The Christie
NHS Foundation Trust

# Learning from deaths policy

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**Key points**

- How The Christie undertakes mortality reviews of deaths occurring on site, including those among people with learning disability
- How decisions to investigate a death are made
- How families are involved in this process
- How the Trust and staff learn from deaths
- The process of reporting to the Board of Directors and NHS Improvement

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## 1. ASSOCIATED DOCUMENTS

Incident reporting and investigation policy
Safeguarding Policy
Complaints and concerns policy
Duty of Candour Policy
Inquest Policy

## 2. INTRODUCTION

### 2.1 Statement of intent

This policy sets out the process for review, investigation and learning in respect of patient deaths that occur on site at The Christie NHS Foundation Trust.

It ensures the Trust meets the expectations of the National Quality Board guidance, March 2017, 'National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'.

### 2.2 Background

As a specialist cancer trust, the Christie has exemption from involvement in 'Hospital Standardised Mortality Ratios' (HSMR) reporting. However a bespoke process for reviewing deaths among inpatients was developed under the leadership of the medical director, and reporting to the Quality Assurance Committee.

The previous process for reviewing inpatient deaths has been revised from 1 April 2017 to comply with the new national framework for mortality reviews and reporting applicable to all NHS organisations. This has followed the Care Quality Commission report published December 2016: Learning, Candour and Accountability which drew attention to an inconsistent approach to death reviews and particular concerns over vulnerable groups and the extent to which families felt excluded from any process or sharing of information. There is now an expectation that any deaths associated with poor care and avoidable deaths are identified, reported and lessons learned from these across all organisations.

### 2.3 Equality Impact Analysis

As part of its development, this policy was analysed to consider its effect on different groups protected from discrimination by the Equality Act 2010. The requirement is to consider if there are any unintended consequences for some groups, and to consider if the policy will be fully effective for all protected groups. This analysis has been undertaken and recorded using the trust's e-tool, and appropriate measures taken to remove barriers or advance equality in the delivery of this policy.

### 2.4 Good Corporate Citizen

As part of its development, this policy was reviewed in line with the Trust's Corporate Citizen ideals. As a result, the document is designed to be used electronically in order to reduce any associated printing costs.

### 2.5 The Christie Commitment

We aim to reward our staff who are committed and motivated to do their best for patients every day. The trusts principles and behaviours describe what our patients

and their families or carers can expect from us, and what our staff can expect from each other.

The trusts behaviours are;
We always give the best quality care
We treat everybody with compassion, dignity and respect
We listen to our patients and each other
We work together as one Christie team
We share knowledge and learning
We support staff to develop to their full potential
We look for new ideas and better ways of working
We promote a fair culture
We provide a safe, clean and tidy environment

All staff are expected to behave in a way that reflects the trusts principles and behaviours.

### 2.6 Purpose

The purpose of this policy is to set out the expectation placed on clinical staff for the review of all patient deaths occurring on site. It provides clarity regarding how decisions to investigate a death are made and the way in which families will be involved in this practice. The importance of learning from deaths and the approach to this is described. The process for reporting to the Board of Directors and to NHS Improvement is explained.

It includes the process to monitor deaths among those with a learning disability and co-ordination with other mortality review activities such as audits of deaths within 30 days of chemotherapy, and where death was outside the Trust.

### 2.7 Scope

This policy applies primarily to inpatient deaths at The Christie NHS Foundation Trust, meaning the main Withington site. For outpatient deaths occurring on any Christie site this will be reported to the Executive Review Group in the first instance, who will advise on the need for further investigation.

## 3. DEFINITIONS

| Term | Meaning |
|---|---|
| Chief Executive | The person who has delegated responsibility from the Board of Directors for the management of governance arrangements within the Trust, and is ultimately responsible for ensuring that the Trust meets its obligations with regards to the safe and effective delivery of services. This is delegated to responsible individuals within the Trust. |
| Clinician | A qualified medically trained doctor, nurse, allied health professional or pharmacist |
| Consent | Agreement approval or permission as to some act or purpose, given voluntarily by a competent person, legally effective. |
| DoLS | The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. |

