MORTALITY MANAGEMENT POLICY (Learning from Deaths)

POLICY

Reference	CPG-TW-MMP/LfD
Approving Body	Patient Safety Committee Learning From Deaths
Date Approved	June-2026
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**

YES	NO	N/A
X		

Issue Date	24-June-2026
Version	5.0
Summary of Changes from Previous Version	Content updated to: 1. Align fully with the **Patient Safety Incident Response Framework (PSIRF)** and the Trust's **Patient Safety Incident Response Plan 2024–26**, emphasising proportionate, system-based learning responses rather than default investigation. 2. Strengthen alignment with **National Quality Board guidance on Learning from Deaths**, including board-level oversight, publication requirements, learning expectations and family engagement. 3. Clarify and formalise the roles of **Divisional and Specialty Clinical Leads for Governance** in mortality review, Structured Judgement Review (SJR), escalation and assurance. 4. Embed statutory **Medical Examiner scrutiny** as a core input into Trust mortality governance and learning processes. 5. Explicitly align deaths thought more likely than not due to problems in care with **PSIRF learning response pathways**, including locally led Patient Safety Incident Investigations where required.
Supersedes	V4.0 Aug 2024 – Aug 2027
Document Category	CLINICAL
Consultation Undertaken	Membership of Learning from Deaths Group Director of Nursing, Quality and Governance Patient Safety Committee
Date of Completion of Equality Impact Assessment	June 2026
Date of Environmental Impact Assessment (if applicable)	Not Applicable

Legal and/or Accreditation Implications	Not applicable
Target Audience	Trust wide
Review Date	June-2029
Sponsor (Position)	Chief Medical Officer (CMO)
Author (Position & Name)	• Dr Nigel Marshall - Chair for Learning from Deaths Group • Dr John Tansley – Clinical Director for Patient Safety • Revision undertaken with support of Microsoft Co-Pilot
Lead Division/ Directorate	Corporate
Lead Specialty/ Service/ Department	Corporate
Position of Person able to provide Further Guidance/Information	Dr Nigel Marshall- Chair for Learning from Deaths

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
N/A	N/A
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

Many patients attend our hospitals' services every year and are discharged 'well', after effective treatment and care. A proportion of patients admitted to hospital will unfortunately die. It is hoped that all patients will have received excellent care and they and those close and important to them frequently report a positive experience of care. However, some patients' deaths will be contributed to by poor quality care. In other cases, even when death is unavoidable, there will be examples where care in the last days of life could have been better. As a Trust we are committed to identifying learning from all these cases.

In June 2018 the government decided to implement the regulations 18-21 of the Coroners and Justice Act 2009 to establish a medical examiner role and service in England and Wales. This service is already well established for hospital deaths and became statutory for all deaths including in the community on 8th September 2024. This means that all deaths will receive a degree of independent review seeking to answer three questions:

- What caused the death of the deceased?
- Does the coroner need to be notified of the death?
- Was the care before death appropriate?

Medical examiners answer these by providing independent scrutiny, with three elements:

- A proportionate review of relevant medical records
- Interaction with the doctor completing the Medical Certificate of Cause of Death
- Interaction with the bereaved, providing opportunity to ask questions and to raise concerns.

Medical examiners' conclusions can inform learning to improve care for future patients. Their involvement should also provide reassurance to the bereaved.

A small number of cases may be referred to others for further review. The purpose of reviews / investigations into patient deaths is to learn. All outcomes result from multiple causal or contributory factors and by understanding our processes better we may be able to help offer explanations to those who are bereaved and prevent recurrence in the future for other patients when things have gone wrong and share things that have gone well to help other teams. The Trust moved across to the Patient Safety Incident Response Framework (PSIRF) from the Serious Incident Framework (SIF) in October 2023. This new framework has more emphasis on learning, particularly from success and normal work. In certain respects, PSIRF is less well aligned with established mortality review and investigation processes. The Trust is working to integrate these legitimate but conflicting requirements.

This policy supports the operational procedures that staff must follow in reporting deaths and reviewing and escalating information in clinical governance meetings in their Specialty and Division via the Trust Learning from Deaths Group and Patient Safety Committee to the Board of Directors.

Further to the requirements for compulsory review set out in the Coroners and Justice Act 2009 and the reporting requirements of individual mortality reviews outlined by the National Quality Board in 2017 the Trust must be able to identify and monitor themes and trends in mortality in our services and benchmark our performance against local and national peers. This information is typically obtained from external providers. It is the role of the Learning from Deaths Group to coordinate understanding of this system-level information and triangulation with the patient and service level information acquired within the Trust and report these findings and resulting actions via Patient Safety Committee to the Board of Directors.

This policy is issued and maintained by the Chief Medical Officer as the sponsor on behalf of the trust; the issue defined on the front sheet supersedes / replaces all previous versions.

This policy reflects national requirements set out by the National Quality Board for how NHS Trusts identify, review, investigate and learn from deaths, and must be read alongside the Trust's Patient Safety Incident Response Plan. Learning from deaths is embedded within the Trust's wider patient safety governance framework and aligned with the Patient Safety Incident Response Framework (PSIRF), ensuring reviews and investigations are

proportionate, learning-focused and system-orientated rather than attributional.

2.0 POLICY STATEMENT

Equality Impact Assessment

This policy is intended to be applied in a fair and consistent process to all patient deaths in the relevant clinical areas. The policy is expected to have its main impact in adult services, and it will enhance existing strategies especially for patients / pathways for specific groups. These are identified in this policy.

The policy will help to identify any possible inequality or inequity of healthcare especially for those perceived to have specific protected characteristics and potential vulnerabilities. The policy promotes listening to and actively supporting bereaved families after death. This policy has been developed in keeping with existing policies in the Trust. It is informed by new national standards that guide the support and information to those that are bereaved by a death of a patient in the Trust's care.

The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminates against individuals directly or indirectly on the basis of gender, colour, race, nationality, ethnic or national origins, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status.

An EIA of this policy/guideline has been conducted by the author using the EIA tool developed by the Diversity and Inclusivity Committee (see Appendix D)

The correct application of this policy will help to identify patients and those close to them who may have been subjective to discrimination.

Privacy Impact Assessment (PIA)

The Policy has been subject to a detailed PIA which has been informed and supported by the Information Governance team.

This policy promotes a thorough examination of the patient's treatment and care during their admission. This process may require examination of other information, for example previous admissions or discussions with other health or social care providers.

