Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Mortality Governance Policy

This is a new procedural document which incorporates CORP/RISK 32 v.2– Learning from Death Policy

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor(s)	Mr R.J Cuschieri - Deputy Medical Director
Author/reviewer	Mandy Dalton and Gemma Wheatcroft – Lead Medical Examiner Officers
Date written/revised:	September 2020
Approved by:	Mortality Governance Group and Policy Approval and Compliance Group
Date of approval:	18 September 2020
Date issued:	21 January 2021
Next review date:	September 2023
Target audience:	Trust Wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 1	21 January 2021	• This is a new procedural document and incorporates CORP/RISK 32 v.1 – Learning from Death Policy – Please read in full.	Mandy Dalton/ Gemma Wheatcroft

Contents

Page No.

1 INTRODUCTION & BACKGROUND

In December 2016, the Care Quality Commission (CQC) published its review on the way NHS trusts review and investigate the deaths of patients in England: *Learning, candour and accountability.* The CQC found that none of the trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

On March 21st 2017 the National Quality Board published "*National Guidance on Learning from Deaths"* which includes very specific guidance on the roles and responsibilities of the Board of Directors and the Non-Executive. It is essential that this guidance be read alongside the *Serious Incident Framework*. Trust Boards are accountable for ensuring compliance with both these frameworks. In July 2018 the National Quality Board published "*Guidance for NHS trusts on working with bereaved families and carers".* This details how trusts should support and engage with families after a loved one's death.

The guidance clearly states that the learning from mortality reviews should be integral to a provider's clinical governance and quality improvement work.

Executives and Non-executive Directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

In January 2020 NHS England and NHS Improvement published "Implementing the medical examiner system: National Medical Examiner's Good Practice Guidelines" on behalf of the National Medical Examiner for England and Wales. These guidelines set out how the National Medical Examiner expects medical examiner offices to operate during the non-statutory phase. Once statutory, further standards will be published.

2 PURPOSE

2.1 This policy sets out the procedures for identifying, recording, scrutinising, reviewing and investigating the deaths of people in the care of the Trust.

2.2 Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (The Trust) will implement the requirements outlined in the Learning From Deaths Framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients. The Trust will also follow the good practice guidelines on implementing the National Medical Examiner (NME) process during the non-statutory phase.

2.3 To confirm the process and ensure a consistent and coordinated approach for the scrutiny and review of all hospital deaths, including those occurring in the Emergency Department and how the process dovetails into existing governance structures.

2.4 To consider mortality rates and national mortality indicators, available at diagnosis and individual patient level.

2.5 To quality check the documentation and so ensure accurate and in depth clinical coding.

2.6 To identify any areas of practice both specific to the individual case and beyond, that could potentially be improved based upon peer group review. Areas of good practice are also identified, acknowledged and supported.

2.7 To ensure clear reporting mechanisms are in place, to escalate any concerns, so that the Trust is aware and can take appropriate actions.

2.8 Statutory Duty of Candour will be applied to all mortality reviews as appropriate.

2.9 Deaths in hospital of patients under the age of 18 years and maternal deaths are excluded from this process document because they are reviewed under other established Trust processes but learning and outcomes of these reviews are fed through to the Mortality Governance Group (MG).

2.10 To engage and support families and carers who express concerns about the care given to patients who have died.

3 ROLES AND RESPONSIBILITIES

3.1 The Medical Director/ Deputy Medical Director will:

- Assure the Board that the mortality review process is in line with the National programme. (*National Guidance on Learning from Death March 2017 and Implementing the Medical Examiner System January 2020).*
- Ensure that arrangements are in place so that all clinical staff, as appropriate, are aware of their responsibilities to contribute to all Mortality review processes.
- Provide advice to the Medical Examiner team and maintain an oversight of the process.
- Chair the Mortality Governance Group (MG).
- In conjunction with the information department and clinical coding, scrutinise the Health Evaluation Data (HED) and ensure that external mortality alerts are investigated and any associated concerns are resolved.

3.2 The Non-Executive Director will:

- Have an oversight of the mortality review processes.
- Constructively challenge and support any systems and processes linked to the review, investigation and learning of deaths.
- Ensure the Trust Board of Directors receives on a quarterly basis, data for which they can be assured is accurate and consistent.

