Alder Hey Children's NHS
NHS Foundation Trust

RM57 – HOSPITAL MORTALITY REVIEW POLICY

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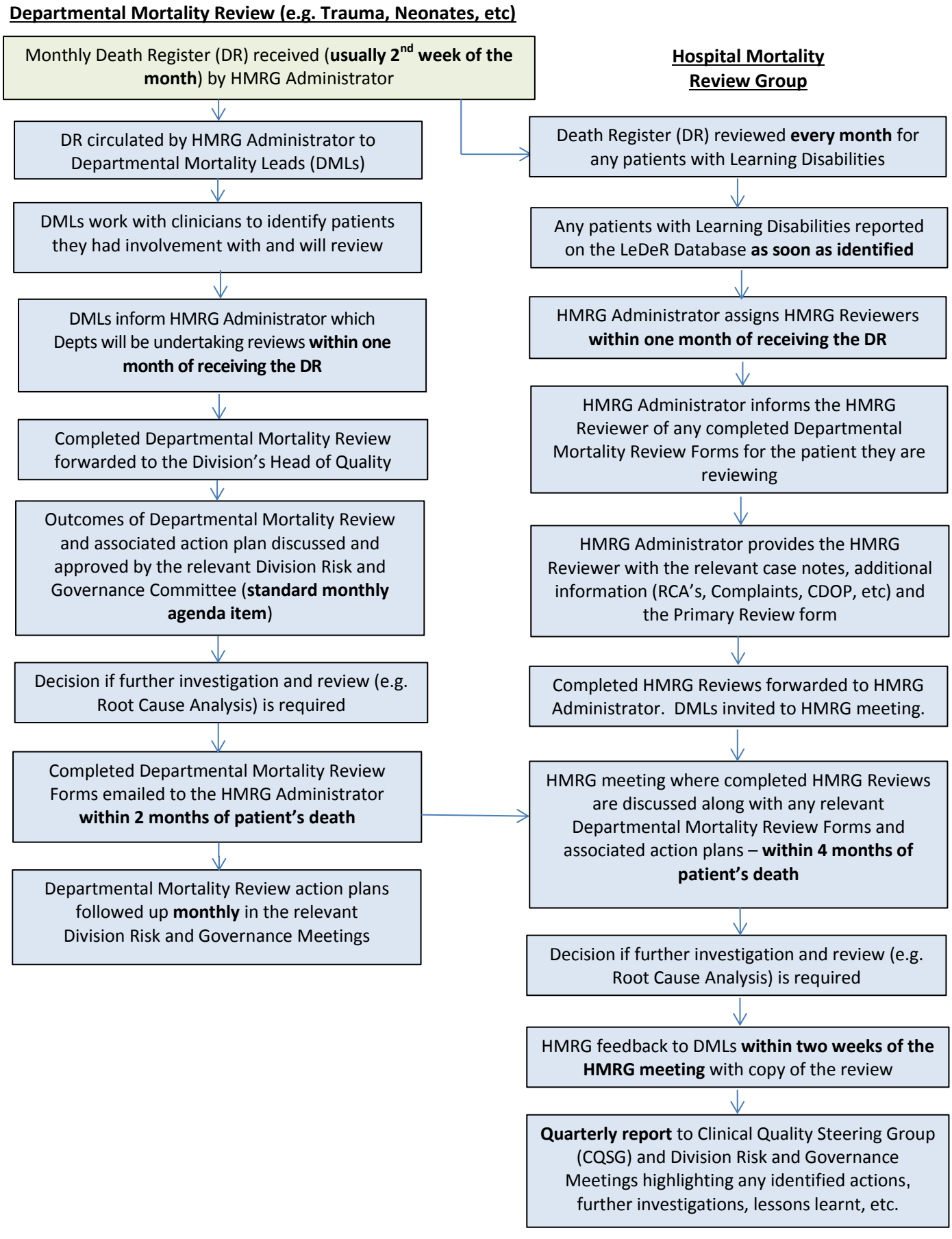
Quick Reference Guide – Hospital Mortality Review Policy

Please refer to the full policy for further guidance.



Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
1	Sept 2017	Julie Grice, Chair of Hospital Mortality Review Group / Sarah Stephenson, Head of Quality	Current	Guideline updated to a Policy
-	October 2013	Kent Thorburn HMRG Chair	Archived	HMRG Guideline

Record of changes made to Hospital Mortality Review Policy – Version 1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
		Not applicable - New Policy	

Contents

1 Introduction

1.1 The death of any patient is incredibly difficult for the patient's family and also the staff involved.

1.2 The Care Quality Commission's 'Learning, Candour and Accountability' (December 2016) and the National Quality Board's 'National Guidance on Learning from Deaths' in March 2017, require all NHS Trusts to implement processes to ensure learning from deaths is integral to the Trust's clinical governance and quality improvement work.

1.3 It is essential that learning from mortality reviews is both shared and acted upon.

2 Definitions

2.1 Departmental Mortality Leads (DMLs) – Nominated mortality lead for a team / department.

2.2 Departmental Mortality Review – Review conducted at departmental level by the multidisciplinary team involved in the care of the patient. This can include mortality reviews for or by external bodies (e.g. Trauma mortality reviews, Neonatal mortality reviews).

2.3 Hospital Mortality Review Group (HMRG) – Committee established by the Clinical Quality Assurance Committee (CQAC) to conduct independent high quality mortality reviews following the death of any hospital inpatients.

2.4 Learning Disabilities Mortality Review (LeDeR) Programme – National programme delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. The LeDeR Programme was established to support local areas to review deaths of people with learning disabilities, and to use the lessons learned to make improvements to service provision.

2.5 Mortality Ratio - Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in a hospital is higher or lower than would be expected in England. HSMR can be both a measure of safe, high quality care and a warning sign that things are going wrong. HSMR is reported in the quarterly mortality report to the Trust Board. The HSMR is the ratio of the observed number of in-hospital deaths divided by the number that is expected, and is based on 56 diagnoses. Although the scores are based on a basket of diagnoses that are more commonly found in adults, it allows a comparison of the performance of Alder Hey against other Trusts.

2.6 Sequential Probability Ratio Test (SPRT) – SPRT can be used to monitor the performance of Paediatric Intensive Care Unit (PICU) services in such a way as to give early warning of potentially irregular results. SPRT charts display

an upper warning limit and an upper action limit to help identify whether mortality is occurring at a higher level than expected. If these limits are triggered, this suggests that mortality is occurring higher than expected, and the deaths should be investigated to determine whether they could have been prevented. SPRT is reported in the quarterly reports to the Trust Board.

2.7 Death Register – Monthly report produced by the IM&T Department listing all inpatient deaths in the month.

2.8 Child Death Overview Panels (CDOP) – Local Safeguarding Children Boards (LSCB) are responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a CDOP. The purpose of the child death review is to learn lessons and help prevent further such child deaths.

3 Duties

3.1 Chief Executive

- Has ultimate executive accountability for the quality of services in the Trust.

3.2 Medical Director –

- Executive Director responsibility for mortality review in the Trust.
- Provide the Trust Board with assurance regarding the Trust Mortality Review process.
- Provide support and guidance to the HMRG Chair and Departmental Mortality Leads as required.
- Take action where concern is raised through mortality ratio analysis and / or mortality reviews.

3.3 HMRG Chair –

- Chair the monthly Hospital Mortality Review Group
- Produce quarterly reports to the Clinical Quality Steering Group (CQSG)
- Produce quarterly reports to Trust Board
- Lead on developing the processes to ensure learning from deaths is shared widely across the Trust, with the support of the HMRG Group members.
- Ensure that HMRG cases are reviewed within 4 months of patient's death.
- Where HMRG reviews exceed the 4 month target, take action to increase the rate of reviews completed and bring reviews back to within target timescale.
- Liaise with the PICU Departmental Mortality Lead to ensure mortality ratio analysis is presented at the HMRG meetings.
- Ensure any concerns / questions raised by the patient's family are addressed as part of the HMRG review and acted on accordingly.