This policy now requires an active consideration of the necessity to involve the bereaved family (as set in the National Quality Guidance, comply with the statutory requirement of the Duty of Candour and related information sharing procedures) and or those with specific legal / administrative relationships to the deceased. Where necessary and practicable, there will be a specific informed consent / assent with those close to the deceased patient.

is clinical document applies to:

Staff group(s)

- This is a Trust-wide clinical policy, which focuses on those staff directly or indirectly providing

a clinical service to the patients. It also applies to service managers, administrative and governance staff in the Trust. Specific responsibilities are identified in this policy.

Clinical area(s) and Patient group(s)

- This policy is intended to be applied in a fair and consistent process to all patient deaths in all clinical areas. The policy is expected to have is main impact in adult services; there are clear and existing patients / pathways patient for specific groups.

3.0 DEFINITIONS AND / OR ABBREVIATIONS

'The Trust'	Means the Sherwood Forest Hospitals NHS Foundation Trust
'Staff'	Means all employees of the Trust including those managed by a third-party organisation on behalf of the Trust.
Case record or Mortality review	The use of a structured methodology to review the case record/notes associated with the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians model.
PSIRF	Patient Safety Incident Response Framework
LeDeR	People with a learning disability and autistic people
HSMR	Hospital Standardised Mortality Ratio
SHMI	Summary Hospital Mortality Indicator
CuSUM	Cumulative Sum. A type of control chart used to monitor small shifts in the process mean
Investigation	The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on a range of evidence, including physical evidence, witness accounts / statements, policies, procedures, guidance, audit data and observation - in order to understand care or service delivery. The process aims to identify not only problems in care but also good practice to be shared in order to inform us what may need to change in service provision to reduce the risk of future adverse events.
Death due to a problem in care	A death that has been clinically assessed using a recognised and specified methodology and determined (with a stated degree of objectivity) *more likely than not* to have resulted from problems in healthcare and therefore to have been potentially avoidable. This is different to the Coronial standard of avoidability which only requires a problem in care to have made a "more than minimal, negligible or trivial contribution."

4.0 ROLES AND RESPONSIBILITIES

The Board of Directors

1. The Board of Directors is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, taking into consideration the views of the **Board of Governors.**

2. The Board of Directors must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. The Trust should ensure such activities are adequately resourced. The Board of Directors must ensure the Trust works with commissioners and other providers to develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

3. All Trust Directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the Board and help develop proposals on strategy.

Non-executive directors, in particular, have a duty to ensure that such challenge is made. They play a crucial role in bringing an independent perspective and should scrutinise the performance of the Trust's management in meeting agreed goals and objectives and monitor the reporting of performance. Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

Executive and non-executive directors have a key role in ensuring their Trust is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:

- the processes are in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support.
- quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change.
- the information the Trust publishes is a fair and accurate reflection of its achievements and challenges.
- there is a system to collect, publish and learn from new data to monitor trends in deaths. Board oversight of this process is as important as board oversight of the data itself. As a critical friend, non-executive directors should hold the Trust to account particularly those deaths assessed as having been avoidable.

The roles and responsibilities of non-executive directors (as set out by the National Quality Board guidance- March 2017) include:

1. **"Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support. For example:**
    - be curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust, are they sufficiently senior/experienced/trained?
    - seek similar data and trend information from peer providers, to help challenge potential for improvements in your own organisation's processes, but understand limitations of any direct comparisons
    - ensure timely reviews/investigations (what is the interval between death and review or investigation?), calibre of reviewer/investigator and quality of the review or investigation;
    - is the Care Record Review process objective, conducted by clinicians not directly involved in the care of the deceased?
    - how was the case-record review selection done? For example, does selection reflect the evidence base which suggests older patients who die or those where death may be expected are no less likely to have experienced problems in healthcare that are associated with potentially preventable death? Does it ensure all vulnerable patient

groups (not just those with learning disabilities or mental health needs) are not disadvantaged?
- are deaths of people with learning disabilities reviewed according to the LeDeR methodology?
- for coordination of responses to reviews/investigations through the provider's clinical governance processes, who is responsible for preparing the report, do problems in care identified as being likely to have contributed to a death feed into the organisation's Serious Incident processes?"

2. **"Champion and support learning and quality improvement such as:**
   - ensuring the organisation has a long-term vision and strategy for learning and improvement and is actively working towards this
   - understanding the learning being generated, including from where deaths may be expected but the quality of care could have been better
   - understanding how the learning from things going wrong is translated into sustainable effective action that measurably reduces the risks to patients - ensuring that learning and improvements are reported to the board and relevant providers
   - supporting any changes in clinical practice that are needed to improve care resulting from this learning
   - ensuring families and carers are involved reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes
   - paying attention to the provision of best practice and how the learning from this can be more broadly implemented."

3. **"Assure published information; ensure that information published is a fair and accurate reflection of the provider's achievements and challenges, such as:**
   - ensuring that information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement
   - checking that relevant team are working towards a timely quarterly publication, in line with the Quality Accounts regulations and guidance
   - checking that arrangements are in place to invite, gather and act on stakeholder feedback on a quarter-by-quarter basis
   - ensuring the organisation can demonstrate to stakeholders that "this is what we said we would do, and this is what we did" (learning and action), and explain the impact of the quality improvement actions**."**

Doctors

All doctors have an organisational responsibility and professional duty (and where required a legal duty) to report any perceived concerns or deficiencies in treatment and care that may have caused or contributed to a patient death. Doctors must also cooperate with the review and investigation process, maintaining the highest professional standards.

- Consultant staff must
  - ensure all patients that have died in their care have the standard of the treatment and care expected and the mechanism of their death reviewed (as set out in the relevant standard procedure)
  - offer support to non-consultant medical / healthcare staff to complete this process in a timely and accurate manner complying to the information standards set out in the mortality reporting systems

  - correctly identify deaths that need to be subject to the different steps of review as set out in the procedure and where relevant escalate cases quickly where serious failings have been identified.

- Non-consultant staff must:
  - ensure that they have discussed the care of all patients that have died in their care with the relevant responsible consultant before discussing the case with the Medical Examiner in order to correctly communicate any concerns regarding the standard of care.