3.3 The Chief Medical Examiner/Medical Examiner will:

- Have completed the 26 core E-Learning Modules and the Face to face training within 1 year of appointment and complete any further training as stipulated by the National Medical Examiner.
- Offer training and advice to colleagues involved with the medical examiner process.
- Develop and maintain a robust and dynamic scrutiny process for all deaths, complete Form ME-1 (Part B) (see Appendix 3).
- Develop effective communication with the Coroner and Registrar.
- Ensure that any case where a relative or carer or member of staff has expressed concern about quality of care has a full Structured Judgement Review (SJR) undertaken.
- Scrutinise all elective admissions and confirm the mode of admission with the coding department. Provide a short narrative for the monthly MG meeting. When potential lapses in care are identified these will be forwarded to the Specialty Governance Lead for SJR.
- Feedback concerns raised at MG to relevant specialties using the specialty governance processes.
- Use the Trust incident reporting system (Datix) to report incidents where a significant concern has been raised to enable review as part of the risk management process.
- Refer any concerns not resolved by the provider health care service to the Regional Medical Examiner.
- Ensure compliance with the Statutory Duty of Candour.
- Work with the Clinical Coding Team to provide training and highlight the importance of documenting a working diagnosis and co-morbidities at time of admission.
- Provide quarterly data returns to the National Medical Examiner as required.

3.4 The Lead Medical Examiner Officer will:

- Develop and maintain a preliminary review of all medical records, complete form ME-1 (Part A) (see Appendix 2) for the Medical Examiner.
- Refer any potential serious incident (SI)(i.e. avoidable death) to the Deputy Medical Director for consideration to take to SI panel. These will be reported on Datix as significant concerns.
- Ensure that all confirmed elective admissions resulting in death are scrutinised by the Medical Examiner (ME) team and actioned accordingly.
- Develop effective communication with the Coroner, coroner's officers and Registrar.
- Offer training and advice to colleagues involved with the mortality review process including Structured Judgement Reviews.
- Ensure that any case where a relative, carer or member of staff has expressed concern about quality of care has a full SJR undertaken. Log the "concern" on Datix.
- Liaise with the Trust lead for learning disabilities to ensure accurate coding and involve them in the SJR.

- Report all deaths of patients with a learning disability to LeDeR http://www.bristol.ac.uk/sps/leder/notify-a-death/
- Ensure cases graded as a concern by the SJR process (based on phases of care scores of 3 and below) are referred to Deputy Medical Director to agree any further actions.
- Feedback concerns raised during mortality review processes to the relevant speciality via the Speciality Governance Lead.
- Work with the Clinical Coding Team to provide training and highlight the importance of documenting a working diagnosis and co-morbidities at time of admission.
- Use the Trust incident reporting system (Datix) to report incidents identified during the scrutiny process and to record any concerns raised by family or carers.
- Provide monthly reports to MG on specialty compliance with process.
- Provide a quarterly mortality governance report to :
    - Deputy Medical Director
    - Lead Nurse for End of Life care services.
    - Mortality Governance
    - Clinical Governance Committee
    - Quality and Effectiveness Committee
    - Acute Clinical Quality Review Group
- Ensure that any actions identified in relation to mortality review are recorded, progressed and monitored via specialty clinical governance minute audits.
- Complete the mortality database
- Work with the chief ME in providing quarterly data returns to the National Medical examiner as required.
- Ensure compliance with the Statutory Duty of Candour.

3.5 The Medical Examiner Officer will:

- Develop and maintain a preliminary review of all medical records, complete form ME-1 (Part A) (see Appendix 2) for the Medical Examiner.
- Refer any potential serious incident (SI)(i.e. avoidable death) to the Deputy Medical Director for consideration to take to SI panel.
- Ensure that all confirmed elective admissions resulting in death are scrutinised by the ME team and actioned accordingly.
- Develop effective communication with the Coroner, Coroner's Officers and Registrar.
- Ensure that any case where a relative, carer or member of staff has expressed concern about quality of care has a full SJR undertaken. Log the "concern" on Datix.
- Liaise with the Trust Lead for learning disabilities to ensure accurate coding and involve them in the SJR.
- Report all deaths of patients with a learning disability to the Learning Disabilities Mortality Review Programme (LeDeR). http://www.bristol.ac.uk/sps/leder/notify-a-death/
- Complete the mortality database.