| | |
|---|---|
| Examination | The act of being examined or state of being examined. To look at inspect or scrutinise carefully or in detail. To investigate the patients state of health. |
| Executive Review Group (ERG) | Weekly meeting where the Executive Medical Director and/or deputy, the Executive Director of Nursing and Quality and/or deputy attend with members of the Quality and Standards team to review incidents, complaints, mortality information and hear the outcome of investigations |
| LeDeR | The Learning Disabilities Mortality Review (LeDeR) Programme aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere. |
| NCEPOD | National Confidential Enquiry into Patient Outcome and Death |
| On call | Contactable and available to attend a patient or incident. |
| Out of hours | Outside of normal working shift hours, 17:00 – 09:00 and weekends/Bank holidays |
| Patient | A person who is receiving medical care from the Christie. |
| Structured Case Review | A process to assess aspects of care in each phase of the last admission, using the Royal College of Physicians structured judgment tool |
| Treatment | The application of medicines, surgery, therapy etc. to a patient; the care and management of a patient in order to combat, ameliorate or prevent a disease, disorder or injury. |
| Triggers | A defined list against which all on site deaths are screened to identify whether a structured case note review is necessary (see Section 5.4) |
| Trust | The Christie NHS Foundation Trust |

## 4. DUTIES

### 4.1 Board of directors

The board of directors, and in particular the medical director, has overall responsibility for reviewing hospital deaths within the trust. The medical director will report to the board at regular intervals on hospital deaths throughout the trust and on any issues that need the board's specific consideration.

### 4.2 Chief executive

The Chief Executive has overall responsibility for ensuring that the organisation adheres to the standards set out in this policy. This duty may be delegated to an executive/senior manager but accountability to the Board remains with the chief executive.

### 4.3 The Executive Medical Director/ Responsible Officer

The Executive Medical Director/Responsible Officer is responsible for ensuring a robust, open and transparent process is in place to learn from all deaths and for reporting on these to the Board of Directors and external bodies.

### 4.4 Quality Assurance Committee

The Quality Assurance Committee is responsible for receiving assurance that the process in place for reporting and learning from deaths is robust and effective. It will receive regular reports reviewing data about deaths on site, the results of mortality

reviews undertaken and the learning that has taken place as a result of those reviews.

### 4.5 Risk and Quality Governance Committee (R&QGC)

The R&QGC is responsible for monitoring and reviewing the risk, control and governance processes which have been established in the organisation, and the associated assurance processes.

### 4.6 Patient Safety Committee (PSC)

The Patient Safety committee is a sub-committee of R&QGC and is responsible for identifying, monitoring and escalating any concerns in relation to the safety of patients. The committee has overall accountability for approving the content of this policy, requesting and reviewing any thematic reviews, reviewing audit data and action plans and escalating any concerns.

### 4.7 Safe Medicines Practice Committee

The Safe Medicines Practice Committee provides assurance to the Patient Safety Committee that all risks associated with the safe prescribing, administration, supply, dispensing, administration and disposal of medicines within the Trust are appropriately identified, assessed and managed.

### 4.8 Systemic Anti-Cancer Treatment (SACT) Delivery Group

The SACT Delivery Group is responsible for reporting to Safe Medicines Practice Group a summary of any incidences on a monthly basis. The Group receives the actions from learning following review of deaths within 30 days of SACT by the treating oncology team.

### 4.9 Mortality Surveillance Group (MSG)

A group made up of medical, nursing, clinical audit and bereavement suite representatives and chaired by the Executive Medical Director. It is responsible for the coordination of the structured case note review process, the identification of areas where lessons can be learnt and ensuring timely reports to the Patient Safety Committee and the Quality Assurance Committee.

### 4.10 Executive Review Group (ERG)

This group is made up of The Executive Medical Director and/or deputy, the Executive Director of Nursing and Quality and/or deputy who meet weekly with members of the Quality and Standards team to review incidents, complaints, mortality information and hear the outcome of investigations.

### 4.11 Consultant Medical Staff

Consultant medical staff are responsible for engaging actively in the process of screening deaths for triggers (see Section 5.4) and carrying out structured case note reviews for cases where one or more trigger occurs. They will receive reports about their own patients for whom a structured case note review has been triggered and will be expected to share any learning with their teams.

### 4.12 Nursing staff

All nursing staff are responsible for carrying out screening of deaths occurring in their ward/clinical area. Nursing staff represented on the mortality steering group will assist in the process of structure case note reviews in partnership with a medical consultant.