Nurses, Allied Healthcare and other registered clinical staff are responsible for:

- contributing to the process of care after death, the support for the bereaved and the timely involvement of other key groups or specific groups where relevant e.g. if there was a concern or complaint about the standard of care
- being involved in working with the medical staff to offer information to support the review and report of a death (as set out in the procedure) as part of a multi-professional approach
- being accountable for the standard of treatment they administer and the care they provide

Trust Mortality Lead

The Trust Mortality Lead provides strategic clinical leadership and assurance for how the Trust identifies, reviews, learns from and responds to patient deaths.

The role:

- Acts as the clinical owner of the Trust's Learning from Deaths framework
- Ensures alignment with the Patient Safety Incident Response Framework
- Oversees integration of Medical Examiner scrutiny, Structured Judgement Reviews and patient safety investigations
- Provides Trust-level assurance regarding quality, consistency and learning
- Supports Board-level oversight of mortality-related learning and improvement

The Trust Mortality Lead works through established divisional and specialty governance arrangements and does not replace existing accountability for mortality review at specialty or divisional level.

Divisional Clinical Lead for Governance

The Divisional Clinical Lead for Governance holds divisional accountability for mortality governance, including:

- oversight of mortality data, SHMI and triangulated mortality intelligence
- quality assurance of Structured Judgement Reviews (SJRs):
  - must undertake SJR methodology and platform access training
  - will be required to close Mortality reviews and provide final sign off
- triangulation and communication of specialty-level mortality learning
- escalation of significant mortality concerns to Trust-level via Patient Safety Committee and closing the loop by reporting outcome to Learning from Deaths

This role provides senior medical leadership and assurance for learning from deaths within divisional clinical governance structures.

Specialty Clinical / Governance Leads are responsible for:

- ensuring robust mortality and morbidity review processes within their specialty, including effective Mortality & Morbidity meetings, allocation and quality assurance of Structured Judgement Reviews, liaison with the Medical Examiner service, and escalation of concerns to Divisional Governance Leads.
    - Leads must ensure that those accessing the SJR system on DCIQ undertake SJR methodology and platform access training (Passwords will not be issues without completing these).
- providing oversight, assurance and coordination of specialty-level mortality learning and ensure integration with divisional and Trust governance systems.
- supporting these staff to perform and report reviews
- facilitating multi-professional forums to allow reviews and performance to be discussed and the lessons learned and shared in a confidential and professional manner
- working with other professional groups e.g. matrons, clinical nurse specialist / teams or specialty teams or services to ensure reviews and discussions are adequately supported, information is shared, and the quality of learning outcomes is optimised.
- referring to appropriate colleagues for review of those elements of care which they are not suitably qualified or experienced to assess.
    - Mortality leads have agreed, at Learning from Deaths, that a response from colleagues in other specialities, and divisions if indicated, will be provided to the referrer within 30 days; ownership remains with the original speciality / division unless otherwise agreed.
- signing off mortality reviews for those elements of care occurring in their Specialty/ Division.
- ensuring that cases where elements of poor or very poor care have been identified are escalated through Specialty, Divisional and Trust processes, investigated where indicated and brought to the attention of the Learning from Deaths Group.
- providing assurance around actions created in response to findings of Learning from Deaths activities.

Heads of Service / Service Directors and Heads of Nursing (supported by General and Senior Management) are responsible for:

- ensuring the policy and procedure is implemented
- meeting the performance requirements set out in the policy and procedure and where there are system problems they are addressed.
- addressing any individual or professional under-performance or lack of competency, and where relevant any serious breaches of professional standards

Mortality Reviewers

Must undertake both methodology and DCIQ platform access training before undertaking reviews. Password and login will not be issued until this is confirmed.

SJR / Datix Leads

Will facilitate training and issue access.

Medical Examiner Service

The Medical Examiner Service will comply with the legal requirements set out in the Coroners and Justice Act 2009 (CJA). Whilst hosted by the Trust, the service is independent and will comprise of locally appointed Medical Examiners and their Medical Examiner Officer/s. This service must comply with the regulatory requirements set out by the National Medical Examiner and the regional deputies which must include the completion of timely reports and submission to the national information system. Whilst governance of the service will be through arrangements put in place by the Regional and National Medical Examiners, the service should be able to provide evidence for quality assurance of its activities to the Trust.

This service will:

- scrutinise all deaths occurring within the Trust
- record the process of scrutiny of the Medical Examiner and their officer/s
- record the outcome from this scrutiny and actions that follow including communication with staff, the bereaved families and carers (where these people have significant concerns or complaints), and other third parties or agencies.
- liaise with the deceased's family or representative
    - to offer an explanation of the medical cause of death
    - to listen to and, where necessary, act on their concerns about the nature of the death and/or the quality of the care provided to them relating to the cause or contributory factors
- approve appropriate certification of the medical cause of death performed by the clinical team where an accurate cause of death has been proposed
- provide support and advice where improvements may be appropriate to the cause of death proposed by the clinical team and then approve amended submissions
- support clinical teams in identifying those cases which according to nationally or locally agreed criteria require further review via the Trust's governance systems for investigation and action
- identify cases that require coronial and or police referral and liaise between these agencies to ensure timely and accurate information sharing
- work in partnership with the local coroner, registrar and other parties such as medical referees of crematoria to develop improved service arrangements to maximise the effectiveness and efficiency and deliver a high-quality service
- support the requirements of the Human Tissue Authority with specific regard to consent to Hospital Post-Mortem examination.
- appoint a Medical Examiner Officer to work alongside members of the Bereavement Centre and Patient Experience Team to be the initial contact and support for bereaved families and carers.

Further information regarding roles and responsibilities can be found in National Quality Board and NHS England guidance (*see Section 10- Evidence base*).

Learning from Deaths Group

The Learning from Deaths Group is a sub-committee of the Patient Safety Committee and reports quarterly via the standard Trust Quadrant report and a dashboard reflecting the Trust's position at a macro level (externally provided mortality metrics such as crude mortality, SHMI and HSMR), meso level (our local Medical Examiners scrutiny, coronial matters and Structured Judgment Review process) and micro level (learning from individual cases, focussed clinical reviews).

The purpose of the group is to use this range of sources of information to identify areas of learning which could improve care.

Each focussed clinical review has an opportunity cost in terms of the work required to undertake it. Work with our previous external provider led to our current approach of using a triangulation methodology requiring an alert in three measures (SHMI, HSMR and CuSUM) or a persistent signal in a single measure (eg three consecutive months).

Patients in diagnosis groups selected for further review are identified to the relevant clinical teams for case note and coding review.

