Great Ormond Street Hospital for Children NHS Foundation Trust

# Learning from Deaths Policy

**Policy**

**Key Points**

**Death in childhood is a rare event. Whenever a child dies, it is important to reflect and to learn if anything could be done differently in the future. This policy outlines how the Trust will review patient deaths, and share and act on learning.**

| | |
|---|---|
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|---|---|
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| • | |

**PLEASE NOTE: Printed copies of this policy may not be the current version. Please refer to the Trust Policy Library for the current, approved version.**

## 1. Introduction

1.1 Death in childhood is a rare event. Whenever a child dies, it is important to reflect and to learn if anything could be done differently in the future.

1.2 In March 2017, the National Quality Board published guidance, *'National Guidance on Learning from Deaths'*, which aims to initiate a standardised approach to reviewing and learning from deaths.

*'Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals'.*

This is reinforced by the recent findings of the Care Quality Commission (CQC) report *'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'*. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed.

1.3 In October 2017, HM Government released *'Child Death Review: Statutory Guidance'* for consultation, which ended on 31 December 2017. The final publication of this guidance is anticipated in May 2018 and will provide a national statutory framework for the review of deaths of children.

1.4 It is essential that learning from the death of a child is both shared and acted upon.

1.5 The National Guidance on Learning from Deaths requires Trusts to have a policy for reviewing and learning from deaths. This is an interim policy that outlines the current and established processes for learning from deaths at Great Ormond Street Hospital (GOSH). A final policy will be written once the *Child Death Review Statutory Guidance*' has been published.

1.6 The GOSH Mortality Review Group (MRG) is a multidisciplinary group of senior clinicians that conducts routine, independent structured case record reviews of all deaths that occur at GOSH. The MRG has been in place since 2012.

1.7 The Serious Incident Management Policy highlights the systematic investigation process that should be undertaken related to Serious Incidents (SI) in the Trust, in accordance with the NHS Improvement Serious Incident Framework. The purpose of the SI investigation is to understand and identify problems in service delivery or care that preceded adverse events, to understand how and why any problems occurred, and to identify what may need to change in service provision/care delivery to reduce the risk of similar events in the future

1.8 The death of a child results in significant distress for families. Being open with parents and their families at all times including when something goes wrong is a key component of developing a safety culture; a culture where all incidents are reported, discussed, investigated and learned from. GOSH recognises that involvement in the care of a child who dies can result in significant distress for staff who have cared for that child. This policy highlights the support for families and staff that is available

through Bereavement Services and must be read in conjunction with the Trust policy "Being Open and the Duty of Candour".

## 2. Aims and Objectives

2.1. To outline a clear and consistent approach to reviewing all deaths of children who die on GOSH premises.

2.2. To ensure that learning from deaths of children at GOSH is embedded into Trust practice.

2.3. To provide a framework so that the Trust is able to meet the current national and statutory requirements for learning from deaths.

2.4. To meet the requirement from the National Guidance on Learning from Deaths for all Trusts to have a policy on learning from deaths.

2.5. The GOSH strategy (Fulfilling Our Potential) is outlined in Figure 1 below. This policy supports the Trust vision by ensuring that there is a process in place to identify and act on any learning identified when a child dies at Great Ormond Street Hospital.


## 3. Duties and Responsibilities

3.1. <u>Chief Executive</u>

Has ultimate executive accountability for the quality of services in the Trust.

3.2. Medical Director

Is the Executive Director responsible for mortality reviews in the Trust.

- Provides the Trust Board with assurance regarding the Trust Mortality Review process.
- Provides support and guidance to the MRG Co-Chairs, as required.
- Takes action where concern is raised through mortality data and/or mortality reviews

3.3. Non-Executive Directors

Have oversight of progress with implementation of National Guidance on Learning from Deaths through review of reports to Trust Board.

