

Sheffield Children's NHS Foundation Trust

**Mortality Review Panel Procedure for In-Patient Deaths
(Learning from Deaths)**

Author and Contact Person	Date Approved by Quality Committee	Implementation Date	Version number	Issue Date	Review Date
Derek Burke	11 September 2017	11 September 2017	1	11 September 2017	10 September 2020

REQUIREMENT	ACTION
Who should be aware of the procedure and where to access it	Mortuary Staff, Head of IT and Mortality Review Panel Members, Legal and Governance Department
Who should understand the procedure	Mortuary Staff, Head of IT and Mortality Review Panel Members, Legal and Governance Department
Who should have a good working knowledge of the procedure	Mortuary Staff, Head of IT and Mortality Review Panel Members, Legal and Governance Department
Whether the procedure should be included in the General Trust Induction Programme and/or departmental specific induction programme	No
Where is the Procedure available:	Intranet
Copy to be sent to personnel with a request for inclusion in employment details	No
Copy to	Compliance Officer for Intranet site
Process for monitoring the effectiveness of this document	Review of Sharepoint System for completion of review details and actions for all in-patient deaths Quarterly report to Quality Committee
Patient version.	No
Groups/persons consulted.	Medical Director Director of Nursing and Quality Mortality Review Panel Members IT Department
Training.	Mortality Review Panel
This Procedure is subject to the Freedom of Information Act	

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1. INTRODUCTION

National Guidance mandates good practice in the process of reviewing in-patient deaths. This procedure describes how in-patient deaths at SC NHS FT are reviewed and how those reviews are updated as new information becomes available. This includes the reporting of deaths in children and young people with Learning Disability to the Learning Disabilities Mortality Review (LeDeR) Programme at Bristol University.

2. SCOPE

This procedure applies to all clinical staff, relevant IT, Legal and Governance and Mortuary staff working within Sheffield Children's NHS Foundation Trust.

3. PURPOSE

It is the purpose of this procedure to define the procedure for reviewing in-patient deaths occurring at Sheffield Children's NHS Foundation Trust (SC NHS FT) and the process for notifying relevant deaths to the Learning Disabilities Mortality Review (LeDeR) Programme at Bristol University.

4. ROLES AND RESPONSIBILITIES

The Medical Director

The Medical Director is responsible for ensuring that all medical staff, relevant IT staff and mortuary staff are aware of and operate within the procedure.

The Director of Nursing and Quality

The Director of Nursing and Quality is responsible for ensuring mechanisms are put in place to ensure legal and governance staff are aware of and comply with the procedure.

Members of the Mortality Review Panel

To follow the procedure.

Mortality Review Panel Procedure for In-Patient Deaths at SC NHS FT

5. BACKGROUND

Information relating to the events leading up to the death of a child who is an in-patient at Sheffield Children's NHS FT comes from a variety of sources, e.g. contemporaneous clinical notes, death certificates, complaints, incident reports, root cause analysis reports, morbidity and mortality meetings, Rapid Response Visits for unexpected deaths, Early Multiagency meeting and Final Case Discussion minutes after unexpected child deaths (part of Child Death Overview Panel (CDOP) procedures, and inquests. This information can be used to inform changes to future clinical practice as a result of lessons learnt, but there may be a time lag between the death and that information becoming available, e.g. clinical records are immediately available but inquest outcomes may only be available a year or more after the child's death. There is the potential that delays in implementing changes in practice due to this information time lag can expose other children to risks which would be preventable if changes in practice had been implemented soon after the original death.

There is currently no formal process for undertaking a rapid review of a child's death to check if there are any concerns requiring an immediate change to clinical practice other than relying on notification from individuals involved in the death of that child. Similarly there is no process for aggregating the different types of information available about a death to come to a view about the need to change practice or updating that view as new information becomes available.

The mortality review panel process has been set up to provide a rapid early review of all in-patient deaths at SC NHS FT and to facilitate the process of on-going review of deaths as new information becomes available. A Sharepoint system is under development to manage the information flows.

6. PROCEDURE

Deaths occurring as in-patients are reported to IT by the QSM notification system who adds them to the Mortality Review Sharepoint System Master List.

Cases are allocated to consultants on the mortality review panel. That consultant will be the case manager for the case and will review any new information relating to that death. Cases are reviewed and uploaded to the Sharepoint System. The cases will be discussed at the monthly mortality review panel meeting and actions agreed and uploaded to the Sharepoint System.

