journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Learning from Deaths Policy: The right thing to do

Ref: CORP-0065-v3

Status: Ratifed
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Contents

1 Introduction

The Keogh review was undertaken after events of Mid Staffordshire and looked broadly at the quality of care and treatment provided within 14 sample organisations and noted that there were opportunities to increase focus on practical steps that could be taken to reduce avoidable deaths in NHS hospitals. These findings were reinforced in the Care Quality Commission (CQC) report Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England 2016. It showed that in some organisations learning from deaths was not being given sufficient priority, valuable opportunities for improvements were being missed and that there is much more we can do to engage families and carers.

The National Quality Board (NQB) guidance on Learning from Deaths (2017) remains the standardised approach across the NHS in the way NHS Trusts report, investigate, and learn from patient deaths. This approach has led to better quality investigations and more embedded learning. Mortality reviews provide the Trust with valuable information in deciding how avoidable the death may have been and how Executive Teams and Boards can use these findings to ensure that safe, high-quality services are provided.

There is extensive evidence that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than the general population and people with learning disability also die 20 years earlier (moreover, 49% of those early deaths are deemed 'avoidable' compared to 22% in general population). Therefore, it is important that organisations widen the scope of deaths which are reviewed to maximise learning.

The Patient Safety Incident Response Framework (PSIRF) which is the overarching approach for Trusts to review patient safety incidents has engagement with families at its core. The Trust's Our Journey to Change sets out why we do what we do, the kind of organisation we want to be and the three big goals we're committing to within our business plan.

The most important way we will achieve our goals is by living our values of respect, compassion, and responsibility, all the time. This Policy supports the delivery of safe and effective care in line with the trust values and the Trusts 5-year strategic goals.

In keeping with goal 1 of Our Journey to Change we will ensure that carers and families receive compassionate care following the loss of a loved one. We will make it a priority to work more closely with families and carers of patients who have died to ensure meaningful support and engagement with them at all stages, from the notification of death through to actions taken following an investigation. As part of goal 2, we will ensure our staff are trained to undertake thorough reviews of deaths to ensure that learning is identified and embedded into practice to improve the services we provide. Our 3rd goal will be to work collaboratively with other Trusts, as part of a Northern Alliance, and the Better Tomorrow Programme to facilitate shared learning/good practice and valid comparisons.

The experience of carers and families must be central in how we respond when care might not have been delivered to the standard expected by the trust. Families and carers can offer us an invaluable insight which can help us to identify how we can learn from these situations. If things do go wrong, families should be able to say:

- We were treated with respect, care, and compassion
- We were supported appropriately and did not feel further harmed by the process
- Our view and information were given the same credence and weight as that of your staff
- We were given meaningful, truthful, and clear answers and information in response to all our queries and concerns regarding the death of our loved one.
- Where our expectations were not met or we were not satisfied, we were given a meaningful, truthful, and clear explanation for why this was not possible.

This policy sets out the principles that guide our work and how we will implement them, it should be read in conjunction with the Incident recording and response policy (CORP-0043) which outlines the Trust processes in line with the Patient Safety Incident Response Framework (PSIRF).

2 Why we need this policy

Working with families/carers of patients who have died offers an invaluable source of insight to improve services. There is a need to ensure appropriate support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital. In line with the NQB guidance on Learning from Deaths, every trust must have a policy in place that sets out how it identifies, reports, investigates, and learns from a patient's death. This should include the care leading up to the patient's death to consider if this could have been improved.

This policy informs the organisation of staffs' roles and responsibilities relating to learning from deaths and promotes a culture of learning lessons.

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

2.1 Purpose

The purpose of this policy is to set out the trust's expectation / principles on how it responds to deaths in our care and identifies the scope of review for each death and how the trust will learn from them.

This policy describes how staff can support the involvement of families and carers when a death has occurred and how to engage with them to ensure there are opportunities to discuss or ask questions about the care received by their loved one.

2.2 Objectives

While a focus on process is important, everything that is done should place emphasis on the outcomes of learning from deaths and supporting families and carers.

