Policy Group: Clinical
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Approved by: Mortality Surveillance Group, Quality and Safety Group

Responding to Death Policy

1. Policy Summary / Statement

The Policy has been written to set out how St Andrews will learn from deaths that occur which were expected and unexpected. This is in response to the National Guidance on Learning from Deaths (published March 2017). St Andrews number one priority is to provide the best quality care and it is important that we review the care provided to people who have died in our care which can help improve care for all patients by identifying problems associated with poor outcomes, and working to understand how and why these occur so that action can be taken.

This policy is to support St Andrews staff with the correct process and procedures to follow in the event of an expected or unexpected death of a patient in our care. We recognise that this can be a very difficult time for all involved. The Francis report (Francis, 2013) outlined several standards that should be met when a person who has been receiving In Patient care dies which relate to the certification of death, and the assessment of whether all could have been done to either improve the care during the terminal stages of life or all could have been done to prevent the death of that person.

In the sad event when a patient in our care dies, the deceased will be accorded the respect and dignity required at this sensitive time. Consideration will be given to the patient's spiritual, cultural and religious wishes. Any special requests that are made by the patient and / or their family will be taken into consideration. All staff will be supported through the St Andrews Trauma Services when required.

St Andrews will make it a priority to work more closely with the families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages, from the notification of death of their loved one, involvement in the investigation process through to actions taken following on from an investigation. This support can help all those involved, process and come to terms with their loss in a safe and natural way.

The policy makes clear the procedure for responding to and learning from deaths across the charity including:

- When and how the death of a patient should be reported.
- How deaths should be reviewed and investigated in the organisation.
- How the organisation should engage with the bereaved families and cares.
- How the organisation learns from deaths to improve and inform clinical practice.

This Policy applies to all staff whether they are employed by St Andrews Healthcare permanently, temporarily, through an agency or work choice arrangements, students on placement are party to joint working arrangements or contractors delivering services on the charity's behalf.

Classification of Death:

Deaths are classified at St Andrews as Expected and Unexpected. Unexpected deaths are deaths which are from natural causes such as sudden death from cardiac conditions or they can be from natural causes which didn't need to be like in cases where there are concerns in care or can be unnatural in cases of suicide or abuse. All unexpected deaths are reviewed, a proportion may need to be investigated as some may have been prevented.

Death of a patient in Mental Health services:

Physical and Mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 – 20 years earlier than other people. (The five year forward view for mental health (NHS England) 2016). In addition, people with long term physical health illness suffer more complications if they also develop mental health problems. Reporting and reviewing of any death of a patient with mental health problems should consider these factors:
Premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

State Detention:

State detention is defined in section 48(2) of the Coroners and Justice Act 2009 as *'A person is in state detention if he or she is compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1998'.* 'But a person is not in state detention at any time when he or she is Deprived of Liberty under section 4A (3) or (5) or (4B) of the Mental Capacity Act (MCA) 2005' Accordingly, for deaths to which section 48 (2A) applies, there is no mandatory and automatic requirement for a Coroner's investigation "state detention" grounds if the person was subject to Deprivation of liberty authorized under the MCA 2005. There may be a requirement for an investigation on other grounds (e.g., that death was unnatural, or indeed the person was in police custody.) Furthermore, a person who dies whilst subject to restrictions "state detention" in a hospital or care home or community, but without there having being a Deprivation of Liberty authorized under the MCA 2005, will still have to be the subject of investigation and inquest on "state detention" grounds.

If the patient was a restricted patient under a section of the Ministry of Justice, (MoJ) must be informed and the appropriate clinical reports must be prepared and forwarded by the relevant professionals.

In circumstances where there is a reason to believe the death may have been due, or in part due to, problems in care including suspected self-inflicted death then the death must be reported to the provider's commissioner(s) as a serious incident and investigated appropriately. Consideration should also be given to Commissioning an independent investigation as detailed in the **Serious Incident Framework**. https://www.england.nhs.uk/patient-safety/serious-incident-framework/.

Police attend all cases of unexpected deaths and will report the death and provide an immediate report for the coroner.

CHILDREN AND YOUNG PEOPLE (13-17)

Historical background to the process of child mortality review:
Since the 1st April 2008, local safeguarding children's boards within England, have a statutory responsibility for Child Death Review (CDR) processes. The child death review (CDR) process reviews the deaths of all children who are aged 4-17 years.