3.4. Mortality Review Group

- The Trust Mortality Review Group (MRG) performs a case record review of all child deaths that occur on Great Ormond Street Hospital (GOSH) premises. The purpose of this review is to provide a Trust-level overview of all deaths to identify themes/risks, and take action as appropriate to address those risks whether they are internally or externally facing. This may include suggestions for improvements in practice as well as changes to clinical care to prevent harm.
- The MRG also functions to provide assurance that the child's pathway has been managed appropriately by the organisation, and where any issues or learning impacting on patient care are identified at a local or organisational level, these are fed back to the relevant leads for sharing or resolution as appropriate.
- The MRG has responsibility for ensuring compliance with national reporting requirements, and providing advice to the Trust on how to implement learning from National Guidance on Learning from Deaths and Child Death Review Statutory Guidance.
- The MRG also coordinates information for relevant programmes e.g. national audits, Child Death Overview Panels, Care Quality Commission and Dr Foster etc. where information on mortality across the Trust needs to be provided.

3.5. Co-Chairs of the MRG

The Co-Chairs are responsible for:

- Guiding the meeting and ensuring that case record review discussions are completed in a timely manner.
- Escalating learning from reviews to the Trust via quarterly reports to the Patient Safety and Outcomes Committee (PSOC) and Trust Board.

- Ensuring that the Trust is meeting recommendations in line with statutory and national guidance on learning from deaths.

3.6. Heads of Clinical Service

- Specialty teams are responsible for conducting local case reviews (Mortality & Morbidity Meetings); information from the local case review should be provided to the MRG to inform their assessment. Specialty teams remain responsible for identifying and addressing issues in the delivery of patient care. The MRG functions to give oversight of the specialty reviews and to identify themes/trends, which may not otherwise be identified.

3.7. Clinical members of the MRG

The clinical members of the MRG are responsible for

- Completing case record reviews and presenting notes as agreed with the administrator and co-chairs.

- Assisting with the peer review of cases.

- Implementing actions assigned to them and feedback issues/concerns to the specialty teams.

3.8. Quality & Safety Team Administrator

The Quality and Safety Team Administrator will:

- Confirm attendees for the meeting and assign cases to reviewers three weeks prior to the meeting.

- Locate, obtain and distribute hard/electronic copies of clinical notes to reviewers, two weeks prior to the meeting.

- Compile and distribute the monthly agenda to members of the MRG, two weeks prior to the meeting.

- Request copies of Datix, Bereavement, Palliative care and Legal Information, two weeks prior to the meeting.

- Maintain and update the MRG Deaths & Review Schedule

- Provide administrative cover/document meeting case summaries in meetings in the absence of the Clinical Governance & Audit Assistant.

3.9. Clinical Governance & Audit Assistant

The Clinical Governance & Audit Assistant will

- Manage and maintain the MRG Deaths & Review Schedule, including updating the list of children who have died at the hospital each month.

- Compile and provide relevant Datix information for case reviews.

- Produce meeting case summaries of key issues, learning points and actions from all case reviews discussed in each meeting; update the MRG analysis spreadsheet and Action Log after each meeting.

- Provide Governance support to the meeting, including data analysis and quarterly reporting to the Patient Safety and Outcomes Committee and Trust Board.

- Provide administrative cover in the absence of the Quality & Safety Team Administrator.

3.10. The Bereavement Services Manager

The Bereavement Services Manager will:

- Acts as the Single Point of Contact (SPOC) for Child Death Overview Panels (CDOPs).

- Facilitates information sharing between GOSH and CDOPs as relevant.

3.11. The Palliative Care Administrative Team

- Provide palliative care information for each case in advance of the meeting.

3.12. Legal Team

- Providing the outcomes and reports from coroner's inquests and police investigations (where applicable) for each case in advance of the meeting.