3.6 Divisional /Specialty Governance Leads will:

- Be responsible for the dissemination of notes requiring structured judgement review. Individuals reviewing cases for which they had sole responsibility should be avoided; the case should be reviewed by a Consultant/Senior Clinician NOT directly involved with the case.
- Ensure that a summary of cases is discussed and recorded in the minutes of the specialty clinical governance meeting and that action plans are completed and monitored.
- Provide feedback to the Trust Clinical Governance Committee of any key learning.
- Be responsible for actioning any DATIX incidents as reported via the Medical Examiner office.
- Ensure all SJR's are completed within the designated timescales.

3.7 The Clinical Coding Department will:

- Collect notes from the Breavement Office at DRI daily and from the General Office at Bassetlaw Hospital (BH) as and when required.
- Code all "death notes" within agreed timescales.
- Complete the clinical coding section of the mortality database.
- Provide support to the Mortality Governance group.
- Work with the Governance Lead and ME Office to ensure a workable process for Consultants and Secretaries to access notes for SJR.
- Receive any elective death alert and confirm method of admission.
- Work with the Medical Examiner Team to provide ongoing training and awareness sessions to highlight the importance of documenting a working diagnosis and co-morbidities at time of admission.

3.8 The Bereavement Team (DRI) and General Office/Bereavement Officer (Bassetlaw Hospital) will:

- Identify all in hospital deaths and obtain medical notes.
- Track all medical notes to the Bereavement Office/General Office.
- Ensure the current patient admission is showing on CAMIS and that the patient is recorded as deceased.
- Contact the family to offer condolences and inform of next steps.
- Complete initial tracker.
- **DRI**: Send all notes of patient's referred for post mortem and cremation paperwork to the mortuary
  BH: Post mortems for Bassetlaw Hospital patients are held at Nottingham Queens Medical Centre. Copy notes will be sent if requested. Send completed cremation forms to the mortuary.
- Scan all Medical Cause of Death Certificated (MCCDs) to the registrar once completed.
- Ensure the GP letter is completed via Medisec- indicating cause of death or that the death has been referred to the Coroner.

3.9 Reviewers will:

- Have received training on the SJR process.
- Review cases within 4 weeks of receipt of the cases identified utilising the Trust's structured judgement case note review form electronically and return to the Lead Medical Examiner Officer (MEO) via the following email: dbth.medical.examineroffice@nhs.net

4 DEFINITIONS

- **Death Certification** : the process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to Coroner
- **MG :** Mortality Governance
- **MCCD:** Medical Cause of Death Certificate
- **Scrutiny :** The initial review of a death
- **SJR :** Structured judgement review is a systematic review of case notes using the agreed methodology to identify any problems in care, highlight learning opportunities to improve the care for other patients
- **ME:** Medical Examiner
- **MEO:** Medical Examiner Officer.
- **LeDeR:** Learning Disabilities Mortality Review Programme
- **HED:** Health Evaluation Data.

5. SELECTING DEATHS FOR REVIEW OR SCREENING

5.1 Child under 18

Reviews of these deaths are mandatory and should be undertaken in accordance with *"working together to safeguard children"* (2015) and the current child death overview panel.

5.2 Stillbirths, perinatal and maternal deaths

All stillbirths and perinatal deaths will be reviewed using the current perinatal mortality review tool. All Maternal deaths will be investigated as per the Serious Incident Policy.

5.3 Adult inpatient with learning disability (LD) or serious mental health concern

The LeDeR process must be followed. All LD deaths will be reported via http://www.bristol.ac.uk/sps/leder/notify-a-death/ An external review will then be undertaken by the responsible Clinical Commissioning Group.

5.4 Elective admission deaths

All confirmed Elective admissions resulting in Death will be scrutinised by the ME team and a short narrative provided for the monthly MG meeting. When potential lapses in care are identified these will be forwarded to the specialty governance lead for SJR. The finding of this will be tabled at the Mortality Governance Meeting.

5.5 Inpatient death where a family member, carer or member of staff has raised a concern

All will be reviewed using the structured judgement review methodology (SJR) (see Appendix 1). This will be requested via the responsible consultant team and the ME team's scrutiny form will accompany the request. If the responsible consultant team/specialty requires further information from another supporting specialty this will be requested by the original responsible consultant team.

5.6 Deaths from a diagnosis or treatment group where an 'alarm' has been raised through Health Evaluation Data (HED)

These will be discussed and actions confirmed at the Mortality Governance meeting.