The Learning from Deaths group is multidisciplinary. Full terms of reference and work plan are available from the Chief Medical Officer (CMO) Office and are reviewed through Learning from Deaths on a bi-annual basis (formal agenda item).

The Learning from Deaths Group reports directly to Trust Board every 6 months.

System Working-

To support regional Learning from Deaths and to better understand system-wide themes and shared learning, the Trust will be represented at the Regional (Cluster) Learning from Deaths forum and will actively share data, themes and key learning.

5.0 APPROVAL

Following consultation, this revised policy has been agreed by the Trust's Learning from Deaths Group and approved by Patient Safety Committee.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

The introduction to this policy sets out the national mandate and the NHS requirement to ensure all patient deaths are reviewed. This helps to identify good care as well as what could have been improved.

Mortality review and investigation under this policy are conducted to support learning and improvement, in line with National Quality Board guidance and the Trust's Patient Safety Incident Response Plan. Reviews and investigations recognise that deaths may result from multiple contributory factors across clinical, organisational and system interfaces, and seek to identify learning that can reduce the risk of future harm.

Alignment with the Patient Safety Incident Response Framework (PSIRF)

Deaths identified as potentially related to problems in care are reviewed using PSIRF-aligned learning responses. These may include Structured Judgement Review, thematic review, After Action Review or locally led Patient Safety Incident Investigation where national or local PSIRF criteria are met. The selection of response is proportionate and designed to maximise actionable learning.

This policy and the associated standard procedures set out how the Trust and its staff must:

- determine which patients are considered to be under their care and included for case record review if they die
- respond to the death of an individual using the established and where required specific mechanisms (eg those patients with a learning disability or mental health needs; an infant or child death and a stillbirth or maternal death) and the Trust's processes to support such deaths
- report the death within the organisation to ensure that:
    - the Medical Examiner Service can scrutinise all deaths
    - all deaths that should be referred to the coroner are referred in a timely manner
    - deaths initially considered "non-coronial" are referred to the coroner where there is an indication identified by the scrutiny process.
    - any cases where there is concern around the care of the patient are escalated and investigated through the Trust governance processes to establish if this is likely to have contributed to harm or the patient's death
    - ensure patients receive an accurate medical causation on their death certificate
    - offer support and explanation to the bereaved family in the immediate period of loss
    - offer support to staff who have been involved in the death.

This policy requires careful consideration of any staff in the review and discussion of any death where there is potential need for information sharing:

- with other organisations who may have an interest (including the deceased person's GP), including how they determine which other organisations should be informed
- to review the care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past

- Appendix A Standard procedure for adults
- Appendix B Procedure for 'Still Births, Newborn, Infant, Child and Maternal' deaths
- Appendix C Process mapping for Learning Disabilities (LeDeR) Mortality Review.

Data will be collated, checked and analysed at each stage of the procedure by specialties and divisions.

There are existing frameworks and national audit processes for deaths specific to:

- Learning Disabilities
- Patients in Detention (which now excludes DOLS orders)
- Mental Health (and subject to specific detention under this Act)
- Maternal, Infant, Child and Young People

Specific other legal requirements remain the same. For most patients this relates to the reporting of a death to the coroner. There are established procedures in place for this, already subject to monitoring and audit.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Outcomes from mortality reviews, Structured Judgement Reviews and Patient Safety Incident Investigations are reviewed through PSIRF governance routes, including the Patient Safety Incident Review Group, Patient Safety Committee and Trust Board, providing assurance that learning is identified, actions are implemented and improvements sustained.

Macro level data

Trust level mortality data is reported to Patient Safety Committee quarterly via the report and dashboard. A focussed report is also provided to the Board of Directors twice yearly. Data from mortality metrics which can be filtered by specialty and diagnosis are also provided to the divisions on a quarterly basis.

Meso level data

From April 2017, Trusts have been required to collect and publish on a quarterly basis specified information on deaths.

- This should be through a paper and an agenda item to a public Board meeting.
- Publication of the data and learning points should be from quarter 3 2017/2017 onwards.
- This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review.
- Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.
    - This will be established through the Medical Examiners' referrals and Trust's existing internal governance and Coronial processes

Live dashboards are available through Datix platforms which track deaths handled by the Bereavement Centre and Medical Examiners' Service. These deaths are identified automatically from the Trust's CareFlow system.

These dashboards capture

- number of deaths
- numbers of referrals to the Coroner
- numbers of referrals taken for inquest
- number of cases identified for SJRs
- those SJRs which are still open more than 45 days from identification (the same standard as other incidents) and which division they are in.

Micro level data

Live dashboards for scoring of the phases of care are under continued development within the Datix platform at Trust and Divisional level.

Findings of individual and focused case series reviews, multidisciplinary special interest reports (eg LeDeR, end of life care) will be reported according to the group work plan and escalated to patient Safety Committee through routine quarterly reports and dashboard.

Monitoring Focus	SFH Monitoring Arrangements
Quality and timeliness of Structured Judgement Reviews (SJRs)	SJR completion monitored via Datix dashboards, including number initiated, completion within 45 days, and outstanding overdue reviews. Oversight through Specialty Governance, Divisional Governance Leads and Learning from Deaths Group.

Monitoring Focus	SFH Monitoring Arrangements
Identification and review of deaths more likely than not due to problems in care	Deaths identified via Medical Examiner scrutiny, SJRs and PSIRF-aligned learning responses. Outcomes reviewed via PSIRG, Patient Safety Committee and Trust Board.
Sharing learning and implementation of actions	Learning from mortality reviews and investigations reviewed at Specialty, Divisional and Trust level, with actions monitored through governance structures and reported via dashboards and highlight reports.
Trust-level oversight and reporting	Trust-level mortality metrics and themes reviewed quarterly by Patient Safety Committee, reported bi-annually to Trust Board and incorporated into Quality Account reporting.
Monitoring involvement of bereaved families	Compliance with Duty of Candour and bereaved family involvement considered through Medical Examiner processes and PSIRF investigations, with governance oversight via Learning from Deaths Group.
Responsible leads for monitoring	Specialty Governance Leads, Divisional Clinical Leads for Governance, Learning from Deaths Group, Patient Safety Committee and Trust Board.

Monitoring and Compliance- Escalation:

Datix record oversight (including assigning, monitoring and sign off) remains the responsibility of the Speciality / Divisional Governance lead and Divisional Governance Teams. Total number of SJR requests and completion within agreed timescales are to form part of formal reporting at Divisional and Speciality governance meetings.