- Providing the outcomes and reports from coroner's inquests and police investigations completed after the mortality review, where not available earlier. The MRG report is then reviewed by the co-chairs with any new information taken into account

3.13. Clinical Nurse Specialist for Learning Disabilities.

- Submitting death notifications as required to the Learning Disabilities Mortality Review (see item 5 for further detail)

## 4. Process of Learning from Deaths at Great Ormond Street Hospital

This policy focuses on the Trust wide process for reviewing child deaths, which takes place through the MRG. This is through a case record review by clinicians who review the child's care that received around the time of death. Specialty teams are responsible for conducting local case reviews (Mortality & Morbidity [M&M] Meetings).The explicit process for reviewing speciality local case reviews is outside the scope of this policy. It should be noted that approximately 80% of GOSH inpatient deaths take place on ICU. All ICU deaths are subject to review at the weekly ICU M&M meetings.

4.1. The MRG will :

- Review all deaths of children who die on GOSH premises. In reviewing these deaths, the patient pathway from the last admission will be taken into account, not just the immediate period before death. If indicated, previous admissions will also be reviewed and taken into account.

- Review Ad hoc deaths on request e.g. by a Child Death Overview Panel, Palliative Care Team, Children's Acute Transport Service (CATS).

- Review Cases in response to requests from other organisations to review the care provided to people who are current or past GOSH patients but who were not under GOSH direct care at time of death.

- Collaborate with others as requested to carry out reviews and investigations when a person has received care from several health and care providers.

4.2. Within the scope described above, the MRG will review deaths within 12 weeks of the date of death.

4.3. Case record[1] reviews will be conducted using the complete set of patient notes, which are readily accessible to reviewers. At a minimum, the hard copy notes (when in use), CareVue and Electronic Document Management should be reviewed. Datix incident reports, outcomes from coroner's inquests, bereavement and palliative care notes will also be provided in advance of the meeting.

4.4. Post-mortem reports should be obtained from the Legal Team for review when available. Reviewers are not expected to seek outpatient data that is stored in non-readily accessible locations (e.g. specialty-held clinical databases). Notes should always be made available and prioritised for the MRG, to ensure the timely review of deaths within 12 weeks (as per national requirements) and support timely quarterly reporting.

4.5. Each child death will be reviewed using a structured case record review tool that was established at GOSH in 2012. The Structured Judgement Review documentation recommended in the National Quality Board's 'National Guidance on Learning from Deaths' (2017), is not currently being used at GOSH as it is not validated for children and young people. Until further national guidance for paediatrics is published, the case record form in appendix i will continue to be used.

4.6. The MRG will:

- Review any local case review (M&M meeting) documentation provided by the specialty team.

[1] A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

- Identify any modifiable factors that may have contributed to the child's death. Modifiable factors are defined as those, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths.

- Where modifiable factors or other issues are identified, these must be fed back in an appropriate manner to the relevant clinical team and/or the Divisional Director(s) for action. The feedback mechanism will be determined based on the nature of the information to be shared, but could include via specialty case review meeting, email, Divisional Board meeting etc.

- Identify any issues that require action at a Specialty, Divisional, Trust-wide, London, or National level, and take responsibility for liaising and/or engaging with relevant stakeholders to implement these actions.

- Where Trust-wide learning is identified, communicate this via the quarterly reports presented at the Patient Safety and Outcomes Committee (PSOC) and Trust Board for dissemination and action. Where resolution requires Executive input or oversight, the MRG may escalate issues to the Medical Director(s) or Senior Management Team as appropriate.

- Review relevant reports from, and/or provide data/analysis as appropriate to, national audits and other programmes reviewing child deaths.

This process has been summarised in Figure 2 below.