- Ensure families are given feedback which addresses any concerns / questions they have raised. The Bereavement Team can provide support to the family if requested.
- Share monthly report to monitor compliance with review timescales with HMRG members.

3.4 Departmental Mortality Leads (DMLs) –
- Share the Death Register with clinical teams (medical / nursing / AHPs)
- Inform the HMRG Administrator what teams / clinicians are taking responsibility for completing the departmental review.
- Inform other DMLs if a joint departmental review is indicated
- Ensure a departmental review is completed within two months by the team involved in the patient's care.
- Report to the relevant Division Risk and Governance Committee to highlight any teams not completing the departmental review in the two month timescale.
- Monitor completion of action plans following departmental reviews
- Ensure completed departmental reviews and action plans are submitted to the Division Risk and Governance Committee for review, discussion and approval.
- Circulate summary learning points following each HMRG meeting to share learning.

3.5 PICU Departmental Mortality Lead –
- Monitor the monthly Cumulative Sum of Mortality (CUSUM) and Sequential Probability Ratio Test (SPRT) produced by the Paediatric Intensive Care Unit (PICU), and highlight any concerns immediately to the Medical Director / HMRG Chair.

3.6 HMRG Administrator –
- Liaise with Departmental Mortality Leads (DMLs) to identify the departments / clinicians completing departmental mortality reviews.
- Where case notes are not scanned on Image Now, liaise with Medical Records Department to obtain the hard copy notes of deceased patients listed on the monthly Death Register.
- Assign the clinicians who will complete the Hospital Mortality Reviews for the cases listed on the Death Register within one month of the Death Register being published.
- Summary learning points sent to DMLs by the HMRG Administrator following each HMRG meeting.
- Produce monthly report to monitor compliance with review timescales for the HMRG Chair.

3.7 Heads of Quality (HoQ) –
- Ensure completed departmental mortality reviews and action plans are reviewed at the Division Risk and Governance Committee as a standing agenda item.
- Where a departmental mortality review raises concerns that a death was avoidable, instigate Trust risk management process to trigger a further detailed review (e.g. RCA). (Refer to the Management of

Incidents and Serious Incidents Requiring Investigation (SIRI) Policy (RM2))
- If required, and following the Trust process detailed in the Management of Incidents and Serious Incidents Requiring Investigation (SIRI) Policy (RM2), ensure the death is reported on the Strategic Executive Information System (STEIS) where applicable.
- Use Trust governance processes to ensure learning from deaths is shared widely and acted upon across the Divisions.

3.8 Learning Disabilities Clinical Lead -
- Following the publication of the Death Register, review all patients aged 4 years old and above, residing in England at the time of their death, to identify any patients with a Learning Disability.
- Ensure the Learning Disability Liaison Team are reporting the deaths of all patients with Learning Disabilities onto the Learning Disabilities Mortality Review (LeDeR) database.
- Attend HMRG meetings to raise appropriate questions in relation to patients who had a Learning Disability.

3.9 CDOP Lead Nurse –
- Ensure where available that sudden unexpected death in infancy (SUDI) and sudden unexpected deaths in childhood (SUDiC) reports and Child Death Overview Panels (CDOP) reports are shared with the HMRG Administrator to aid HMRG reviewers in their review process.
- Attend monthly HMRG meetings. If CDOP Lead Nurse not available a Safeguarding Representative to attend where possible.

3.10 Bereavement Team –
- Will inform family members at an appropriate time that the policy of Alder Hey Children's NHS Trust is to review the deaths of all inpatients.
- Offer families the opportunity to raise any questions or concerns they may have in relation to the patient's last admission, or from an earlier stage in the patient's medical journey if the family feel it is relevant to the review of their child's death.
- Attend HMRG meetings to represent and share the questions and concerns of deceased patients' families.