The DATIX system has been developed to track SJR progress and flag when agreed completion timescales are missed. Sign-off is not possible until all mandatory fields, including the outcome, are completed.

Where SJRs fail to be completed within 45 days, this will be escalated to Patient Safety Committee, as part of the Divisional highlight report alongside inclusion (and discussion) within Divisional Performance Reporting to further support operational delivery and adherence. For individual cases where breaches occur and cases of persistent non-compliance, the Trust will take measures for further action in accordance with their performance and governance mechanisms.

Total number of SJRs and reporting of PSII numbers related to deaths are highlighted within the bi-annual board report but also form part of the annual report.

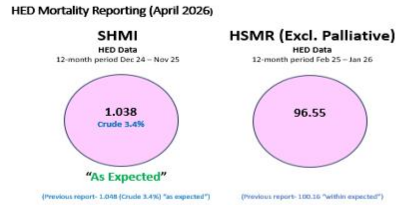
Attendance, quoracy, and reporting adherence will be monitored as part of routine Learning from Deaths meetings and form part of the quarterly highlight report to Patient Safety Committee. Where a divisional report is not provided for discussion, this will (with Chairs approval) be carried forward to the next meeting. Further episodes of non-reporting will be escalated through Division and Patient Safety Committee.

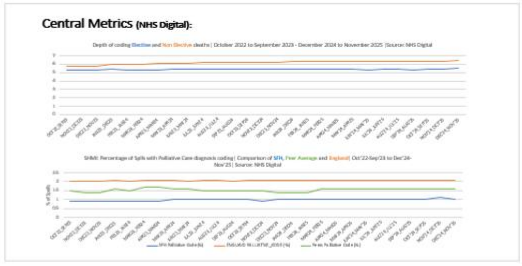
Monitoring Responsibilities Summary:

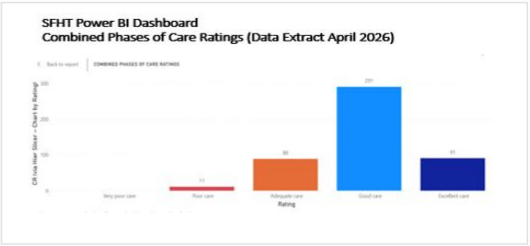
Minimum Requirement to be Monitored **(WHAT – element of compliance or effectiveness within the document will be monitored)**	**Responsible Individual** **(WHO – is going to monitor this element)**	**Process for Monitoring e.g. Audit** **(HOW – will this element be monitored (method used))**	**Frequency of Monitoring** **(WHEN – will this element be monitored (frequency/ how often))**	**Responsible Individual or Committee / Group for Review of Results** **(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)**
Structured Judgement reviews	Specialty Governance Lead Divisional Governance Leads	See dashboard. Trends, themes and changes from reviews must be reported.	Monthly monitoring Quarterly LfD reporting	Specialty Division
Outlying diagnosis groups	Specialty Governance Lead Divisional Governance Leads	Trust and Divisional/ Specialty level mortality data	Monthly monitoring Quarterly LfD reporting	Specialty Division
Attendance at meetings	Chair of the Learning from Deaths Group	Attendance record	Monthly Bi-annual Board report	Learning from Deaths Group

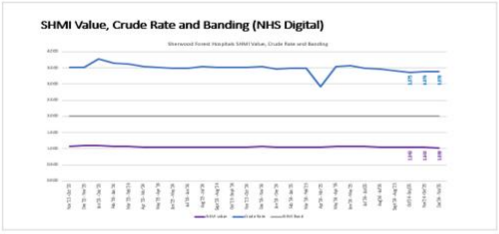
Sample Mortality Dashboard for Patient Safety Committee:

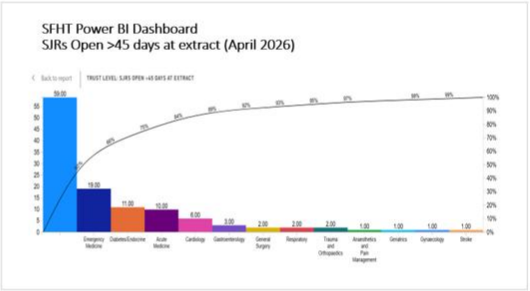
PSC - Learning from Deaths (May 2026)

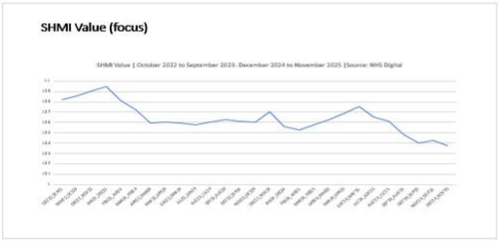


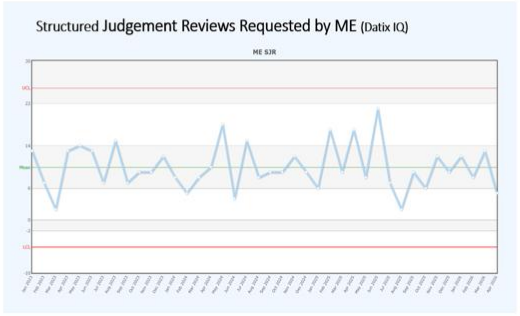


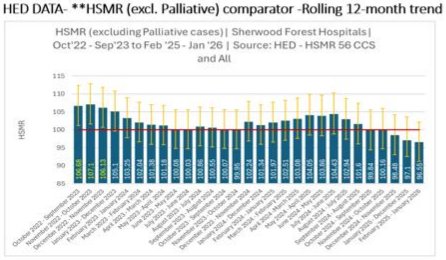












8.0 TRAINING AND IMPLEMENTATION

Training opportunities support and resources will be made available by this Trust to employees including any doctor performing the role of a Medical Examiner. Staff involved in the process of death certification and reporting to the coroner have a professional requirement to proactively seek to gain competency at this Trust or achieve this through other approved routes such as through training programmes, professional associations and accredited Colleges or membership of professional indemnity unions or societies.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix D
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix E

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- **CQC report: Learning, Candour and Accountability – a review of the way NHS Trusts review and investigate the deaths of patients in England (Dec 2016)**
  - Learning, candour and accountability - Care Quality Commission

- **Royal College of Physicians: National Mortality Case Record Review Programme**
  - https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme
  - https://www.rcplondon.ac.uk/search?query=national+mortality+case+record+review+programme

- **National Quality Board: National Guidance on Mortality Reporting (update Feb 18)**
  - NHS England » National Quality Board
  - NHS England » National Guidance on Learning from Deaths
  - nqb-national-guidance-learning-from-deaths.pdf

- **LeDeR- Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR).**
  - National LeDeR Policy: NHS (2021)
  - Roll out of the Learning Disabilities Mortality Review programme (LeDeR) – Important information for Acute General and Specialist Hospitals (2017).