### 4.13 Bereavement Suite Team

The members of the bereavement suite team are responsible for reporting all on site deaths to the clinical audit team so that the screening process can commence. They liaise with the appropriate medical staff to ensure timely and accurate completion of the required screening information and they liaise with the patients' family/carers to ascertain if they have any concerns about care and/or treatment prior to the patient's death. Any concerns raised are forwarded to the PALS service for on-going management. They are also represented on the Mortality Surveillance Group.

### 4.14 Patient Advice and Liaison Service (PALS)

PALS is a central point of contact for patients, carers and the public, who express concerns about their care, or need information, advice and support.

### 4.15 Informatics Team

The Informatics Team produce a list of deaths via SQL reporting (computer generated hospital activity data) services and this is used to triangulate the data with that provided to clinical audit via the bereavement suite team.

### 4.16 Clinical Audit and Improvement Team

The clinical audit and improvement team are responsible for the overall management and effectiveness of the learning from deaths process. This includes elements such as the development of data collection tools, maintenance of the associated database, collation of all relevant information and liaison and negotiation with relevant clinical colleagues. In addition the team ensures that all elements of the process are completed correctly and within the designated timescales. This includes the regular production of written reports for MSG, PSC and QAC.

## 5.0 LEARNING FROM DEATHS – EXISTING PRACTICE

### 5.1 Systemic Anti-Cancer Treatment (SACT)

- A review of all deaths within 30 days of Systemic Anti-Cancer Treatment (SACT) has been in place following the NCEPOD report 'For Better, for Worse '2008.
- The treating oncology team complete the on-line audit form
- The audit identifies if there were any concerns about the decision to treat, prescribing and administration of treatment, and the management of complications.
- The findings are discussed within disease-site morbidity and mortality meeting.
- Actions from the learning are raised at the SACT Delivery Group and then reported to Safe Medicines Practice Committee.
- Trust wide data is collated and benchmarked with other large cancer centres.

### 5.2 Deaths within specific patient groups

- These include deaths in association with:
    - bone marrow transplants,
    - deaths on the critical care unit
    - post-operative deaths
- Mortality discussions take place within these specialties and disease groups.

### 5.3 End of life care

- The Trust participates in external audits
- Internally there is a system for on-going monitoring of randomly sampled deaths against principles of good end of life care which will be replaced by the structured case note review process.

### 5.4 Deaths in association with an untoward incident

- These are discussed weekly at the Executive Review Group (ERG).
- The Duty of Candour process is followed for all moderate incidents whether or not these link to causality of a death.
- A death suspected to be due to a serious lapse in care would be deemed a Significant Incident and would be managed under the Incident reporting and investigation policy.
- The ERG also review concerns raised about a Christie patient who dies following admission to another hospital and will work with colleagues in that organisation.
- Presentations of inpatient death reviews take place at Trust-wide Morbidity and Mortality meetings 4-5 times a year, providing an opportunity for wider discussion.

## 6.0 LEARNING FROM DEATHS – NEW PRACTICE

- All patient deaths occurring on The Christie Withington site, including concerns raised by a family member are reviewed against defined triggers (see Section 6.42) (commenced April 2017)
- One or more triggers will lead to a structured case note review of the patients' health records.
- Quarterly information will be provided to the Patient Safety Committee and through the performance reports to Board of Directors.
- An annual summary will be presented to the Quality Assurance Committee.
- Regular reporting to NHS Improvement will take place from June 2018.

### 6.1 Monitoring of deaths, process for review and escalation

- The bereavement suite staff report all on-site deaths to the clinical audit team.
- The clinical audit team provide a weekly report to ERG which includes:
    - all deaths occurring in the previous week,
    - the number screened,
    - the detail of any which trigger,
    - the status of those in case note review process each quarter.
- Completion of screening and/or case note reviews which fall behind the agreed timescales will be escalated to the executive team (Deputy Director of Nursing and Quality (ward teams) and Clinical Medical Director (medical teams)).

### 6.2 Screening of deaths and triggers for review

- All deaths must be screened against specific triggers, including any concern identified by family, nursing/ ward based teams and senior medical staff about care in the last admission.
- A three part screening process is in place, all of which must be completed as soon as possible and at most within 2 weeks of the death.