3.11 Departmental Mortality Review Lead Clinician –
- When conducting the Departmental Mortality Reviews, lead clinicians should ensure all relevant staff are invited to attend the mortality review meeting to discuss the case.

4 Conducting HMRG Mortality Reviews

4.1 The HMRG mortality reviews should make use of all available data sources to enable a detailed and thorough review of events leading up to and following a patient's death. This includes, but is not limited to:

- Patient's case note on Image Now / Meditech / hard copy notes

- Clinic letters on Medisec
- Incident reports
- Any investigations (e.g. Root Cause Analysis (RCA) Reports)
- SUDI and SUDiC reports
- CDOP forms
- Post mortem reports
- Coroner's Reports
- Death Certificate
- PALS concerns
- Formal Complaints / Trust response
- External mortality reports (e.g. Trauma, Neonatal)
- Safeguarding reports
- Claim reports

4.2 Where available, this information will be made available to the HMRG reviewer by the HMRG Administrator.

4.3 The Structured Judgement Review documentation recommended in the National Quality Board's 'National Guidance on Learning from Deaths' (2017), is not currently being used at Alder Hey as it is not validated for children and young people. Until further national guidance for paediatrics is published, the Departmental and HMRG Mortality Review Forms in Appendix A and B will continue to be used.

4.4 For Departmental and HMRG Mortality Reviews, the Trust's Being Open and Duty of Candour Policy (RM47) may apply to the review of a patient's death, where a moderate or above incident is reported. Policy processes will be followed.

4.5 For Departmental and/or HMRG Mortality Reviews, where an incident is logged on Ulysses following a patient's death (e.g. due to the death being deemed avoidable), the Trust process detailed in the Management of Incidents and Serious Incidents Requiring Investigation (SIRI) Policy (RM2) will be followed. Advice will be taken from the Governance and Quality Assurance Team regarding the level of Root Cause Analysis (RCA) required. The Chair of the HMRG will be informed and the resulting RCA will form part of HMRG group's consideration. Where applicable, the death must be reported on the Strategic Executive Information System (STEIS).

5 Learning Disabilities

5.1 Following the preventable death of Connor Sparrowhawk in July 2013 at Southern Health NHS Foundation Trust, the independent Mazars (2015) review was commissioned by NHS England. The report highlighted that unexpected deaths of adult Mental Health and Learning Disability patients were not sufficiently reviewed or investigated. The report also highlighted the views and concerns of families were not actively sought, and where concerns were raised they were not responded to.

5.2 Many adult Trusts only conduct mortality reviews on cases where the death is unexpected or is flagged through an incident report. At Alder Hey Children's NHS Foundation Trust, all inpatient deaths are reviewed.

5.3 The Learning Disabilities Mortality Review (LeDeR) Programme was set up to ensure all deaths of patients with Learning Disabilities are comprehensively reviewed. Following notification of a patient's details to the LeDeR database, all deaths will receive an initial review by LeDeR. If any concerns are identified about the death by LeDeR, or it is felt that further learning could come from a fuller review of the death, a detailed, multiagency review will be held. Where possible this will be through the HMRG process, with a LeDeR representative present.

5.4 Since January 2017, all patients aged 4 years old and above, residing in England at the time of their death, are required to be reported to the LeDeR database. Further details of the LeDeR process can be viewed on their website: http://www.bristol.ac.uk/sps/leder/

5.5 Reviewers conducting Departmental Mortality Reviews and HMRG Reviews must consider the implications of a patient's Learning Disability.

6 Concerns of families

6.1 The publication 'National Guidance on Learning from Deaths' (2017), requires Trusts to ask bereaved families if they have any concerns about the quality of care received by the deceased patient.

6.2 At Alder Hey, this process will be led by the Bereavement Team, who actively support families throughout the bereavement process.