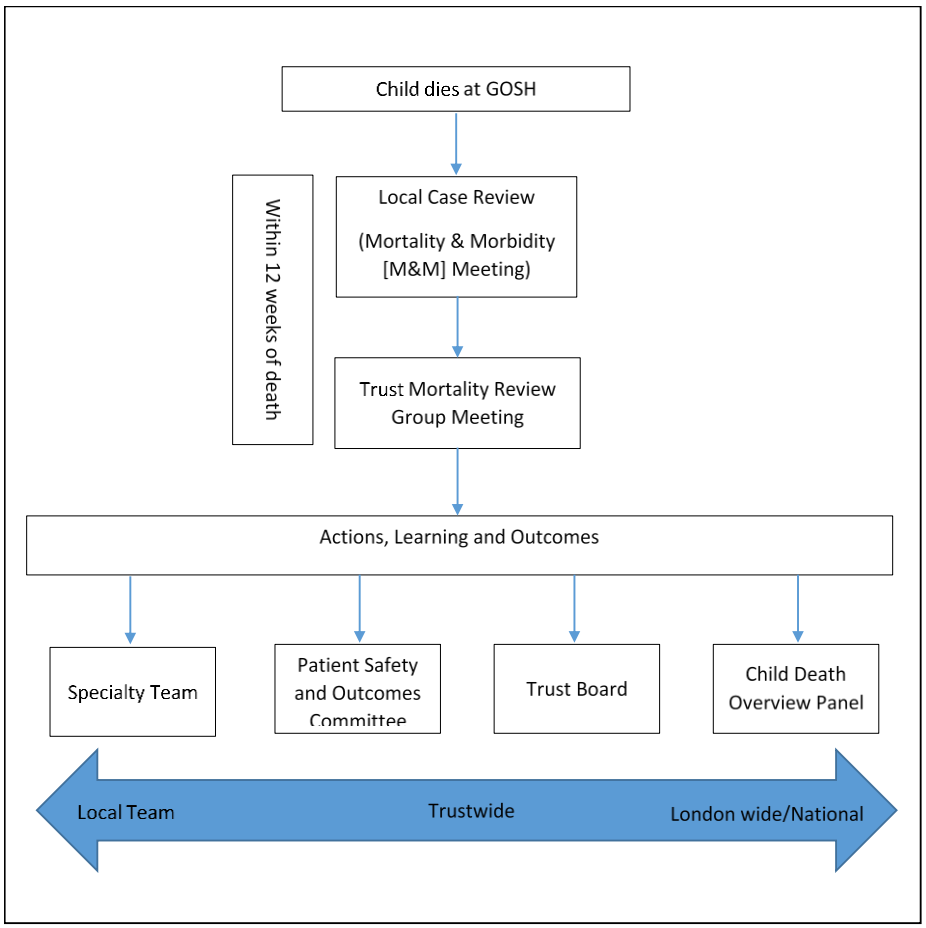


***Figure 2. Process of learning from deaths at GOSH***

## 5. The Learning Disabilities Mortality Review (LeDeR) Programme

5.1. The Learning Disabilities Mortality Review (LeDeR) Programme was commissioned in June 2015, by the Healthcare Quality Improvement Partnership (HQIP) & NHS England. The programme aims to make improvements to the lives of people with learning disabilities, identify any modifiable factors associated with a person's death and ensure learning is implemented. The roll out of the pilot phase completed successfully at the end of December 2017.

5.2. The 'National Guidance on Learning from Deaths' recognizes the LeDeR programme as an established methodology for reviewing of deaths of patients with learning disabilities, and requires that 'All deaths of people with learning disabilities aged four years and older are subject to review using LeDeR methodology'. The guidance recognises that Trusts may want to complete their own internal review, and recommends that providers notify LeDeR of the deaths of children with a learning disability (aged 4yrs+) utilising the LeDeR online notification form.

5.3. The Clinical Nurse Specialist for Learning Disabilities is responsible for submitting the LeDeR notification forms.

## 6. Support for families, carers, and staff

6.1 The Bereavement services department operates across the Trust, offering advice and support to staff and parents in dealing with end of life issues and related difficult situations.