**6.2.1 Screening in the hospital bereavement suite:** this takes place in conjunction with completion of the medical certificate for cause of death and/or referral to the coroner. Completion of an electronic form is used to document whether any of the following triggers apply to this death:

- Death reported to coroner
- Death of inpatient aged 18 years or younger
- Death on Critical care Unit
- Death within 24 hours of admission or transfer to The Christie
- Death following a cardiac or respiratory arrest
- Consent Form 4 used in last admission
- Concerns raised by the bereaved family

**6.2.3 Nurse screening questionnaire:** the senior sister/charge nurse and/or ward nurse who looked after the patient at the end of life must complete the electronic form. This documents whether any of these following triggers apply:

- Patient identified as having a learning disability
- Patient identified as having significant mental health issues such as psychosis, during last admission
- IV antibiotics recently commenced for sepsis
- Concerns about frequency of senior medical reviews
- Staff have raised a significant concern about care in last admission
- Family have raised a significant concern about care in last admission

**6.2.4 Medical screening questionnaire:** The consultant responsible for the care of the patient in the last admission must complete the electronic form. This may be delegated to a senior specialty trainee (ST4 or above) on the oncology team. This documents whether any of these following triggers apply:

- Death was linked to a planned procedure/surgery at the Christie during the last admission
- Death was related to/as a consequence of sepsis
- Death substantially related to/ as a consequence of Stage 3 Acute Kidney Injury (AKI)
- Death substantially related to/ as a consequence of poor control of diabetes mellitus
- Death unexpected this admission (excluding cancer-related event)
- Death of this patient on this admission is considered as possibly or probably avoidable
- There is another concern where review of this death is indicated

### 6.3 Structured Case note Reviews (SCRs)

#### 6.3.1 Allocation of the SCR

- The Mortality Surveillance Group (MSG) receives and reviews an updated list of deaths at each weekly meeting.
- A case note review will be undertaken on all deaths that trigger on the screening process.
- If triggers are deemed non-applicable, for example reasons for referral to coroner unrelated to recent admission this will not proceed to a full SCR.
- If the trigger relates to a concern about care earlier in the pathway such as transfer from another Trust, this will be referred to ERG for review.
- One or more independent reviewers will be allocated to look at each death: as a minimum this MUST be a member of medical staff but where possible it is best practice to undertake the review jointly with a member of nursing staff.
- The individuals completing the review should not be clinicians with overall responsibility for care of that patient.
- Where a clinician member of the MSG has had interaction (acute oncology or critical care), however limited, this must be declared. This does not preclude input alongside a first independent reviewer.
- The allocated reviewers will receive notification via email from the clinical audit team after each MSG, this will include: the case note number and link to the on-line form.
- The Clinical Audit team will also monitor completion and escalate overdue reviews to the MSG chair.
- Where an urgent review is required which falls outside of the scheduled meeting process will be addressed by the chair of the MSG as part of the ERG process.

#### 6.3.2 Process and timescales

- The review must be completed within 6 weeks of the death.

- The Royal College of Physicians tool for Structured Clinical Judgements must be used to ensure consistency of the reviews. This is completed via an electronic process after scrutiny of paper and electronic clinical records.
- Reviewers must follow the RCP guidance on the use of the tool.

### 6.3.3 Findings and actions

- Any serious concern must be escalated as soon as it is identified by either the reviewers or the clinical team on receipt of the completed form (see section 5.7).
- The conclusions from completed reviewers will be discussed at the following MSG meeting.
- MSG will capture examples of good practice and consider areas identified for improvement.
- The MSG will decide if further action is needed, this may include:
    - Request for clarification and or discussion with the clinical director
    - Referral to respective Disease Group or relevant governance leads (30 day SACT mortality lead, critical care mortality lead, haematology and transplant quality lead)
    - Referral to ERG for second stage investigation (see section 5.7)
- The MSG provides a quarterly report to the Patient Safety Committee and within the Integrated Performance Report to the Board of Directors. In addition, an annual report is provided to the Board's Quality Assurance committee.
- The MSG is responsible for dissemination of learning

### 6.4 Involvement of responsible clinicians

- The responsible clinician is responsible for completing the electronic screening tool. At this point they should declare any concerns about the death.
- The responsible clinician will be notified via email when the death of a patient in their care has been identified for a case note review and the reasons for this.
- The responsible clinician can be involved in the case note review if they so wish.
- Findings of each review will in all cases be provided to the responsible clinician.
- Where there are outstanding exemplars of good practice or a significant concern this will be copied to the respective clinical director, with information on the next steps if applicable.
- The responsible clinician has the opportunity to send comments or clarification to MSG
- Where there are significant concerns about standard of care, the responsible clinician would be directly involved in a second stage investigation through ERG.