6.3 The Bereavement Team will inform family members at an appropriate time that the policy of Alder Hey Children's NHS Trust is to review the deaths of all inpatients. The Bereavement Team will offer families the opportunity to raise any questions or concerns they may have in relation to the patient's last admission, or from an earlier stage in the patient's medical journey if the family feel it is relevant to the review of their child's death.

6.4 Any concerns raised should be notified by the Bereavement Team to the HMRG Administrator as soon as possible, in order that the concerns / queries can be incorporated into the HMRG review process.

6.5 Raising concerns as part of the HMRG process, does not exclude families also raising these concerns through the Patient and Liaison Service (PALS) and Complaints process. In this situation, the processes in the Complaints and Concerns Policy (RM6) will be followed. If during the complaint investigation, it is found at any point that a patient safety incident has occurred, the Trust process detailed in the Management of Incidents and Serious Incidents Requiring Investigation (SIRI) Policy (RM2) will be followed.

(A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.)

6.6 Following completion of the HMRG review, where no further investigation is required (e.g. RCA), feedback should be provided to the family by clinicians. The Bereavement Team can provide support to the family if requested. The format of this feedback (e.g. face to face meeting, letter, phone call, etc.) will be led by the family.

6.7 If a moderate or above incident has been logged relating to the patient's case, this feedback will be as part of the Trust's Being Open and Duty of Candour Policy (RM47). In this situation Senior Managers / Clinicians will feed back to the family in a face to face meeting if acceptable to the family. The Bereavement Team can provide support to the family if requested.

7 Learning Lessons from Mortality Reviews

7.1 The three reports: 'National Guidance on Learning from Deaths' (2017), 'Learning, Candour and Accountability' (December 2016) and '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' (2015), all agree that more needs to be done to ensure learning from deaths is shared and acted upon.

7.2 The process for sharing information from mortality reviews needs to be managed in a number of ways to ensure the maximum number of staff have access to the information. These include, but are not limited to:

- Reports to key Trust committees (e.g. Division Risk and Governance Committees, Clinical Quality Steering Group (CQSG), Trust Board, Infection Control Committee, etc)
- Summary learning points sent to DMLs by the HMRG Administrator following each HMRG meeting.
- Trust internal communication methods (e.g. Trust intranet, Trust newsletter, etc)
- Presentations (e.g. Grand Round)

7.3 Monitoring actions arising from mortality reviews will be the responsibility of the action lead, with the Division's Head of Quality and the Chair of HMRG monitoring compliance.

7.4 Any opportunities to spread the learning from deaths further than Alder Hey should be taken (e.g. presenting at meetings and conferences, etc) .

8 Monitoring

8.1 The following monitoring will take place to confirm compliance with this policy:

Monitoring	Lead Responsible	Frequency	Responsible Committee
Report produced to monitor compliance with mortality review timescales	HMRG Administrator	Monthly	HMRG
Report produced summarising findings and learning points from all completed mortality reviews	HMRG Chair	Quarterly	Clinical Quality Steering Group (CQSG)
Report produced summarising findings and learning points from all completed mortality reviews	HMRG Chair	Quarterly	Trust Board

9 Further Information

9.1 National Quality Board (2017), *National Guidance on Learning from Deaths* https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

9.2 Care Quality Commission (2016), *Learning, Candour and Accountability - A review of the way NHS trusts review and investigate the deaths of patients in England* https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

9.3 Mazars (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* https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

9.4 Management of Incidents and Serious Incidents Requiring Investigation (SIRI) Policy (RM2)

9.5 Being Open and Duty of Candour Policy (RM47)

9.6 Policy for Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims (E31)

9.7 Complaints and Concerns Policy (RM6)

9.8 Equality Analysis

Appendix A - Departmental Mortality Review Form

Alder Hey Children's NHS
NHS Foundation Trust

SERVICE GROUP / DEPARTMENTAL MORTALITY REVIEW FORM

Please complete electronically

SECTION A - PATIENT DETAILS

1) Hospital Number:
2) Date of Birth:
3) Date of Death:
4) Lead Clinician:
5) CBU:
6) Service Group:
7) Clinical Diagnosis:
8) Context of Involvement:
9) Patient Risk Factors:
10) Probable Cause of Death:
11) Did the patient have a Learning Disability (e.g. Developmental Delay, ASD)?
Yes ☐ Possibly / was on pathway ☐ No ☐
Details:

SECTION B - PLANNING FOR DEATH

1) Was the patient's death anticipated or not? *(please tick)* Yes ☐ No ☐
2) If the death was anticipated, at which stage in the patient's treatment was this the case?
3) Did the patient have a 'Life Plan' or 'Limitation of Treatment'? *(please tick)*
Yes ☐ No ☐

SECTION C – CLINICAL MANAGEMENT AND TREATMENT

Please consider each of the factors listed in this section and record whether the factor applies to this patient and, if relevant, what the consequences were.

1a) Appropriate and timely admission to Alder Hey on this occasion? *(please tick)* Yes ☐ No ☐
1b) If not, why not?
1c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

2a) Were medical / surgical reviews of a timely and senior enough nature, in relation to the patient's condition? *(please tick)* Yes ☐ No ☐
2b) If not, why not?
2c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

3a) If any procedures were performed, was the most senior practitioner present of suitable skill and experience for that procedure on that patient? *(please tick)*
Yes ☐ No ☐ Not applicable ☐

3b) If not, why not?
3c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

SECTION C – CLINICAL MANAGEMENT AND TREATMENT (cont.)

4a) Were there any deficiencies or errors in clinical management? *(e.g. failure of prescribing antibiotics / anticoagulation; admission of incorrect drug or dose; failure to refer to another specialty or PICU; etc.)* *(please tick)* Yes ☐ No ☐
4b) If 'yes', what were they?
4c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

5a) Were there any failings in technical skill undertaking the procedure? *(please tick)* Yes ☐ No ☐ Not applicable ☐
5b) If 'yes', what were they?
5c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

6a) Were any deficiencies in patient monitoring / observations / nursing care identified? *(please tick)* Yes ☐ No ☐
6b) If 'yes', what were they?
6c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

7a) Any delays in accessing support services at Alder Hey? (e.g. radiology, laboratory services, theatres, PICU, etc.) *(please tick)* Yes ☐ No ☐
7b) If 'yes', what were they?
7c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

8a) Any other concerns relating to the management of this patient? *(please tick)* Yes ☐ No ☐
8b) If 'yes', what were they?
8c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

9) If you believe that the death was preventable in some way that is not covered above, please record what the major avoidable factors were:

10a) Has follow-up been offered or already undertaken? *(please tick)* Yes ☐ No ☐
10b) If not, why not?

SECTION D – CONCLUSION / ASSESSMENT

Please tick whichever one description best matches

1) Aspects of the care provided were less than adequate; and different management would reasonably be expected to have altered the outcome. ☐

2) Aspects of the care provided were less than adequate; and different management may have altered the outcome. ☐

3) Aspects of the care provided were less than adequate; and different management would not reasonably be expected to have altered the outcome. ☐

4) Adequate or above standard care provided ☐

SECTION E – ROOM FOR IMPROVEMENT

Please tick whichever one description best matches

1) Example of good practice ☐

2) Adequate / standard practice ☐

3) Aspects of clinical care could have been better ☐

4) Aspects of organisational care could have been better ☐

5) Aspects of clinical and organisational care could have been better ☐

6a) What aspects?
6b) ACTION PLAN:
6c) Timeframe of Action Plan:
6d) Lead for Action Plan:

SECTION F – FURTHER CONTACT DETAILS

Date of review:
Name of person completing form:
Designation of person completing form:
Preferred contact details for person completing the form:

Appendix B - Hospital Mortality Review Group (HMRG) Review Form

Alder Hey Children's NHS
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Audit No:

HOSPITAL MORTALITY REVIEW GROUP (HMRG) – REVIEW FORM

You have been nominated to complete a mortality audit primary review. Please complete the form below using the case notes and any supporting information provided. The first section has been completed for you.