Principles
The principles set out in this section apply to all children in inpatient mental health settings whether they are treated 'voluntarily' as informal inpatients or detained under the Mental Health Act 1983 (MHA).

All child deaths in an inpatient mental health setting (general and secure) should be reported to the coroner. If the death was not due to natural causes, the coroner is likely to open a formal investigation that may lead to an inquest.

When a child dies while detained under the MHA, there should also be a safeguarding practice review.

- "Rapid response" Multi professional investigations of an individual unexpected death.
- A Child Death Overview Panel (CDOP) review of all deaths in a defined geographical area. The purpose of the CPOD is to establish the exact cause of death, identify patterns of death in community and remedial factors, and to contribute to improved forensic intelligence in suspicious deaths. The family should be kept central to the process. The Child Death review Meeting (CDRM) should involve the care coordinator for the community mental health team as well as other professionals from children and young people's mental health services. Other necessary attendees might be: GP, education/school representative, and social worker.

Local Authorities and Clinical Commissioning Groups are named as "Child Death Review Partners" and must make arrangements for the review of each death of a child, normally resident in the local authority area.
They may also, if they consider appropriate, make arrangements for the review of a death in their area of a child not normally resident there.

Child death review process
The professional confirming the death should inform the local designated doctor for child deaths at the same time as informing the coroner and the police. NHS and independent providers of inpatient mental health settings must notify the Care Quality Commission (CQC) or they can notify NHS England of the death of a patient through a local manager, or by reporting on the risk management system where information is uploaded to the national reporting and learning system. Where a child was detained under the Mental Health Act 1983, the death must be reported to the CQC.

Child Safeguarding Practice Reviews
When a child dies while detained under the Mental Health Act 1983 or while deprived of their liberty by the state, the death must be notified to Ofsted and the local safeguarding partners. These deaths, along with the death of any child in custody or secure accommodation, may trigger a local or national child safeguarding practice review.

Involvement and Support to Parents, Carers and Staff
As in any child death review process, there should be meaningful involvement of families Effective co-ordination is vital when parallel investigations take place. The Carer Engagement Lead should be offered as a "Family Liaison Support" as a single point of contact to every bereaved family who is independent of the service. Bereavement support should be provided for families and consideration given to providing psychological support for staff involved in the care of the child through the Trauma care centre.

Learning Disabilities:

Notification of the deaths of people with a learning disability or autistic people to the LeDeR programme is not mandated. However, there is a strong expectation – supported by CQC – that providers of health and social care services, including GPs, will do so. Notification of a death can be made by anyone including health and social care staff, administrative staff, family members and others who knew the person to LeDeR via the University of Bristol's website. This website will be replaced by a new notification website when the new system goes live from 1st June 2021. Something to note with the new policy is that it **announces the inclusion of autistic people within LeDeR for the first time, but this will not come into effect until late 2021/early 2022.** Below is the link for the new LeDeR policy.
https://www.england.nhs.uk/publication/learning-from-lives-and-deaths-people-with-a-learning-disability-and-autistic-people-leder-policy-2021/
St Andrews will report the deaths of people who have died whilst under their care.

Once a death is notified to LeDeR, it is allocated to the relevant CCG (dependent upon the address of the GP surgery the person is registered with) and a CCG reviewer will be allocated to conduct the review. St Andrews' role in the LeDeR review is to support CCG reviewers by providing access to the person's notes/records and the staff who were involved in their care when requested. Once a review is complete and recommendations/actions for improvement have been developed, the CCG should share the review with all who were involved in the care of the person so that they are aware of the learning that has been generated and any actions which might apply to them.

The LeDeR programme provides annual reports on its findings, collating learning and recommendations at a regional and national level and how best to take forward the learning identified following the review.

This policy does not override the current End of life Policy or the Resuscitation Policy.
Please refer to End of Life Policy.

Infection Control:
Handling of the patient's body should be in accordance with the charity's standard Infection Prevention Control procedures. If the patient has had a confirmed or suspected infection, whoever handles or removes the body should be informed accordingly. If the infection is blood borne (e.g. HIV, Hepatitis B or C) refer to the relevant procedure under the Infection Prevention and control Policy"

Relatives / family/ Next of kin:
The National guidance on learning from Deaths (2017) states that families should be informed immediately after death, in a clear, sensitive and honest manner.