### 6.5 Concerns about a death

- The Executive Medical Director and Executive Director of Nursing and Quality will be informed by a member of the clinical audit team of any death where a serious concern has been identified, for example
    - previously unidentified moderate incident
    - rating of poor care (score 1-2)
    - a death deemed to be >50% chance of being avoidable (score 1-3)
- These will be taken through ERG for decision on second stage investigation.

- Any poor care or avoidable death identified by MSC will be escalated to ERG with a recommendation for second stage investigation.
- An unrecognised clinical incident should be reported to Datix by the reviewer.

- The ERG will decide on the second stage process, this could be:
    - following the moderate incident investigation process
    - a request for Clinical Director and internal peer review
    - an external review of clinical care.

- This is a further opportunity to consider the involvement of families to date and how this would be undertaken in relation to the next steps.
- ERG will also consider action where there is a concern relating to earlier in the patient's pathway of care and will liaise with the external organisations if this is indicated.
- If there has been serious harm or death as a consequence of lapses in care this will be reported externally as a serious incident in line with the incident reporting and investigation policy.

### 6.6 Deaths in patients with a learning disability or with a serious mental health condition

- It is important to review the care of vulnerable patients and particularly those with serious mental health conditions or a learning disability.
- The screening process identifies deaths where a consent form 4 has been used, where a DOLS was in place during the last admission, or where the patient was known to have a learning disability.
- The screening process will also identify those deaths where the patient had experienced a significant mental health condition relevant to their care in the last admission. e.g. psychosis
- The trust SCR reviews of all such deaths will involve the Safeguarding named nurse.
- All deaths of a patient with learning disabilities will be notified to the national LeDeR team, using their on-line form and the outcome of the trust review will be made available to them.
- If there has been serious harm or death as a consequence of lapses in care, this will be reported to NHS Improvement via the Learning from Deaths website, who will inform and involve other agencies, e.g. CQC, as appropriate.

### 6.7 Involvement of families

- Families/carers must be informed of all moderate incidents (grade 3 and 4) and the duty of candour process must be followed.
- Families/carers are offered a copy of the Trust investigation and conclusions at the outcome of the ERG process.
- Complaints involving aspects of care are managed in accordance with the complaints policy. Families/carers are included routinely in the investigatory process and meetings with families/carers are encouraged, enabling early resolution where possible.
- Families/carers are offered the bereavement pack after a death and the bereavement suite staff will ask each family a general question: *"How did you find the care and support for yourselves and your loved one at The Christie? Did you have any concerns about care?"*
- Responses will be noted. Should these disclose a concern; the family will be contacted by the PALS team.
- In the follow up conversation they will be asked if the Trust should review care in the last admission and if so, how they would like to be involved in this process.

### 6.8 Shared learning

- A summary of reviews and recommended actions will be produced by the MSG and forwarded for specialty/directorate based learning.
- These will be discussed with the relevant staff groups and subsequent actions captured via quarterly responses to MSG.
- A template letter (Appendix 1) is used to provide direct feedback to the responsible clinician about overall care plus any noted examples of excellence/areas for improvement.

- This can be used as an example of evidence of clinical practice for annual appraisal.

### 6.9 Reporting of findings and outcomes

- A summary report will be provided for the Patient Safety Committee on a quarterly basis.
- Trust wide sharing of learning will take place via the Grand Round education programme and via discussion at Morbidity and Mortality meetings at least once /year.
- Summary reports will be made to the Quality Assurance Committee.

### 6.10 Coordination with other mortality reviews

- Other morbidity and mortality reviews take place within clinical groups and departments but depending on frequency of meetings these are usually held after the inpatient death review – for example a detailed NCEPOD audit on all deaths within 30 days of the last systemic anti-cancer treatment.
- Findings of the inpatient review process should be available to the respective consultant and clinical directors.

## 7. CONSULTATION, APPROVAL & RATIFICATION PROCESS

This policy has been developed through consultation with all members of the Mortality Surveillance Group. It has been approved by the Patient Safety Committee and ratified by the Document Ratification Committee in line with the trust's approval process for all procedural documents.

## 8. DISSEMINATION, IMPLEMENTATION & TRAINING

### 8.1 Dissemination

This policy will be disseminated to clinical directors, matrons and divisional managers by email and posted on the intranet. All staff will be notified of its introduction via Team Brief.

