Mortality Review Panel Report November 2018

	ED	PCCU	Ward	Other Hosp	Bluebell Wood	N/K	TOTAL**
Jan	1	4				1	**6**
Feb	2	4					**6**
March	1	1	1	1		1	**5**
April	1	1		1		1	**4**
May	1	4				1	**6**
June							**0**
July	1	1					**2**
Aug		1				1	**2**
Sept		1			1		**2**
Oct	3	2	1			1	**7**
Nov	1	2					**3**

2 SI investigations opened associated with deaths in last quarter (Coroner involved in both cases)

** Includes all deaths in hospital and those patient with a significant involvement from Trust

All deaths within the hospital are put on Share Point but this does not take into account those children / young people who die outside of hospital where classification on Share Point is more ad hoc.

Update on mortality review process:

1. Single point of contact for administration through Legal and Governance

2. New TOR for Mortality Review Panel and Learning from Deaths Policy being discussed at meeting 17/12/18 and will then be brought to next Quality Committee

3. This Policy takes into account –

    a. 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..

    b. The reporting of deaths in children and young people with Learning Disability to the Learning Disabilities Mortality Review (LeDeR) Programme at Bristol University.

Jeff Perring

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