6 SELECTING DEATHS FOR FURTHER INVESTIGATION

Where an SJR identifies an overall assessment score of 1, 2 or 3 the Lead MEO will discuss the case with the Deputy Medical Director - who will advise on further action. This action will be monitored via the Mortality Governance meeting.

If an SI is not declared but the care indicates quality improvement and/or potential learning then this will be taken to the Mortality Governance meeting and sent to the appropriate specialty. Evidence of shared learning will be gained from the minutes of the meeting.

7 QUARTERLY REPORTING

Under the *National Guidance on Learning from Deaths*, published by the National Quality Board in March 2017, the Trust is required to report to the Board on the following information every quarter:

- the total number of inpatient deaths
- the number of deaths that have been subject to case record review
- of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care

- the themes and issues identified from review and investigation, including examples of good practice
- how the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.

In addition to this, the following data from the ME process will be reported on:

- Number of deaths scrutinised by an MEO
- Number of deaths scrutinised by an ME
- Number of referrals to a Coroner
- Number of SJRs requested
- Number of MCCDs issued within 3 working days.
- Number of rejected MCCDs
- The "learns" for each division
- Main themes

8 SUPPORTING AND INVOLVING FAMILIES AND CARERS

- The Bereavement Officer will contact the family initially to offer condolences and to inform and offer support with the next steps.

- Once the MCCD is completed, the Medical Examiner Team will then contact the bereaved family/carer to inform them of what is written on the MCCD and ensure they understand or explain why the death needs to be referred to the Coroner. They will enquire as to whether they have any questions or any concerns in care provision to raise.

- Bereaved families and carers will be involved in the investigation of any death that is concluded to be due to problems in care as part of the Serious Incident investigation process. They will receive an investigation report including any actions taken to ensure lessons are learned.

9 TRAINING/ SUPPORT

- SJR training will be available twice a year.
- Governance leads will ensure that sufficient clinicians within each specialty are trained in the use of SJR.

10 LEARNING

- The Training and Education department will support development of educational tools to support any identified learning.
- Learning identified will be shared within the identified specialty and/or Trust wide, dependant on issue, following established clinical governance processes and structures.
- Themes will be identified as part of a quarterly thematic analysis and taken forward as Quality Improvement projects.

11 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
All SJR's to be returned within 4 weeks of request	Lead MEO	Monthly	Mortality Governance meeting.
Themes for learning	Lead MEO	Quarterly	Mortality Governance meeting and quarterly report circulated to all specialty governance leads via the Clinical Governance committee
SJR training twice a year	Lead MEO	Reported Annually	Mortality Governance Meeting.

12 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 4).

13 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

14 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Serious Incident (SI) Policy - CORP/RISK 15
- Being Open, Saying Sorry and Duty of Candour Policy - CORP/RISK 14
- Equality Analysis Policy – CORP/EMP 27
- Fair Treatment for All Policy – CORP/EMP 4
- Complaints, Concerns, Comments and Compliments: Resolution and Learning – CORP/COMM 4
- Care after Death and Bereavement Policy: Operational Policy for Staff to follow in the event of a Patient Death – PAT/T 60
- Rapid Response to Unexpected Child Deaths and Child Deaths Function – Standard Operating Procedure – PAT/T 62

15 REFERENCES

1. Hutchinson A, National Mortality Case Record Review programme. Nov 2016
2. Learning, candour and accountability. CQC. December 2016
3. National Guidance on learning from Deaths. NQB. March 2017
4. Learning from Deaths: Guidance for NHS Trusts on working with bereaved families and carers. July 2018
5. Implementing the medical examiner system: National Medical Examiner's good practice guidelines. January 2020.

APPENDIX 1 – STRUCTURED CASE NOTE REVIEW DATA COLLECTION FORM

National Mortality Case Record Review Programme: Structured case note review data collection

Please enter the following.

Age at death (years):

Gender: M/F

First 3/4 digits of the patient's postcode:

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between arrival and death:

Month cluster during which the patient died:
Jan/Feb/Mar Apr/May/June Jul/Aug/Sept Oct/Nov/Dec

Specialty team at time of death:

Specific location of death:

Type of admission:

The certified cause of death if known:

Guidance for reviewers

1) Did the patient have a learning disability?

1. No indication of a learning disability – proceed with this review.
2. Yes – clear or possible indications from the case records of a learning disability. Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Learning Disability Mortality Review Programme.