The core objectives of this policy are:

- To prioritise and enable consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.
- To help to identify what can be improved to ultimately reduce inequality in the life expectancy of people with a serious mental illness/learning disability/Autism.
- To standardise approaches to reviewing deaths across the northern cohort of mental health trusts to share information and key learning.
- To enhance learning at a personal, team and organisational level.
- To ensure, in keeping with Our Journey to Change, that the trust engages with other stakeholders (Medical Examiner, Acute Trusts, Primary care, Public Health, Safeguarding, Health and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximise learning from deaths.

3 Scope

3.1 Who this policy applies to

This policy applies to all Trust staff with a responsibility for patient care:

Some deaths will be reviewed using alternate processes and these include (But are not limited to):

- unexpected deaths believed to be as a result of self-harm – these will be reviewed as incidents using PSIRF
- Deaths within the Prison estate – these are reviewed as deaths in custody
- Deaths of Under 18's – these are reviewed as incidents under PSIRF / Through Child Death Review process in conjunction with Safeguarding

3.2 Roles and responsibilities

Mortality governance is a priority for all Trust Boards and the Learning from Deaths Framework places a greater emphasis on the importance of Board Leadership to ensure that learning from patient deaths becomes embedded in the organisation.

Role	Responsibility
Chief Executive, Executive Trust Board Directors and Non-Executive Directors	Trust Boards are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths and working towards achieving the highest standards in mortality governance. They must ensure quality improvement remains key by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change. They can do this by demonstrating their commitment to the work, for example, spending time developing Board thinking; ensuring a corporate understanding of the key issues around the deaths of patients and by ensuring that sufficient priority and resource is available for the work. The Chief Nurse is the Board level 'Patient Safety Director' and the Executive Medical Director has responsibility for learning from deaths. A named Non-Executive Director takes lead responsibility for oversight of progress to act as a critical friend holding the organisation to account for its approach in learning from deaths. The Board will ensure that: • Robust systems are in place for reporting, reviewing, and investigating deaths • Bereaved families are engaged and supported • There is evidenced learning from deaths both internally and with our external partners and quality improvement is championed • Those processes focusing on learning, can withstand external scrutiny, by providing challenge and support and assurance of published information
Specialty Clinical Directors, Associate Medical Directors, Medical Staff, General Managers, Associate Directors of Nursing and Quality, Associate Directors of	Staff should familiarise themselves with this policy, understand the process for learning from deaths and identify the key changes required to implement this policy ensuring all appropriate actions are taken. In conjunction with the Patient Safety Team staff will be supported to:

Therapy, Service Managers, Modern Matrons, Ward and Team Managers and all Registered Nurses and Allied Healthcare Professionals	• Ensure all deaths are reported and recorded accurately on the InPhase system as either a Patient Safety Incident or as an outcome. • Be involved in the different reviews and investigations of deaths ensuring they have the time to carry this process out in skilled way to a high standard. • Have the correct level of skill through training and experience. • Promote learning from deaths. • Ensure that sufficient time is assigned in local governance forums to outline and plan for any lessons learned. • Ensure that learning is acted upon.
The Patient Safety Team	This corporate Trust department has a responsibility to ensure: • Data is collected and published to monitor trends in deaths with Board level oversight of this process • The InPhase incident reporting system is used to its full potential to monitor and oversee the learning from deaths (expected and unexpected) in accordance with Trust policy. • Information is processed consistently and precisely to maintain high standards in mortality governance

The Trust requires all staff to be open, honest, and transparent about reporting deaths and for engaging with families and carers, actively enabling them to ask questions about care and identify if care can be improved.

4 Policy

4.1 Encouraging a learning from death culture

By educating our staff and encouraging a more open culture of listening to the views and opinions of families and carers, staff will become more confident in identifying what can be done differently and improving patient experience in the future.

4.2 Family engagement

Dealing respectfully, sensitively, and compassionately with families and carers when someone has died is paramount. At times families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received.