Any communications to the relatives before certification by a doctor should take into account that nurses cannot certify death. Where possible, the news of the death should be informed face to face. If the relatives are not present then they should be contacted via telephone. Breaking news of this nature over the phone is never easy but sometimes unavoidable. However, it is important that staff do not avoid telling the truth. If the relative asks if the patient has died they should be told. Withholding information or hiding facts will impact on the relationship between the Charity and the families. Staff should offer as much support to the relatives as possible and follow the Duty of Candour process in the event of it being an unexpected death. The Carer Engagement Lead should be offered as a "Family Liaison Support" as a single point of contact to every bereaved family who is independent of the service.

If it is felt that breaking this news in this way is inappropriate or there are difficulties making contact or obtaining contact details for the Next of kin / relative, the police should be asked to visit the family / relatives to deliver this information in person.
In the event that the patient does not have family and friends, the Social Worker will be involved in making the necessary arrangement to facilitate burial/cremation.

REPORTING

Reporting and investigation of an individual's death should be carried out as outlined in the Charity's Incident Management and Reporting Policy.

External Reporting

Care Quality Commission:
The Care Quality Commission (CQC) must be notified by the Registered Manager without delay, of the death of a patient after sign off by the Responsible Executive (Chief Nurse or Medical director) CQC outcome 18 is 'Notification of Death of a Person who uses Services' and it should be completed for patients who are not detained under the Mental Health Act 1983. CQC outcome 19 is 'Notification of death or unauthorized absence of a person who is detained or liable to be detained under the Mental Health Act 1983' and should be completed to report the death of a detained patient. These outcomes refer to Regulation 16 and Regulation 17 of the Care Quality Commission (Registration) Regulations 2009 respectively.

Coroner's Office:
Statements are to be collected within four weeks from date of death, and a request will be made by the legal team to the Responsible Clinician for a medical report which should contain information about the patient's condition, circumstances leading to death, and their opinion on the cause of death.

Commissioners:
For unexpected deaths, or any deaths in low and medium secure units the SI process should be followed and an initial report sent to the commissioners within the relevant timeframe. Where a Serious Incident has been declared these reports will be sent to the Commissioners. For expected deaths the mortality review process will be followed and the report may be shared with commissioners as requested.

LeDeR:

LeDeR should be notified of any death of a patient with Learning Disability or Autism at the earliest opportunity. The Registered Manager, Responsible Clinician or Responsible Executive member will notify The Quality team who will complete this notification from the information provided in the CQC notification.

Reporting Internally
End of Life care and deaths will report into the Charity's Mortality Surveillance Group and the Quality and Safety Group.

Mortality Review
The aim of the Mortality Review process is to:

- Identify and minimise "avoidable" deaths within St Andrews Healthcare.
- Improve the experience of patients' families and carers through better opportunities for involvement in investigations and reviews ensuring Duty of Candour (DoC).
- Enable informed reporting with transparent method.
- Promote organisational learning and improvement.

For every death at St Andrew's Healthcare, a mortality review will be completed in line with national guidance. This process is different from an investigation process. However, if concerns with care are identified that meet the threshold for a Serious Incident, this process will be triggered instead. Further information about this process and a copy of the template can be found on the intranet Physical Healthcare - End of Life.

For deaths of patients with learning disability, there is a national requirement for the mortality review to be conducted using the LeDeR methodology. When the family/careers wish to be involved, their preference regarding how, when and where they want to engage will be paramount and built on the principles of compassionate engagement.

Patients who 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. The organisation will also exercise the responsibilities under Duty of Candour. However, 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 cause of death) and in the case of joint investigations who the lead organisation will be:

Exception
In addition to the above, if any act or omission on the part of a member of 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 St Andrews Healthcare. Where problems are identified relating to other organisations, St Andrews Healthcare should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement. 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?