2) Did the patient have a serious mental health issue?

- No indication of a severe mental health issue – proceed with this review
- Yes- clear or possible indications from the case records of a severe mental health issues. Action: after your review, please refer the case to the hospital's clinical governance group.

3) Is the patient under 18 years old?

- No the patient is 18 years or older – proceed with this review.
- Yes- the patient is under 18 years old. Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Child's Deaths review programme.

Structured case note review data collection

Phase of care: **Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **Ongoing care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **Care during a procedure (excluding IV cannulation)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **Perioperative care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **End-of-life care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **Overall assessment**

Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this overall phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care

Please circle only one score.

Please rate the quality of the patient record.

1 = very poor 2 = poor 3 = adequate 4 = good 5 = Excellent

Please circle only one score.

Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here) **Yes** ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)* **Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)*

   Yes ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)* **Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

4. **Problem with infection management Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

5. **Problem related to operation / invasive procedure** *(other than infection control)*

   Yes ☐ **No** ☐
   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)* **Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))* **Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

8. Problem of any other type not fitting the categories above Yes ☐ No ☐

Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239

APPENDIX 2 – ADMINISTRATIVE INFORMATION
FORM ME-1 (PART A)

National Exemplar Form
This form may be used and evaluated by pilot areas working with the Department of Health to improve the process of death certification.

If urgent: Response required by: __ / __ / ____ Reference No.: _____ / _____ / ____
(To be completed by medical examiner's office.)

Reason: _____

Administrative Information

Form ME-1 (Part A)

To be provided to a medical examiner or coroner following a death.

The information provided in this form is confidential.

The administrative information to be provided to a medical examiner or, where necessary, a coroner is prescribed by Regulations made under the Coroners and Justice Act 2009. It can be documented in the deceased person's clinical records or given on this form.

A1. Name of deceased person and the date and time of death

Name: *(Forename)* *(Family name)*	Date and time of death: *(Date)* *(Time)*

A2. Key information about the deceased person

M/F D.O.B: NHS No.: Residential address: Ethnicity:	Name of organisation responsible for care prior to death: Last occupation *(and any relevant work history)*:

Place and address where death occurred *(If address is same as residential, state 'As above'.)*

☐ Home ☐ Hospital ☐ Hospice _____
☐ Nursing or care home ☐ Other _____

A3. Next of kin, partner, relative or representative of the deceased person *(Include more than one if appropriate.)*

Name *(Provide names of best contacts, see A5.)*	Relationship *(Note if expected to register death.)*	Phone No. *(Include mobile No. if possible.)*	Present at death	Informed *(If not present)*

Reference No: _ _ _ _ _ / _ _ _ _ _ _ / _ _ _ _
(To be completed by medical examiner's office.)

A4. Names and contact details for medical practitioners, clinicians etc. *(Complete where applicable.)*

(Use 'N/A' for not applicable and 'N/K' for not known. If the person's details have been provided in a previous row, state 'As above'.)

Role	Name	Organisation/location	Personal phone/ bleep No. *(**Not** the on-call number.)*
Doctor(s) able to write a MCCD* *(Must be qualified to certify.)*			
Usual GP *(or alternative GP at practice)*			
Person responsible for nursing or care before death			
Person who verified fact of death			
Hospital consultant responsible for care *(where applicable)*			

** Medical Certificate of Cause of Death*

A5. Information provided by or regarding next of kin

(E.g. concerns expressed about the circumstances or cause of death, who to contact/not contact, people who may be vulnerable, etc.)

☐ A formal complaint has been (or is expected to be) received about care or treatment *(include relevant information above)*

A6. Other relevant administrative information

APPENDIX 3 – MEDICAL EXAMINER'S ADVICE AND SCRUTITY FORM ME-1 (PART B)

National Exemplar Form
This form may be used and evaluated by pilot areas working with the Department of Health to improve the process of death certification.

Notified on: __/__/____ at _____

Reference No.: _____/_____/____
(To be completed by medical examiner's office.)

Required by: __/__/____

Medical Examiner's Advice and Scrutiny

Form ME-1 (Part B)

The information provided in this form is confidential.

Information in Sections B2, B3, B4, B10 must be recorded by a medical examiner. Other information may be recorded by a medical examiner's officer (MEO) or another person acting on behalf of a medical examiner.