Where clinicians have had close contact with a patient and their family/carer, they will often be the first to offer condolences and support and to give appropriate information regarding the opportunity to be involved in a review of care their loved one received. Where there is a delay in the Trust being informed about the death of a patient, a discussion should take place between the Patient Safety team and the clinical team involved to determine how best to approach families/carers.

If a mortality review is being undertaken, Staff should be approaching families and carers and explaining the purpose of the review and giving the family / carer the opportunity to contribute as equal partners. The family/carer views about involvement in the process should be respected. If they do not wish to be involved this should be documented. Where family/carers do wish to be involved this can include families sharing their feedback on care received, raising any questions for consideration and where appropriate reviewing draft reports of the reviews. Consent to share information needs to be considered, however even where consent was not agreed, this does prevent the family/carer sharing their views and feedback.

Where families have concerns, this should, where possible be addressed through the Mortality process alongside the Early Resolution Approach overseen by the complaints team

4.3 Identifying and Reporting Deaths

The Trust captures the known deaths of its patients on its InPhase recording system. This is to help ensure that the Trust Board has a comprehensive picture of the deaths of all its patients and the opportunities to learn from them.

Trust staff must InPhase report **all deaths** that they are made aware of, within 24 hours of being informed. This applies to all deaths of patients open to TEWV services or who have been discharged from TEWV services in the 6 months preceding their death. A cause of death should be provided where known. Unexpected deaths or deaths believed to be as a result of an incident should be reported as an InPhase Patient Safety Incident. Expected deaths through natural causes including those on end-of-life pathway should be recorded as an InPhase outcome.

4.4 The decision to investigate or review

The NQB guidance requires that all inpatient, outpatient, and community patient deaths of people with severe mental illness (SMI) should be subject to case record review.

In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses,

including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis, and schizoaffective disorder. It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems.

Where Trusts such as ours provide a wide range of clinical services across inpatient, community and other provider organisations this can lead to both a degree of confusion as to who is responsible for the reporting and investigating of a patient's death and the risk of double reporting and investigation.

It is recognised that people with mental health problems, learning disabilities and autism often access a range of health services and may be in receipt of care by multiple agencies at the time of their death. To support consistency in determining the scope of deaths for further review by the Trust as the main provider of care or to participate in the review with another provider, the cohort of Northern Mental Health Trusts agreed the following approach to provide further guidance and clarity to the definition in the NQB guidance:

To support staff in their decision making regarding the investigation of deaths and whose responsibility it is under PSIRF and / or the Learning from deaths process, staff should refer to the following guidelines. If there is any doubt staff should contact their line manager or the Patient Safety department for advice.

A We are the main provider if at the time of death, the patient was subject to:

- An episode of inpatient care within our service.
- An episode of community treatment due to identified mental health needs
- An episode of community treatment due to identified learning disability or autism
- A Community Treatment Order.
- A conditional discharge.
- An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
- Guardianship

B Patients who meet the above criteria but are inpatients within another health care provider or custodial establishment at the time of their death.

In these circumstances the death will be reported by the organisation under whose direct care the patient was at the time of their death. That organisation will also exercise the responsibilities under duty of candour. There will be a discussion to agree on if it is to be a joint or single agency investigation (this will be determined by the suspected cause of death) and in the case of joint investigations who the lead organisation will be.

C Services provided by the Trust where we are not classed as the main provider.

For the following services the Trust may only be providing a small component of an overarching package of care and the lead provider is the patients GP.

- Tissue viability
- Dietetics
- Drug and alcohol shared care services
- Care home liaison
- Acute hospital liaison
- Community physiotherapy
- Memory clinic

D Exception.

In addition to the above, if any act or omission on the part of a member of Trust staff where we are not classed as the main provider is felt to have in any way contributed to the death of a patient, an investigation will be undertaken by the Trust.