Q1) Hospital number:

Q2) Gender: Male ☐ Female ☐

Q3) Date of admission:

Q4) Transferred from another hospital? Yes ☐ No ☐

If yes, where was the child transferred from?

Q5) Date of birth:

Q6) Date of death:

Q7) Place of death:

Q8) Admitting ward:

Q9) Admitting consultant:

Q10) Further information provided as part of Primary Review:

Incident report/s	☐	
Root Cause Analysis	☐	
Complaints	☐	
PALS	☐	
Legal	☐	
Bereavement Team	☐	
Child Protection	☐	
CDOP Form	☐	
Trauma Review	☐	

Q11) Name of reviewing consultant:

CLINICAL DIAGNOSIS

Q12) Brief clinical summary: see Death Summary letter

Q13) Clinical diagnosis:

Q14a) Did the patient have a Learning Disability (e.g. developmental delay, ASD)?

Yes ☐ Possibly / was on pathway ☐ No ☐

Details:

Q14b) Was the patient known to CAMHS? Yes ☐ No ☐

Details:

Q15) Was the lead consultant clearly identified in the case notes? Yes *(please select from list)*

Q16a) Other consultants involved:

Q16b) Other teams involved:

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

PREVIOUS ADMISSION(S) TO ALDER HEY

Q17) Did the patient have a previous admission to Alder Hey? Yes ☐ No ☐

Q18) If yes, was the last admission a readmission with the same problem?

Yes ☐ No ☐ Not known ☐

Q19) Please detail any relevant previous admission/attendances:

Q20) Did the patient have a chronic illness? Yes ☐ No ☐ Not known ☐

If yes, please specify:

OPERATIONS / PROCEDURES PERFORMED IN THIS ADMISSION

Q21) Were any operations/procedures performed during the last admission?

Yes ☐ No ☐ (If no, go to Q22)

Q22) **1st operation / procedure:**
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

2nd operation / procedure:
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

3rd operation / procedure:
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

4th operation / procedure:
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

5th operation / procedure:
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

6th operation / procedure:
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

CAUSE OF DEATH / POST MORTEM

Q23a) Case referred to coroner? Yes ☐ No ☐

If yes, name of consultant referring case:

Q23b) Case discussed with coroner? Yes ☐ No ☐ (If no, go to Q26)

If yes, name of consultant discussing case:

Q24) Discussion with coroner documented in medical record? Yes ☐ No ☐

Q25) Outcome of discussion with coroner:

Q26) Request for hospital post mortem? Yes ☐ No ☐ (If no, go to Q31)

Q27) If yes, request for post mortem made to parents by: Consultant ☐ Other ☐

If other, please state grade:

Q28) Permission for hospital post mortem given? Yes ☐ No ☐

Q29) Type of post mortem performed: Full hospital post mortem ☐

Limited hospital post mortem ☐

Q30) Findings of post mortem:

Q31) Death certificate issued? Yes ☐ No ☐

Q32) Cause of death:

1a)

b)

c)

2)

Q33) Do you agree with the probable cause of death on the Service Group Mortality Review form (Section B)?

Yes ☐ No ☐

If no, state reasons:

Q34) Death certificate correct? Yes ☐ No ☐

If no, why?

Q35) Any SUDC issues? Yes ☐ No ☐

Action: Referred to:

Q36) Healthcare associated infection related to death? Yes ☐ No ☐

FOLLOW-UP / DOCUMENTATION

Q37) Offer / arrangements for follow up documented? Yes ☐ No ☐

Q38) Follow up: Declined ☐ Awaiting ☐ Has occurred ☐
Done locally ☐ Unknown ☐

Q39) Has there been feedback / follow-up with the referral hospital?

