4.2 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**

4.3 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, this information should also be included.

4.4 Any referral made to adult or child safeguarding should be noted on the form.

4.5 If the person was in receipt of palliative/end of life care this should also be recorded.

4.6 Once completed and submitted, the Death Notification Form will then trigger the relevant manager to be notified automatically and they will be prompted to complete an electronic IMA on Ulysses.

5 Initial Management Assessment (IMA)

5.1 Any death which meets the criteria (outlined in Figure 1 above) for reporting onto Ulysses will require review by the service manager within 48 hours. This is the same approach taken when completing an IMA for patient safety incidents.

5.2 The IMA will also need to be reviewed by a clinically-led panel (see Section 6) within the same 48 hour period so every attempt should be made to complete the IMA as quickly as possible.

5.3 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 but contains some questions specific to deaths.

5.4 The purpose of the IMA is to:

- assess whether there any concerns about the care provided prior to the death
- identify any issues or risks which require immediate action
- determine whether further investigation is required and whether the death is SIRI reportable

5.5 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.

5.6 The patient's clinical/support records must always be reviewed as part of the IMA process. Consideration should also be given to contact with the family of the deceased (see Section 10 below).

5.7 One of the key functions of an IMA is to determine if further investigation is required and if this **is** the case, this will then proceed to a root cause analysis investigation. 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 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.

5.8 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".

5.9 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
- 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

5.10 An IMA cannot conclude that no further investigation is required unless the cause of death is known. The service manager should make contact with certifying doctor to establish this (this might be the GP surgery or the acute hospital). If a death has been referred to the Coroner to establish the cause, and this is not known by the time the IMA is being completed, steps should be taken to commence a full investigation. If necessary, this can be scaled back once the cause of death is received. Conversely, if the cause of death reinforces the need for further investigation, the TOR for the investigation should be modified to include reference to the newly established information.

6 48 Hour Panel Review

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

6.2 Each completed IMA will need to be quality assured by a clinically-led panel to ensure that the recommendations made in the IMA are appropriate. In particular, the recommendation as to whether to proceed to a full investigation or not and whether the death is reportable as a serious incident.

6.3 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) and 'attended' by the IMA author.

6.4 A template for confirming the quality, actions and recommendations within the IMA report is provided for use as a 'questionnaire' and is attached to the incident within Ulysses.

6.5 In addition to confirming the recommendations and actions arising from the IMA, the panel should confirm a commissioning manager and also take steps to nominate an investigating officer. The panel should agree a process for drafting the Terms of Reference for the investigation.

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

6.7 The Chair's name is recorded in the questionnaire against the incident 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.

7 Full Investigation – Root Cause Analysis (RCA)

7.1 Every death which is reportable as a Serious Incident under the national framework must have a full RCA investigation.

7.2 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.

7.3 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.

7.4 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.

7.5 The Investigation report must follow the Divisional Panel and Corporate Panel processes for review within the 60 working day timeframe required by Commissioners. The Corporate Panel will agree the actual impact grading for any death subject to full investigation as per section 8 below.

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

8 Grading the Actual Impact of the incident

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

8.2 Grading the impact is about considering any gaps, omissions or acts during the care provided which may have caused or contributed to the patient's death.

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

Actual Impact Grading	
Actual Impact	**Definition**
No Harm	No root cause or contributory factors relating to SHFT care or gap in care No Care or service delivery problems identified. We could not have prevented the death.
Low Harm	No root cause or contributory factors relating to SHFT care or gap in care Care or service delivery problems identified but only impact on quality of service, not on outcome. We could not have prevented the death.
Moderate Harm	No root cause relating to SHFT care or gap in care Contributory factors identified may have had a minor impact on the outcome for the person. We could not have prevented the death.
Major Harm	No root cause relating to SHFT care or gap in care Contributory factors identified may have an impact on the outcome for the person. Not clear we could have prevented the death.
Catastrophic Harm	Preventable inpatient death Root cause linked to SHFT care or gap in care

9 Mortality Meetings and Thematic Reviews

9.1 Mortality meetings should be held at least quarterly in each Division. 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.

9.2 Terms of reference for Mortality meetings are attached at Appendix 2 and provide further guidance.

9.3 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.

10 Involvement and support of the deceased's family and Duty of Candour

10.1 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.

10.2 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.

10.3 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.

10.4 The Service Manager is responsible for ensuring that family members and carers who may have been affected by the death are offered the opportunity of counselling and support. This offer should also be extended to other patients or members of the public directly affected by the death.

10.5 Further guidance can be found in SH NCP 12 Duty of Candour Policy and SH NCP 13 Duty of Candour Procedure.

11 Supporting Staff

11.1 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

11.2 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.

12 Associated Documents

This procedure supports the following policy and associated procedures:

SH NCP 16 Policy for the Management of Incidents
SH NCP 60 Procedure for the management of SIRIs

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 Duty of Candour Procedure

Appendix 1: TOR for 48 hour panels

1. Constitution

1.1. The Trust Executive Group (TEG) resolve to establish 48 hr Incident Panel Meetings which function as part of the incident process.

1.2. The 48 hr panel meetings are authorised by the Quality & Safety Committee (QSC) via the Quality Improvement & Development Forum (QID) 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.

1.3. The definition of 48 hrs 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 hr Incident Panel meeting is to review information pertaining to the occurrence of a death or incident. They panel is responsible for reviewing IMAs linked to patient deaths and those incidents with significant patient harm graded as major or catastrophic.

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 SIRI reportable)
    - 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 membership and its conclusions on the Ulysses system
- Communicate the outcome with regards to SIRI 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 hrs (2 working days).
- Develop a plan for internal executive communication if required
- Develop a plan for external media communications if required

3. Membership

3.1. The Divisional Clinical Director, Clinical Service Director or Associate Director of Nursing 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 SIRI 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 hr panels are held to review IMAs involving a patient / service user death or those incidents with significant patient harm graded as major or catastrophic.

5. Review

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

Appendix 2: TOR for Mortality Meetings

(These are awaiting approval and will be added shortly)