Where problems are identified relating to other NHS Trusts or organisations the Trust should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement. In line with PSIRF, a culture of compassionate curiosity should be adopted, and the following questions should be asked:

- Which deaths can we review together?
- What could we have done better between us?
- Did we look at the care from a family and carers perspective?
- How can we demonstrate that we have learnt and improved care, systems, and processes?

4.5 Types of Review:

InPhase reports for deaths are initially reviewed by the Patient Safety Team through the huddle process.

Depending on the facts of the case, completion of either an After Action Review (AAR) or a Mortality Review Part 1 by the clinical service may be considered to identify any learning as well as appropriate actions to address this learning. Other tools may be considered as part of the PSIRF processes.

Upon receipt of the AAR or Mortality Review Part 1 (or other tool) by the Patient Safety Team, the Patient Safety Huddle will determine if further investigation is required through consideration of any red flags (identified within part 1 reviews) or concerns noted within the review. This could be a Patient Safety Incident Investigation (PSII) or a Mortality

Review Part 2: Structured Judgement Review (SJR). Each case will be reviewed on an individual basis to ensure the correct approach, level of review is requested.

Mortality reviews are completed in-line with guidance from the Royal College of Psychiatry and the National Quality Board standards. The mortality review tool used consists of a Part 1 and Part 2 review (see appendix 1). Mortality Review Part 1 is a review of the care records by one or more members of the multi-disciplinary team and should include consideration of Family/Carer feedback.

Mortality Review Part 1:

To prioritise the most significant cases for learning from unexpected and expected **physical** health deaths the following reviews take place where we are the main care provider:

- All in-patient deaths, that are not subject to a Patient Safety Incident Investigation will have a Mortality Review Part 1 completed by clinicians in line with the terms of reference outlined for AAR /Part 1. Families will be offered the opportunity to be involved by sharing their experience of care where appropriate.
- All Learning Disability and Autism deaths that are not subject to a Patient Safety Incident Investigation will have a Mortality Review Part 1 completed by clinicians in line with the terms of reference outlined for AAR /Part 1 and reported to LeDER who carry out a structured judgement review. Families will be offered the opportunity to be involved by sharing their experience of care where appropriate.
- All community deaths for patients aged under 65 are reviewed under Mortality Review Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review will be considered. Families will be offered the opportunity to be involved by sharing their experience of care where appropriate.
- A minimum of 20% of community deaths for patients aged between 65 and 74 that are not subject to a Patient Safety Incident Investigation including AAR are reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review is considered. This 20% is selected from deaths within Trust services and should focus on those diagnosed with a Severe Mental Illness (SMI) as opposed to deaths within care homes or memory services, for example, where the Trust is not the main care provider. The cases will be identified by the Patient Safety Team from the mortality database and requested from services accordingly. Families will be offered the opportunity to be involved by sharing their experience of care where appropriate.
- A minimum of 10% of community deaths for patients aged 75 onwards that are not subject to a Patient Safety Incident Investigation including AAR are reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review is considered. This 10% is selected from deaths within Trust services by the Patient Safety Team and should focus on those diagnosed with a Severe Mental Illness (SMI) as opposed to deaths within care homes or memory services, for example, where the Trust is not the main care

provider. Families will be offered the opportunity to be involved by sharing their experience of care where appropriate.

Evidence of "red-flags" to be considered during the Mortality Review Part 1 are as follows:

- Family, carers, or staff have raised concerns about the care provided.
- People with a diagnosis of psychosis or eating disorders during the last episode of care, who were under the care of services at the time of their death or who had been discharged within the 6 months prior to their death.
- Psychiatric in-patient at the time of death, or discharged from care within the last month (where the death does not fit into the category of a Patient Safety Incident Investigation).
- People under Crisis Resolution and Home Treatment Team (or equivalent) at the time of death (where the death does not fit into the category of a Patient Safety Incident Investigation).
- Concerns raised about the care provision which in the view of those completing the Mortality Review Part 1 warrant further investigation.