6.1.1Bereavement support

The Bereavement services department aims to be a point of contact for anyone working in the Trust, requiring support in caring for a dying child and after the death of a child. Bereavement services can be contacted on 020 7813 8551

6.1.2 End of Life Care group

The End Of Life Care group meets regularly to develop core standards for issues around death and dying and to monitor implementation of an end of life care pathway.

It also seeks to enable staff who already have strong professional links with the children and families in their care to identify, address and support decision-making choices.

6.1.3 Child Death Helpline (CDH)

The Child Death Helpline is a National freephone service run by GOSH and Alder Hey, for anyone affected by the death of a child of any age, in any circumstance, however long ago. It provides free confidential telephone advice and support that can be accessed by bereaved families.

## 7. Training requirements

7.1. The clinical reviewers of the MRG will receive guidance from the co-chairs of the MRG to ensure that reviews are undertaken appropriately using the specified review tool.

## 8. Communication and Consultation

8.1. This policy is based upon the terms of reference for the Mortality Review Group which have been consulted upon by the clinical membership of the MRG.

8.2. The GOSH process for Learning from Deaths was outlined and shared as part of Trustwide feedback for input into the December 2017 National consultation of 'Working Together to Safeguard Children', which included new Child Death Review: Statutory Guidance, which is anticipated to be published in May 2018.

8.3. Once the Child Death Review: Statutory Guidance is published the Trust will review the guidance requirements and produce a revised edition of this policy to meet the requirements. This will require further Trust wide consultation and consideration of how local specialty reviews and an overview mortality review will work alongside each other. This interim policy has been approved by the Medical Director.

## 9. Monitoring arrangements

| Policy element to be monitored | Lead | Frequency | Reporting arrangements (Committee or group) |
|---|---|---|---|
| Assurance that all child deaths that occurred at GOSH have been reviewed within 12 weeks | Clinical Audit Manager | Monthly | Included in quarterly report to Patient Safety and Outcomes Committee |
| Report produced summarising findings and learning points from all completed mortality reviews. Report includes following data<br>• Total number of deaths at GOSH in each quarter<br>• Number of those deaths subject to case record review by the MRG<br>• Number of those deaths investigated under the serious incident framework and declared as serious incidents<br>• Number of deaths where a modifiable factor was identified at GOSH with an influence score of 2<br>• Number of deaths where a modifiable factor was identified at GOSH with an influence score of 3<br>• Number of deaths of people with learning disabilities<br>• Number of people with learning disabilities that have been reviewed<br>• Number of deaths of people with learning disabilities where a | Co-chair of MRG | Quarterly | Patient Safety and Outcomes Committee |

| | | | |
|---|---|---|---|
| modifiable factor was identified at GOSH with an influence score of 2 or more | | | |
| Executive summary of finding and learning points from all completed mortality reviews | Co-chair of MRG | Quarterly | Trust Board |
| Trust inpatient mortality rate | Quality Improvement Analyst | Monthly | Integrated Quality and Safety Report |

**10. Equality Impact Assessment**

10.1. An equality impact assessment has been completed for this policy and attached as appendix ii.

**11. References**

**Relevant statutory documents, guidelines**

National Quality Board (2017). National Guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

Care Quality Commission (2016). Learning, Candour and Accountability - A review of the way NHS trusts review and investigate the deaths of patients in England https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

Mazars (2015). Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015 https://www.england.nhs.uk/south/wpcontent/uploads/sites/6/2015/12/mazars-rep.pdf

HM Government (2017 Consultation). Working Together to Safeguard Children: changes to statutory guidance (including Child Death Review Statutory guidance).