### 8.2 Implementation

Clinical directors, matrons and divisional managers are required to ensure appropriate implementation of this policy within their areas of responsibility.

### 8.3 Training/Awareness

The Mortality Surveillance Group will be responsible for ensuring that training in the SCR process is undertaken through the NHS Improvement/RCP workshops in 2017 and cascaded to the rest of the reviewers.

## 9. PROCESS FOR MONITORING EFFECTIVE IMPLEMENTATION

The effectiveness of the Learning from Deaths policy will be audited by the medical director monitoring the standards set out below.

The findings will be reported to the patient safety committee and assurance sought via the Board's Quality Assurance Committee.

| **Standard to be monitored** | **Process for monitoring**<br><br>e.g. audit, ongoing evaluation etc. | **Frequency**<br><br>e.g. annually 3 yearly | **Person responsible for:** undertaking monitoring & developing action plans | **Committee accountable for:** review of results, monitoring action plan & implementation | **Frequency of monitoring**<br><br>e.g. monthly, quarterly |
|---|---|---|---|---|---|
| All deaths which trigger SCR are reviewed within 6 weeks of death | Progress reports to ERG | Weekly | Medical director | ERG | Weekly |
| | Performance report | Monthly and quarterly | Medical director | Board of Directors | Monthly and quarterly |
| Mortality review process: There is a robust, open and transparent process in place to learn from all deaths and for reporting on these to Board of Directors and external bodies. | Summary overview report | Annually | Medical director | Patient Safety Committee;<br><br>Quality Assurance Committee | Annually |
| All deaths which trigger SCR are reviewed to identify learning | Reports | Quarterly and annually | MSG chair | MSG | Quarterly |

## 10. REFERENCES

Care Quality Commission (December 2016) *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*

National Quality Board (March 2017) *Learning from Deaths*

## 11. VERSION CONTROL SHEET

| Version | Date | Author | Status | Comment |
|---|---|---|---|---|
| 01 | 08/17 | Dr Wendy Makin, Executive Medical Director | Draft | New policy |
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## 12. APPENDICES

### Appendix 1: Template letter to Consultants re MSG outcome

The Christie
NHS Foundation Trust

Learning from deaths
Mortality Review process

☎: 0161 446 3703
: Wendy.Makin@christie.nhs.uk
: www.christie.nhs.uk

Date:

Dear

**Case xxxxxxxxx Date of death:**

This letter is to provide you with the outcome of our case review process concerning the above patient.

In response to the requirements of NHS Improvement we have established a process to review the deaths of patients who die on the Christie site. The primary aim is to learn from deaths using a consistent approach across all organisations. This process is overseen by the Mortality Surveillance Group, chaired by the medical director, with clinical representatives (nursing and medical) from surgery, haematology, clinical and medical oncology, acute medicine and critical care.. Reviewers are allocated a case note number and are responsible for reviewing both the paper and electronic health records of the last admission.

This death triggered a review which has now been undertaken using the Royal College of Physicians (RCP) structured judgement review tool. Reviewers use this tool to assess:

- Care in the first 24 hours of admission
- On-going care
- Perioperative care (if applicable)
- Care in relation to an intervention ( requiring consent)
- Care at the end of life

The following ratings are used

- Care:
  - 1=Very poor care
  - 2=Poor care
  - 3=Adequate care
  - 4=Good care

- 5=Excellent care

- Quality of documentation in clinical noting: 1-5 as above
- Avoidability of this death:
  - 1 = Definitely avoidable
  - 2 = Strong evidence of avoidability
  - 3 = Probably avoidable (more than 50:50)
  - 4 = Possibly avoidable but not very likely (less than 50:50)
  - 5 = Slight evidence of avoidability
  - 6 = Definitely not avoidable.

**Feedback from Mortality Surveillance Group**

This SCR was discussed at the Mortality Surveillance Group on

Overall care rated as:

Quality of clinical noting rated as:

Avoidability rated as:

Comments (including excellence and where improvements could be made):

**Further actions recommend by MSG (if applicable):**

**Any actions for yourself (if applicable):**

This document may be used as part of your portfolio for annual appraisal.

A copy of the case note review form can be requested from Tony McGurk, clinical audit and improvement team. If you wish to discuss further please contact either Wendy Makin or Neil Bayman.

Kind regards

Wendy Makin
**Executive Medical Director & Responsible Officer**