Yes ☐ No ☐ Not applicable ☐

If no, should there have been? Yes ☐ No ☐

If yes, what aspects?

Q40) Overall evaluation of case note documentation of this admission:

Adequate – no issues ☐ Inadequate ☐

Comments on documentation:

SERVICE GROUP / DEPARTMENTAL MORTALITY REVIEWS

Q41) Service Group / Departmental review(s) of case? Yes ☐ No ☐

If no, which Service Groups / Departments?

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

Q42) Departmental / Service Group Mortality Review – Minutes and action plans: (cut and paste)

Q43) Do you agree with the assessment (section C) of the clinical management and treatment issues?

Yes ☐ No ☐

If not, what are the areas of disagreement?

HMRG

Q44) How would you rate the care given?

1) Aspects of the care provided were less than adequate; and different management would reasonably be expected to have altered the outcome. ☐

2) Aspects of the care provided were less than adequate; and different management may have altered the outcome. ☐

3) Aspects of the care provided were less than adequate; and different management would not reasonably be expected to have altered the outcome. ☐

4) Adequate or above standard care provided ☐

Q45) Please tick whichever one description best matches:-

1) Example of good practice ☐

2) Adequate / standard practice ☐

3) Aspects of clinical care could have been better ☐

4) Aspects of organisational care could have been better ☐

5) Aspects of clinical and organisational care could have been better ☐

Q46) If your assessment from Q44 and Q45 above varies from the Service Group / Departmental Review, please explain why:

Q47) Requires formal HMRG discussion? Yes ☐ No ☐

Q48) Any further information / clarification required?

Q49) Any significant questions that remain unanswered?

Diagnostic Categories – *only one primary & no more than two secondary*

Diagnostic/Disease Categories

D1. Deliberately inflicted injury, abuse or neglect
D2. Suicide or deliberate self-inflicted harm
D3. Trauma & other external factors – *excludes deliberate self-inflicted harm (D2)*
D4. Malignancy
D5. Acute Medical or Surgical condition – subcategories:
D5a. Medical D5b. Surgical D5c. Cardiac
D6. Chronic medical condition
D7. Chromosomal, genetic and congenital anomalies
D8. Perinatal / Neonatal event
D9. Infection / Sepsis (proven or clinical) – subcategory:
D9a. Healthcare-associated infection (home or away)
D10. Sudden unexplained, unexpected death / SUDI / SUDC – *excludes SUDE (D5)*

Primary:

Secondary:

Recurring Themes

Recurring Themes

R0. No RT
R1. Failure to recognise severity of illness – subcategories: R1a. Failure to ask for Senior/Consultant review
R2. Possible management issues – subcategories:
R2a. External R2b. Delay in Transfer R2c. in Alder Hey
R2d. Delay in supporting services or accessing supporting service
R2e. Difference of opinion re: Rx – Patients & families
R2f. Difference of opinion re: Rx – Clinical teams
R3. Communication issues – subcategories:
R3a. Patients & families R3b. Clinical teams
R4. Death inevitable before admission
R5. Potentially avoidable death – subcategories:
R5a. Alder Hey R5b. Medical R5c. External
R6. Cause(s) of death issue – subcategories:
R6a. Incomplete or inaccurate Death Certificate
R6b. Should have had a post-mortem R6c. Not agreed
R6d. Failure to discuss with the Coroner
R7. Documentation – subcategories:
R7a. Recording R7b. Filing
R8. Failure of follow-up
R9. Withdrawal / Limitation of care
R10. Example of Good Practice
R11. Learning disability
R12. Known to CAMHS

Recurring themes:

FOLLOWING DISCUSSION AT HMRG MEETING

Learning points identified:

Actions identified: Lead for action:

Lead for action:

Lead for action:

Outcome of primary review: No further action ☐

Need further information ☐

Diagnostic Categories:

Recurring themes:

HMRG Primary Review Form – Amended June 2017