When additional information is made available this will be uploaded to the Sharepoint system and the case manager will be informed that the new information is available.

The case manager will review the new information and refer the case back to the panel if there are any changes to the actions required.

Deaths involving children aged 4 or over will in addition be reviewed to check if the child had a learning disability and if so the death will be reported to the Learning Disabilities Mortality Review (LeDeR) Programme at Bristol University.

Deaths involving children aged under 28 days will in addition be reported to the MBRRACE study by the Designated Doctor for Child Deaths.

The process is currently being developed in relation to deaths occurring in children who are in-patients at SC NHS FT. Work is underway to widen this to children who die in the community and have previously been under the care of SC NHS FT

Part of the implementation of the Sharepoint system is to streamline the process of death notifications to ensure that we capture all deaths of children who have been under the care of SC NHS FT. There is currently no single source of reliable information on whether a child under the care of SC NHS FT has died, e.g. if a child living in another part of the UK who is under annual follow up at SCH dies in their local area there is no reliable way for us to know about that death unless the GP or family informs SCH.

The mortality review panel will report quarterly to the quality committee on lessons learnt and any actions taken.

7. PROCESS FOR MONITORING COMPLIANCE WITH THIS PROCEDURE

Review of Sharepoint system at Mortality Review Panel Meetings to check reviews and actions are up to date.

Quarterly report to Mortality Review Panel

8. ASSOCIATED DOCUMENTS

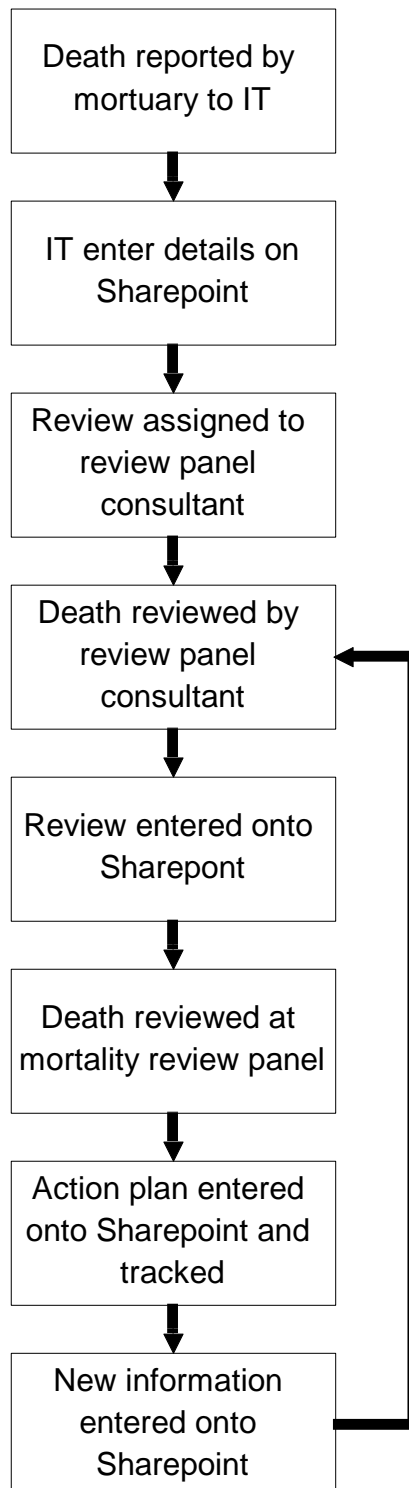
Procedure for Managing and Reporting of Serious Incidents (RM01)

Procedure for the Investigation of Incidents/Complaints and Claims (CP126)

Procedure for Communicating with Patients/Parents following an Incident & Incorporating the Statutory Duty of Candour (CP549)

Sudden Unexpected Death In Infancy and Childhood (CAEC Reg. ID no. 1494v2 Under Review)

9. MORTALITY REVIEW PROCESS FLOW CHART



10. EQUALITY IMPACT ASSESSMENT

This procedure applies to all Trust employees irrespective of age, race, colour, religion, disability, nationality, ethnic origin, sexual orientation or marital status, carer status, social and employment status, HIV status, gender reassignment, political affiliation or trade union membership. All employees will be treated in a fair and equitable manner.

The Trust will take account of any specific access or specialist requirements (e.g. BSL interpreter, documents in large print) for individual employees during the implementation of this procedure

11. VERSION CONTROL

Version	Date	Author	Status	Comment
1	September 2017	Derek Burke	Approved	New Procedure