- **Guidance for NHS trusts on working with bereaved families and carers**
  - National Quality Board publishes guidance for NHS trusts on working with bereaved families and carers - Care Quality Commission
  - NHS England » NHS publishes guidance to help trusts learn from deaths
  - NHS England » National Guidance on Learning from Deaths

- **Government response to the consultation on Medical Examiners**
  - Introduction of medical examiners and reforms to death certification in England and Wales: government response to consultation (June 2018)
  - NHS England » National Medical Examiner's guidance for England and Wales (Updated March 2025)

- **Perinatal Mortality Review Tool**
  - https://www.npeu.ox.ac.uk/pmrt

- **Patient Safety Incident Response Framework**
  - NHS England » Patient Safety Incident Response Framework

- **Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis Related SFHFT documents**
  - Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis | The BMJ

- **Other policies / procedures:**
  - Patient Safety Incident Response Plan and Policy
  - Patient Safety Incident Response Group Terms of Reference
  - Patient Safety Incident Response Oversight Terms of Reference
  - Risk Management and Assurance Policy
  - Last Days of Life for Adults Policy
  - Perinatal deaths reporting procedure
  - Maternal death – standard operating procedure
  - Verification of an Expected Adult Death by Registered Nurses Policy
  - Emergency Department Record Sharing – 'share in' implied consent policy

11.0 KEYWORDS

Death; standard procedure for the review and reporting of adult deaths; medical examiners role

12.0 APPENDICES

Appendix A – Standard Procedure for the Review and Reporting of Adult Deaths

Appendix B – Standard Procedure for the Review and Reporting of Still Births, Newborn, Infant, Child and Maternal Deaths (including Child Death Review Process and Rapid Response Process)

Appendix C – Learning from lives and deaths – (LeDeR) Review Process Overview

Appendix D – Equality Impact Assessment

Appendix E – Alignment with National Learning from Deaths and PSIRF

Appendix A – Standard Procedure for the Review of Adult Deaths

Decision Flow for Structured Judgement Review (SJR) and Patient Safety Incident Investigation (PSII)

(Aligned to Learning from Deaths and PSIRF)

- *Steps1-3 supported by DCIQ*
- *Step 4 & 5 supported by Trust Governance Processes / Datix Web*
- *Step 6 Final outcomes should be documented on DCIQ*

Step 1 – Death occurs in Trust care (or recent Trust care)

All deaths receive **Medical Examiner scrutiny**, including:

- Proportionate review of records
- Discussion with Qualified Attending Practitioner (QAP) and responsible Consultant (where required)
- Listening to bereaved family / carers

This scrutiny may identify:

- No concerns
- Opportunities for learning
- Concerns about problems in care
- Examples of good care / practice

Step 2 – Does the death meet national Learning from Deaths criteria for case record review (SJR)?

A **Structured Judgement Review (SJR) must be initiated** where **any** of the following apply:

National Learning from Deaths criteria

- Death where **problems in care are suspected** or identified
- Death of a **person with a learning disability** (LeDeR)
- Death of a **patient detained under the Mental Health Act**
- **Unexpected death**, including where deterioration was not anticipated
- Death following **concerns raised by staff, family, Medical Examiner or Coroner**
- Any death meeting **national or locally agreed alert criteria** (e.g. diagnosis or pathway-specific signals)

➞ **Yes** → Proceed to **SJR** (if case has been identified by Coroner, ensure Factual Recollection of Event(s) (FROEs) have been requested and completed)

➞ **No** → Record outcome; no further mortality review required (unless concerns arise later)

Step 3 – Undertake Structured Judgement Review (SJR)

Purpose:

To determine **quality of care across phases**, identify **learning**, and understand whether there were **problems in care** using a recognised structured methodology.

Key requirements

- Initiated by either the **Medical Examiner** (at scrutiny) OR the **responsible clinical team**
- **Specialty/division** notified within DATIX system and confirms reviewing clinician to complete SJR
- Completed by a **reviewer not involved in the patient's care**
- SJR to be commenced within **7 days** and completed **within 45 days**
- Learning and actions **documented and shared**

Step 4 – Does the SJR identify problems in care that meet PSIRF criteria for investigation?
Following SJR (or at any point via escalation), consider **PSIRF decision-making**:
A **Patient Safety Incident Investigation (PSII)** should be initiated where:

- Problems in care are assessed as **more likely than not to have contributed to death**, **or**
- There is **potential for significant system learning beyond the specialty/division**, **or**
- The incident meets **national PSIRF investigation triggers**

➞ **Yes** → Initiate **PSII** (PSIRF-aligned investigation)

➞ **No** → Manage learning via **local actions, thematic review, or After-Action Review**

Step 5 – Select proportionate PSIRF learning response
Learning responses may include:

- **Local SJR-led improvement actions**
- **Thematic or cross-case review**
- **After Action Review**
- **PSII** (where criteria met)

The selected response must:

- Be **proportionate**
- Focus on **system learning**
- Avoid attributional or disciplinary framing