B1. Name of deceased person and the date and time of death

Name: *(Forename)* – *(Family name)*	Date and time of death: *(Date)* *(Time)*

B2. Scrutiny of clinical records and other documented information

Information scrutinised: ☐ Full clinical record ☐ Summary clinical record ☐ Coroner documentation ☐ Other

Notes made by medical examiner during scrutiny:

Reference No.: _____/_____/____
(To be completed by medical examiner's office.

B3. Outcome of scrutiny by medical examiner

Death: ☐ Unexpected ☐ Sudden but not unexpected ☐ Expected ☐ Individualised end of life care plan

Case to be referred to HMC ☐ Yes ☐ No

Reason

Potential learning identified ☐ Yes ☐ No

Refer to ☐ Speciality M&M ☐ Clinical Governance ☐ Medical team ☐ Nursing ☐ Other please specify

Reason for review

Structured Judgment Review case ☐ Yes ☐ No

Reason:

☐ Deaths where the bereaved or staff raise significant concerns about the care

☐ Deaths of those with learning disabilities or severe mental illness

☐ Deaths in a specialty, diagnosis or treatment group where an 'alarm' has been raised (for example, an elevated mortality rate, concerns from audit, CQC concerns)

☐ Deaths where the patient was not expected to die –for example, in elective procedures

☐ Deaths where learning will inform the provider's quality improvement work.

☐ Maternal or neonatal deaths

B4. Cause of death established during scrutiny by the medical examiner

	Approximate interval between onset and death
1a	
1b	
1c	
2	

Reference No.: _____/_____/____
(To be completed by medical examiner's office.)

B5. Discussion with qualified attending practitioner (QAP) - *if required*

(If this discussion takes place before certification and the doctor has not provided in writing a preliminary view of the cause of death – or reason why no such view has been formed – then this information must be obtained and noted below at the outset of the discussion.)

QAP talked with: Name | Role: | Date: | Time:

Notes: *(If no preliminary view can be formed before requesting advice, make a note of the reason.)*

continuation sheet

☐ Cause of death provided before scrutiny or noted above is accepted without change
☐ Cause established by the medical examiner and documented is accepted by doctor
☐ Doctor and medical examiner have agreed the following alternative cause of death
☐ Death needs to be discussed with a coroner for reasons noted in B2

		Approximate interval between onset and death
1a	_____	_____
1b	_____	_____
1c	_____	_____
2	_____	_____
	_____	_____

B6. Discussion with coroner/coroner's office *(if required)*

Notes:

☐ Coroner does not need to investigate the death and has agreed to issue a 100A
☐ Coroner has agreed to conduct an investigation

Reference No.: _ _ _ _ _/ _ _ _ _ _ _/ _ _ _ _
(To be completed by medical examiner's office.)

B7. Discussion of cause of death with informant/next of kin or other appropriate person

Cause of death discussed with: *(name)* *(relationship)*

Cause of death discussed by: *(name)* on *(date)* at *(time)*

Notes

☐ *continuation sheet*

☐ Cause of death accepted without any concerns being raised *(Continue at B8)*

☐ Concerns raised and addressed without requiring discussion with a coroner *(Continue at B8)*

☐ Concerns raised that require the death to be discussed with a coroner *(Record details in B6)*

B8. Medical examiner's details and signature

I confirm that I have carried out an independent and proportionate scrutiny of this death in a way that complies with the relevant standards and procedures.

Name of medical examiner *(print)*: Office:

Signature: Date:

(Where the information on this form is provided electronically, the signature may also be electronic.)

APPENDIX 4 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Mortality Governance Policy – CORP/RISK 35 v.1	Corporate Directorate	Mandy Dalton	New Policy	September 2020

1) Who is responsible for this policy? The Corporate Medical Directorate

2) Describe the purpose of the policy: To ensure scrutiny and learning following all in hospital deaths.

3) Are there any associated objectives? Compliance with best practice and CQC requirements

4) What factors contribute or detract from achieving intended outcomes? – Non-compliance with policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? NO

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? N/A

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	no	
b) Disability	no	
c) Gender	no	
d) Gender Reassignment	no	
e) Marriage/Civil Partnership	no	
f) Maternity/Pregnancy	no	
g) Race	no	
h) Religion/Belief	no	
i) Sexual Orientation	no	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

**If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: September 2023

Checked by: Gemma Wheatcroft **Date: September 2020**