4.6 Reporting the deaths of those with a Learning Disability and / or Autism

In addition to internally reporting Learning Disability and autism deaths, there is also a requirement to report them externally where this is a confirmed diagnosis. We need to ensure that throughout the Trust we report the death of a patient (aged four years and older) with a Learning Disability and Autism to the Learning from the Lives and Deaths of People with Learning Disability and/or Autism (referred to as LeDER).

When a member of a clinical team is informed about the death of a patient with a Learning Disability or Autism, over the age of four, who is receiving care and treatment from TEWV, they must follow the below steps as soon as practicable:

- Check whether the death has been reported to LeDeR, you should find this on PARIS/Cito, and if not, take responsibility of notifying LeDeR about the death. If in doubt, please report to LeDeR anyway (it's better to over report than under report).
- Report the death on InPhase.
- The Patient Safety team review all reported deaths through the daily Patient Safety Team huddle and will monitor compliance with the LeDeR process.

Reporting the death of a person with a learning disability

Anyone can notify a death to the LeDeR programme. To report a death please use the following link.

online form on the LeDeR website

Integrated Care systems (ICS) are now responsible for ensuring LeDeR reviews take place. TEWV staff may be asked to be involved with this process, and it is important that they assist with this review and provide any information requested; the sharing of information in these cases is authorised under Section 251 of the Health Research Authorities Confidential Advisory Group. Support should be provided to staff by their line manager during this process.

Following the LeDeR review, it will be agreed whether there are any contributory factors, lessons learned, good practice and recommendations. If any learning is identified through these external reviews, these will be shared by the ICS lead with the Trust Patient safety team who will share with relevant clinical networks to be taken to their local forums for discussion.

4.6.1 Learning from mortality reviews

The Trust has a multi-disciplinary mortality review panel which meets monthly. The purpose of the mortality review panel is to review and discuss findings/learning from structured judgement reviews, seeking assurance that all elements of care have been reviewed and relevant learning/themes have been identified.

Learning points are captured and shared In line with the learning flow chart detailed in the incident policy

4.7 Data reporting

Trusts are required to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings.

5 Definitions

Term	Definition
After Action Review (AAR)	Local, multi-disciplinary forum to review an incident using a systems based approach to learning incorporating all relevant stakeholders including the patient and/or family.

Mortality Review Part 1 (Case record review))	Reviewing case records/notes to determine whether there were any problems in the care provided to the patient who died to learn from what happened. The Royal College of Physicians Structured Judgement Review methodology provides an agreed template for this.
Death due to a problem in care	A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.
Patient Safety Incident Investigation (PSII)	The act or process of investigating; a systematic analysis of what happened, how it happened and why to support learning. This draws on evidence, including physical evidence, witness accounts, policies and procedures, guidance, good practice, and observation – to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. This should be done in line with PSIRF
Mortality Review Part 2: Structured Judgement Review (SJR)	A Structured Judgement Review (SJR) is carried out by an experienced clinician who is trained in investigation skills or supported through clinical supervision by someone skilled in this. The SJR considers the care and treatment the patient received and any lessons that can be learned
NQB	National Quality Board

6 Related documents

This Policy document is to be read in conjunction with:

- Incident Recording and Response Policy (CORP-0043)
- Duty of Candour Policy (CORP-0064)

7 How this policy will be implemented

This updated policy will be scrutinised by the Executive Directors Group and published on the Trust's intranet and external website. Policies are disseminated via the Trust e-bulletin

7.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All corporate staff up to and including band 6	Incident recording - corporate	30 minutes	One off
All clinical staff up to and including band 6	Incident recording - clinical	45 minutes	One off
All corporate staff Band 7 upwards	Incident Management - corporate	45 minutes	One off
All clinical staff band 7 upwards	Incident management – clinical	60 minutes	One off
All staff	Patient safety syllabus level 1: Essentials for patient safety	Approximately 30 minutes	One off
All staff – clinical, career and training grade staff	Patient safety syllabus level 2: Access to practice	Approximately 45 minutes	One off
Key identified clinical staff within leadership teams	PSIRF training	1 days	One off
Key identified staff to be Patient Safety Specialists (Key staff identified via Patient Safety team	Patient Safety Specialist training level 3-5	Ongoing modules through blended learning	One off

8 How the implementation of this policy will be monitored

	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented, and monitored; (this will usually be via the relevant Governance Group).
1	Learning From Deaths data and key learning points will be collated	Quarterly in a report of both data and qualitative findings by Executive Medical Director supported by Patient Safety	The results will be considered at the Quality Assurance Committee and at Trust Board.