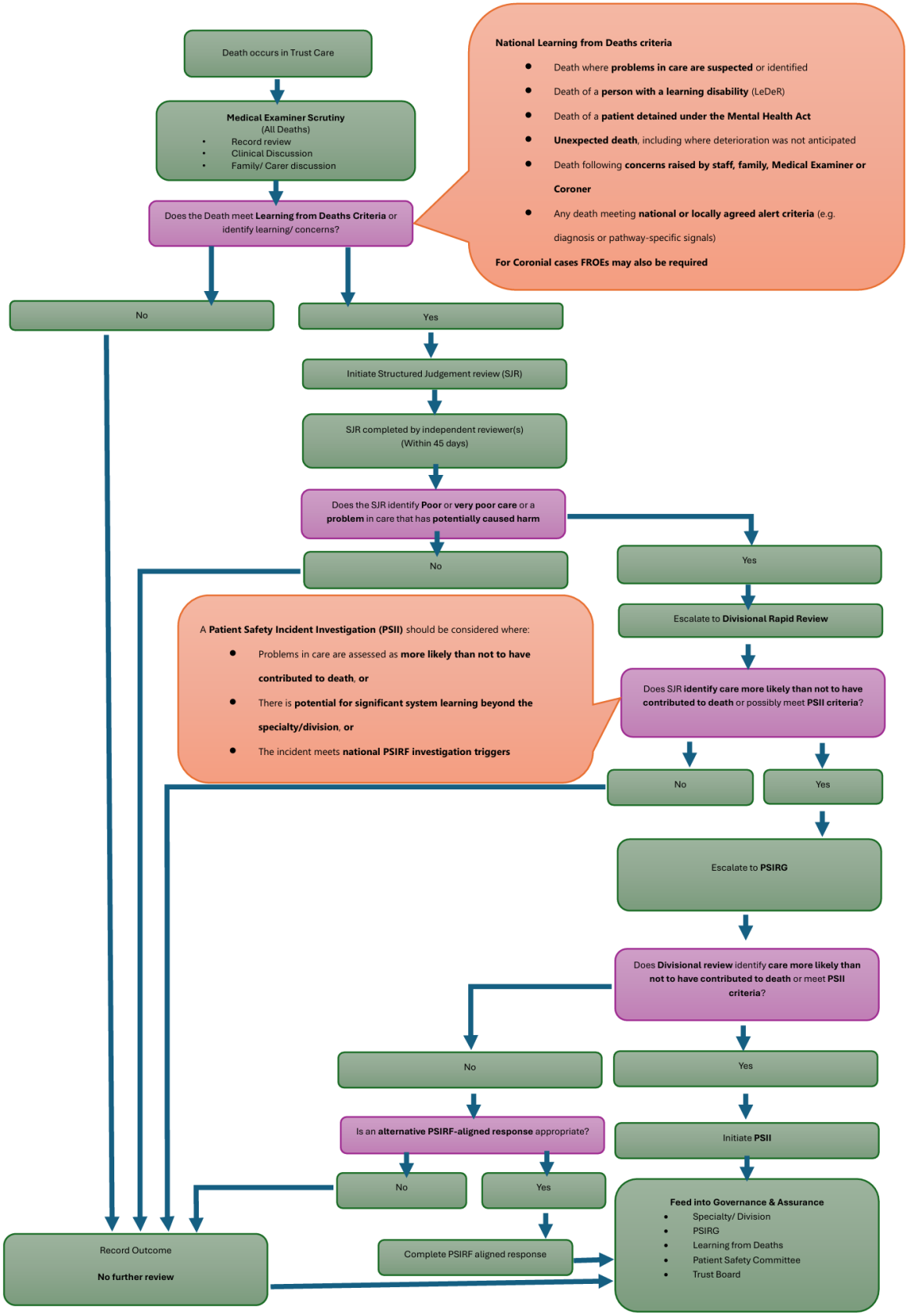
Step 6 – Governance, oversight and assurance

- **Specialty / Divisional Governance**
  - Oversight of SJR quality, timeliness and learning
  - Escalation of significant concerns, including PSIRG and, where appropriate, PSC.

Step 7 Oversight and assurance

- **Learning from Deaths Group**
  - Trust-wide oversight of:
    - Total SJRs
    - PSII activity related to deaths
    - System-level themes and learning
  - Reporting / escalation through PSC (quarterly highlight), Trust Public Board (bi-annual) and Quality Account (annual)
- **Patient Safety Committee / Board**
  - Assurance that learning is identified, acted upon and sustained

Key principle:
Not every death requires an investigation, but every death that meets Learning from Deaths criteria requires structured review; investigation under PSIRF is reserved for those where proportionate system-level learning requires it.



1. Where there are concerns or potential learning, the SJR should be raised with the specialty/division where the concern occurred rather than the responsible clinician at the time of death
2. For statutory review the SJR should be raised with the specialty/ division of the responsible clinician at the time of death

Appendix B: Standard Procedure for the Review and Reporting of Still Births, Newborn, Infant, Child and Maternal Deaths (including Child Death Review Process and Rapid Response Process)

SFH contributes to the national system of the reporting of these deaths, and the information can be found at https://www.npeu.ox.ac.uk/mbrrace-uk.

'MBRRACE-UK' is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP) which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. **The aim** of the MNI-CORP MBRRACE-UK programme is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.

MBRRACE-UK achieves this by:

- Surveillance of all maternal deaths
- Confidential enquiries into maternal deaths during and up to one year after the end of the pregnancy
- Confidential enquiries into cases of serious maternal morbidity on a rolling basis
- Surveillance of perinatal deaths including late fetal losses (22-23 weeks gestation), stillbirths and neonatal deaths
- Confidential enquiries into stillbirths, infant deaths and cases of serious infant morbidity on a rolling basis

The Trust must also comply with the new systems of Perinatal Mortality Review and use the approved review tool (PMRT).

The Trust has a detailed and robust reporting and review system for deaths of children through the Nottinghamshire Safeguarding system, which sets out the processes to be followed when a child dies in the Nottingham City and Nottinghamshire Local Authority areas. Further information is contained in Chapter 6 (Child Death Reviews) of Working Together to Safeguard Children (2026).

The deaths are reported to the Coroner and supported by the Child Death Review Team. The deaths are reported to the Child Death Overview Panel a multi-agency group (for the appropriate local authority area) that informs reports to the Safeguarding Childrens Board.

Monthly mortality review meetings occur in the women and children's division (appropriately supported by other clinical team representatives) to ensure all cases are reviewed and understand and act upon any learning from any of the local or statutory review processes.