St Andrews recognizes some potential triggers for a Review / Investigation. These include deaths: Where a Family / clinical staff / risk management staff flag or raise a concern

- Where medication with known risks such as Clozapine was a significant part of the treatment regime
- From causes or in clinical areas where concerns had already been flagged - (possibly at Charity Board level or via complaints or from data)
- Where they had been subjected to a care intervention where death – wouldn't have been an expected outcome e.g. Electroconvulsive Therapy (ECT) rapid tranquilisation
- Where the service user had no active family or friends and so were particularly isolated e.g. with no one independent to raise concerns.
- Where there had been previous safeguarding and public protection concerns.
- Where there had been known delays to treatment e.g. assessment had taken place or a GP referral made but care and treatment not provided, or where there was a gap in services
- Associated with known risk factors / correlations
- Particular causes of death e.g. epilepsy
- Where a proactive initial assessment of a death has potentially identified that there was a deterioration in the physical health of a service user which wasn't responded to in a timely manner

Data Reporting

Where there are recommendations made from the Mortality Review, the lead reviewer will develop action plans against the recommendations in conjunction with the relevant Division or department.

The relevant action lead (and subject matter expert) must be consulted and agree the action(s), prior to submission of the investigation report. Action plans will be detailed, indicating how the action will be undertaken, when, by whom, and how evidence of completion can be verified. Nominated individuals will complete the actions allocated to them. Senior Team within the respective Division will ensure that actions are implemented, evidenced and closed.

Any learning which has a wider audience will be shared via newsletters, staff meetings, red top alerts or email.

2. Links to Policies and Procedures

- Responding to A Death Procedure
- Blood borne Virus (BBV) Procedure
- End of Life Policy
- Deprivation of Liberty Safeguards (DoLS) Policy
- Mental Health Act 1983
- Incident Management and Reporting Policy
- Resuscitation Procedure
- Infection Prevention and Control Policy

Policies and procedures available via the Policy A-Z:
Policies - Policies - A-Z (sharepoint.com)

2. Monitoring and Oversight

All Deaths will be reviewed through the Mortality Review Process and this will ensure that this policy and the linked procedures are adhered to.

Role	Responsibility
Board of Directors	Receives details of each patient death, within seven days of death. Receives annual report on mortality, which includes expected and unexpected deaths. Mortality Surveillance group feeds into the Quality & Safety Group (QSG), chaired by Lead Executive. QSG feeds into the Quality & Safety Committee (QSC), chaired by a Non-Executive Director.
Executive Medical Director (Lead Executive)	Accountable Officer ensuring all deaths are reported to the Board. Responsible for overseeing the implementation of the Mortality Reduction Strategy across the Charity.
End of Life Care Lead	Supervises the Mortality Review Process forms quality to collating data and generating learning which is shared within the organisation.
EA to the Executive Medical Director	Administration associated with the Mortality Surveillance Group and mortality review process
Deputy Director of Quality and Patient Safety.	Oversee the SI systems and process for St Andrews under the SI Framework and Lead on Duty of Candour. The Family Liaison Support is offered to the bereaved family to act as a single point of contact from the time of death.
Divisional Senior Team	They ensure that the reporting of deaths and the Duty of Candour process is followed. All investigations are carried out in a timely manner and identify early learning. They will also ensure that actions are implemented, evidenced and closed.

4. **Diversity and Inclusion**

St Andrew's Healthcare is committed to *Inclusive Healthcare*. This means providing patient outcomes and employment opportunities that embrace diversity and promote equality of opportunity, and not tolerating discrimination for any reason.

Our goal is to ensure that *Inclusive Healthcare* is reinforced by our values, and is embedded in our day-to-day working practices. All of our policies and procedures are analysed in line with these principles to ensure fairness and consistency for all those who use them. If you have any questions on inclusion and diversity please email the inclusion team at DiversityAndInclusion@standrew.co.uk.

5. **Training** – Currently there is no advanced training or support required unless determined by the response to the consultation. For any identified requirements, please contact Holly Taylor, Head of Learning & Development to discuss your requirements.

6. **References to Legislation and Best Practice**

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- Government HM. Working Together to Safeguard Children. London. Department for Education. 2013
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- *Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England*, Care Quality Commission December 2016.

7. How to request a Change or exception to this policy

Please refer to either the Policy and Procedure Update Application Link
Or the exception process Policy and Procedure Exception Application Link

8. Key changes - please state key changes from the previous version of the policy

Version Number	Date	Revisions from previous issue.
V1.0	June 2020	Formatting for publication – Links to A-Z added.
V2.0	May, 2021	The policy has been revised with changes to classification of deaths and addition of roles and responsibilities.
V3.0	August 2021	The change is regarding addition of the role of the family liaison support officer. Addition of the Board are informed of patient deaths within seven days of death.