9 References

National Quality Board: *National Guidance on Learning from Deaths 2017*

NHS Improvement: *Implementing the Learning from Deaths framework – key requirements for trust boards 2017*

Patient Safety Incident Response Framework 2022

Duty of Candour - Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

About Candour - openness and honesty when things go wrong - GMC

Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	16 September 2025
Next review date	16 September 2028
This document replaces	CORP-0065-v2 Learning from Deaths Policy: The right thing to do (Incorporating the Protocol for reporting Learning Disability deaths to the Learning Disabilities Mortality Review (LeDeR) Programme)
This document was approved by	Executive Clinical Leaders Subgroup
This document was approved	16 July 2025
This document was ratified by	Management Group
This document was ratified	16 September 2025
An equality analysis was completed on this policy on	14 March 2025
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
1	27 Sep 2017	New document	Withdrawn
1	18 Jun 2020	Review date extended from 27 September 2020 to 27 March 2021	Withdrawn
1	08 Mar 2020	Review date extended to 27 September 2021	Withdrawn
2	15 Dec 2021	Full review with minor changes. Including transfer to new template and with minor wording changes to reflect current practice. *= Ratified subject to OJTC being corrected, sent for publication March 2022.	Withdrawn
3	16 Sept 2025	• Full review and significant changes to reflect Trust change in incident reporting system (Datix to InPhase) as well to bring the policy in line with the National Patient Safety Incident Response Framework (PSIRF) and the types of reviews that are undertaken within the Trust e.g. After Action Review, Patient Safety Investigation. • Removed areas of duplication. • Amended roles within roles and responsibilities section to reflect current structure. • Reviewed and updated links to external documents within references section. • Amended wording to ensure that the policy is inclusive of mental health, learning disabilities and autism. • Definitions reviewed and updated. • Updated Mortality Review Part 1 and Part 2 templates added to appendices. • Review and update of Training Needs Analysis.	Published

Appendix 1 – Care review tool for mortality reviews

PART 1 Review-

Patient identification number:		**Gender:**	
Date of birth (dd/mm/yyyy)		**Age:**	
Social deprivation index (first 3−4 letters of postcode)		**Ethnicity:**	
Date of death		**Time of death:**	
Location of death			
Was the patient identified as being within the last 12 months of life?			
Cause of death (if known)			
Primary diagnosis, including ICD-10 code			
Co-morbidities			
Mental Health Medication			
Learning disability (if present, this death should be reviewed through the LeDeR process)			
Healthcare teams involved in the patient's care at the time of death			
Dates of last admission to a psychiatric hospital (where relevant)			
Patient summary (can be completed by the clinical team)			
Concerns from family members or carers about the patient's care (please outline concerns, or state if there were no concerns)			
Concerns from staff about the patient's care (please outline concerns, or state if there were no concerns)			
Red flags indicating further review where the death is not being investigated by other means (please indicate):			
1. Family, carers, or staff have raised concerns about the care provided ☐			
2. Diagnosis of psychosis or eating disorders during the last episode of care ☐			

3. Psychiatric inpatient at time of death, or discharged from inpatient care within the last month	☐
4. Under Crisis Resolution and Home Treatment Team (or equivalent) at the time of death	☐
5. Case selected at random	☐

If a red flag is identified, or it has been agreed this death is for a review of care, please proceed to completion of Review 2

Time taken to complete Section 1 of this form (minutes):

Date of completion:

Name of person completing Section 1:

Job title of person completing Section 1

Part 2 Structured Judgement Review

Please state the information sources used for the review, including the names of the electronic systems accessed:

2.1. Phase of care: Allocation and initial assessment or review (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐
2.2. Phase of care: Ongoing care (where relevant) • **Was mental health monitored adequately?** • **Was physical health monitored adequately?** • **Please list medication if known and relevant, and comment on medication monitoring where appropriate** Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐
2.3. Phase of care: Psychiatric Inpatients – comment on care during admission (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐

2.4. Phase of care: End of life care (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐

2.5. Phase of care: Discharge plan of care (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐

2.6. Other area of care (please specify) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐

2.7. Overall care Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐

2.8. If care was below an acceptable standard, did it lead to harm? If yes, please provide details and state an action plan (consider whether a serious incident investigation or another Trust process is required).

2.9. Was the patient's death considered more likely than not to have resulted from problems in care delivery or service provision? If yes, please provide details and state an action plan (consider whether a serious incident investigation is required).

2.10. If a family member, carer, or staff raised concerns, please outline any feedback provided and state who was responsible for providing this feedback. Please state further action required. If no feedback was provided, please consider how the outcome of this review should be fed back to the relevant people, considering the duty of candour principle.

2.11. Were the patient records adequate for the purpose of the review?	Yes ☐ No ☐
Please outline any difficulties in accessing appropriate information:	

Time taken to complete Section 2 of this form (minutes):

Date of completion: 2/11/21.

Name of person completing Section 2:

Job title of person completing Section 2:

Appendix 2 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Nursing and Governance - Patient Safety
Title	Learning from Deaths Policy
Type	Policy
Geographical area covered	Trustwide
Aims and objectives	The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people therefore it is important that organisations widen the scope of deaths which are reviewed to maximise learning.
Start date of Equality Analysis Screening	December 2024
End date of Equality Analysis Screening	March 2025

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Families and Carers; Trust Staff;
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO**

	• **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	
Describe any positive impacts / Human Rights Implications	Gives clarity and understanding around learning from deaths to families, carers, trust staff and external stakeholders. There is an acknowledgement that there could be a negative impact on the families and carers of patients who have died in relation to the protected characteristic of 'Disability' and the effects it could have on the families and carers mental health. The policy therefore identifies ways to ensure that families and carers are supported to access appropriate services via the Trusts Family Liaison Officer/reviewer and that the families and carers are given appropriate information and choice in relation to how they wish to be involved in the review process.

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	See references section

Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No – note all staff six-week consultation
If you answered Yes above, describe the engagement and involvement that has taken place	
If you answered No above, describe future plans that you may have to engage and involve people from different groups	No – however this has been based on discussions with Quality Assurance Improvement Group, Learning from Deaths report (to external stakeholders and the Trust Board of Directors) and Equality and Diversity team have been consulted.

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	No
Describe any training needs for patients	No
Describe any training needs for contractors or other outside agencies	No

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 3 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Y	
Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2. Rationale		
Are reasons for development of the document stated?	Y	
3. Development Process		
Are people involved in the development identified?	Y	
Has relevant expertise has been sought/used?	Y	
Is there evidence of consultation with stakeholders and users?	Y	
Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4. Content		
Is the objective of the document clear?	Y	
Is the target population clear and unambiguous?	Y	
Are the intended outcomes described?	Y	
Are the statements clear and unambiguous?	Y	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Y	
Are key references cited?	Y	
Are supporting documents referenced?	Y	
6. Training		

Have training needs been considered?	Y	
Are training needs included in the document?	Y	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Y	
8. Equality analysis		
Has an equality analysis been completed for the document?	Y	
Have Equality and Diversity reviewed and approved the equality analysis?	Y	
9. Approval		
Does the document identify which committee/group will approve it?	Y	
10. Publication		
Has the policy been reviewed for harm?	Y	NO HARM
Does the document identify whether it is private or public?	Y	PUBLIC
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Y	
Do all pictures and tables have meaningful alternative text?	Y	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Y	