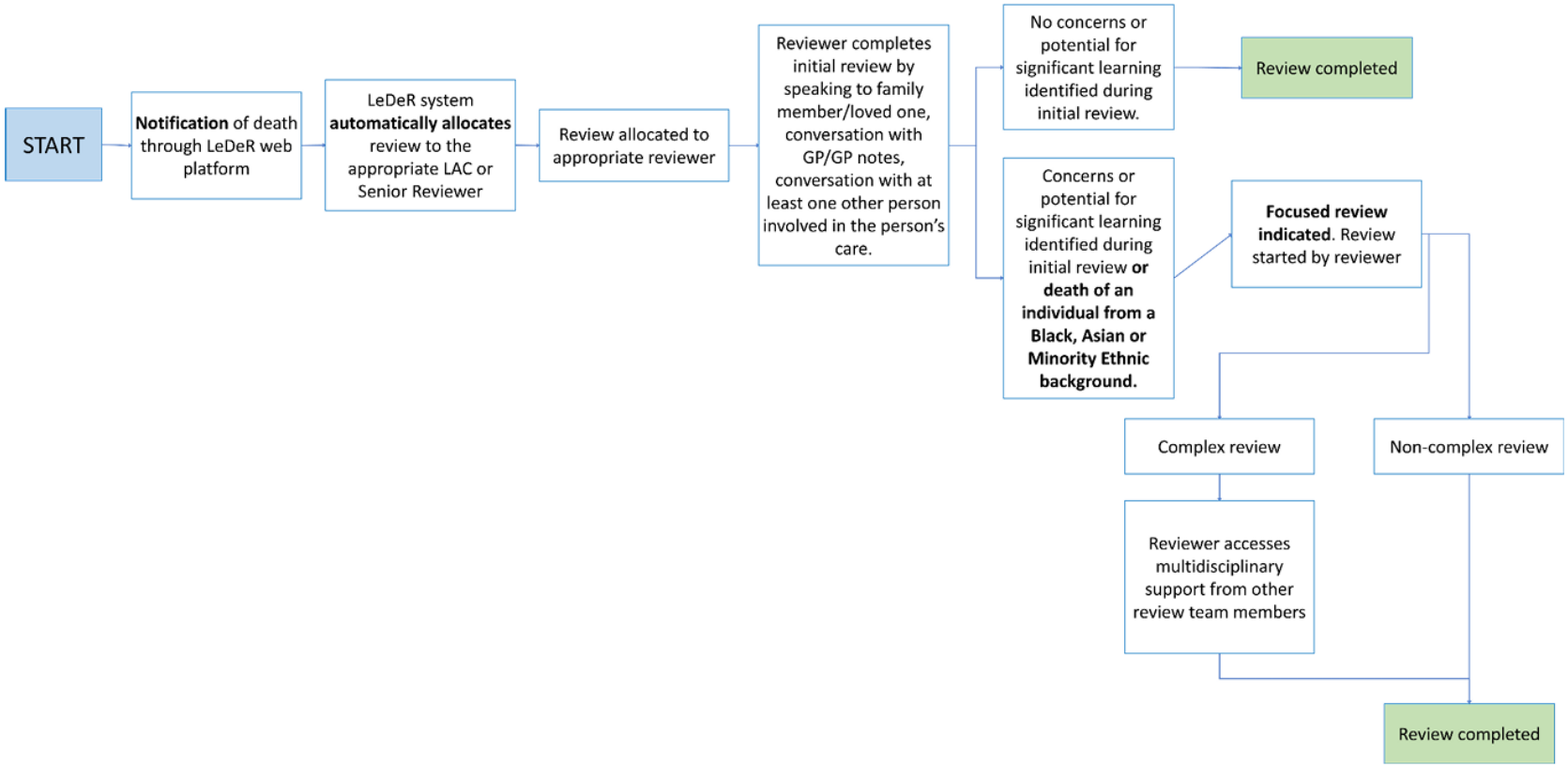
SFHT Intranet- Child Death Documentation- Policies, Procedures & Guidelines

Appendix C –
Learning from lives and deaths – people with learning disability and autistic people (LeDeR) review process overview

The Trust is now part of the national LeDeR Programme with local systems in place.
Local information will be collated and any LeDeR outcomes considered by the Trust (internal) Safeguarding Steering group.
A quarterly report is provided to Learning from Deaths with a summary of case review outcomes.

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

Figure 1: LeDeR review process overview



Appendix D – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Equality Impact Assessment (EIA) form: EIA form stage 1:

NAME of EIA Assessor:	**Date of EIA completion:** 1st June 2026
Department: Corporate	**Division:** Trust-wide
Name of service/policy/procedure being reviewed or created:	Mortality Management Policy (Learning from Deaths)
Name of person responsible for service/policy/procedure:	Dr Nigel Marshall (Chair – Learning from Deaths)

Brief summary of policy, procedure of service being assessed:
This is a policy that looks at the standards and outcomes of treatment and care of patients that have died in this Trust. It does not directly affect these deceased patients and any impact on those important to the deceased patient (the bereaved) will be offered support by the patient experience team. This does not affect the legal or human rights of the deceased or those people close to them. This statement applies to all people with protected characteristics.

Please state who this policy will affect:
Patients, staff
The implementation of this policy, data collection and analysis will help identify any potential inequality especially those who may have a protected characteristic. The establishment of a baseline of information will provide a comparison for trends and themes. This will be supported by information and reports for and by the Trust e.g. Dr Foster; Nottinghamshire Safeguarding and Children's Board

Protected characteristic	**Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)**	**Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening. Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.**
Race & Ethnicity	Please see other statements- low impact policy with safeguards and controls in place	This policy relates to deaths of all patients within SFHT
Sex	No	As above
Age	No	As above
Religion & Belief	No	As above
Disability	No	As above
Sexuality	No	As above
Pregnancy & Maternity	No	As above
Gender reassignment	No	As above
Marriage & Civil Partnership	No	As above
Socio-Economic factors	No	As above

What consultation with protected characteristic groups including patient groups have you carried out?
There has been no external or public consultation at local level. Internal consultation is described on the front page of the document. The national guidance which has been, to a greater extent prescriptive, has been through a formal route.

As far as you are aware are there any Human Rights issues to be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

This is a positive policy approach to the national CQC report: Learning, Candour and Accountability – a review of the way NHS Trusts review and investigate the deaths of patients in England (Dec 2016).						
On the basis of the information/evidence/consideration so far, do you believe that the document will have a positive or negative adverse impact on equality? (delete as appropriate)						
Positive			**Negative**			
High	**Medium**	**Low**	**Nil**	**Low**	**Medium**	**High**
If you identified positive impact, please outline the details here:						

Signature: Nigel Marshall- Chair Learning from Deaths
Date: 01/06/2026

Appendix E – Alignment with National Learning from Deaths and PSIRF

This policy aligns with:

- National Quality Board: *Learning from Deaths* – setting expectations for governance, publication, learning and engagement with bereaved families.
- Trust Patient Safety Incident Response Plan 2024–26 – defining PSIRF-aligned learning responses, investigation approaches and governance oversight.

Mortality review outcomes are integrated into the Trust's wider patient safety and quality improvement systems.