**GOSH internal policies**

Being Open and the Duty of Candour

Serious Incident Management Policy

Complaints policy

Child Death Overview Information Sharing Policy

**GOSH clinical guideline**

When a child dies

**Appendix i: MRG Case record Review Tool**

## Patient Details

| Patient details | |
|---|---|
| Patient surname | |
| Patient first and middle names | |
| Hospital number (no spaces) | |
| NHS Number | |
| Gender | |
| **Demographic data** | |
| Date of birth (dd/mm/yyyy) | |
| Date of death (dd/mm/yyyy) | |
| Time of death (hh:mm) | |
| Age at death | |
| Date of admission (dd/mm/yyyy) | |
| Time of admission (hh:mm) | |
| Day of admission | |
| Length of stay (days) | |
| Day of Death | |
| Date and time of death recorded in notes? | |
| Ethnic group | |
| Country of residence | |
| NHS or Private Patient | |
| **Overall standard of documentation?** | |
| **Comments** | |

| Review details | |
|---|---|
| Name of reviewer | |
| Date of Mortality Review Group discussion | |
| Is there documented evidence of LCR discussion? | |
| If yes, specify which LCR(s) and the dates of review. LCR = local case review aka M&M | |
| Child death summary in notes? | |

| Treatment | |
|---|---|
| Lead consultant | |
| Admitting specialty(ies) | |
| Division(s) *See table below | |
| Where was the child first admitted to GOSH? | |
| Name of ward (if applicable) | |
| Comments: | |

| | |
|---|---|
| **Did the patient have a learning disability diagnosis?** | |
| If yes, please provide details: | |
| **Did the patient have a diagnosis of Autism?** | |
| If yes, please provide details: | |
| **Did the patient have a mental health diagnosis?** | |
| If yes, please provide details: | |

## Case Details

| Case summary |
|---|
| This should be a brief summary of the background and a factual description of the relevant events leading up to death. **This should be as short as possible and extraneous detail avoided** |
| |

| Cause of death as presently understood | |
|---|---|
| Is what's on the MCCD recorded in the notes? | |
| What was on the MCCD (Medical Certificate of the Cause of Death)? | |
| Ia. | |
| Ib. | |
| Ic. | |
| II. | |
| Appropriate? | |
| If no, why not? | |

| Consented (i.e. non-coronial) post mortem examination | |
|---|---|
| Was a consented PME offered? | |
| Was a consented PME undertaken? | |

| Case issues | |
|---|---|
| Were there any safeguarding concerns? | |
| If yes, specify: | |

| Admission to GOSH (do not complete for Palliative Care patient deaths outside of the Trust) | |
|---|---|
| Active treatment on admission? | |
| Referring hospital (if relevant) | |
| CATS/STRS/NTS transfer? | |
| Planned admission to ICU from another hospital? | |
| Unplanned admission to ICU from within GOSH? | |
| Planned transfer to ICU post-surgery? | |
| Readmitted to ICU within 24 hours of discharge from ICU? | |

Comments:

| Coroner | |
|---|---|
| Evidence of decision to inform Coroner? | |
| Was the Coroner informed of the death? | |
| Did the Coroner open an inquest? | |
| Comments: | |

| Relevant social impacts/factors |
|---|
| |

## Incidents

| Patient safety incidents | | |
|---|---|---|
| Any incidents documented in the notes? | | |
| Any incidents on Datix? | | |

| Incident 1 | | Comments: |
|---|---|---|
| Brief description of incident (please summarise rather than copying the detailed incident text) | | |
| Did this incident contribute to death? If influence score is 2 or 3, please include details in the "comments" box | | |
| Reported on Datix? | | |
| If yes, Datix reference | | |
| Root cause analysis done? | | |
| SI declared? | | |
| If no, should an SI have been declared? | | |

| Incident 2 | | Comments: |
|---|---|---|
| Brief description of incident (please summarise rather than copying the detailed incident text) | | |
| Did this incident contribute to death? If influence score is 2 or 3, please include details in the "comments" box | | |
| Reported on Datix? | | |
| If yes, Datix reference | | |
| Root cause analysis done? | | |
| SI declared? | | |
| If no, should an SI have been declared? | | |

| Incident 3 | | Comments: |
|---|---|---|
| Brief description of incident (please summarise rather than copying the detailed incident text) | | |
| Did this incident contribute to death? If influence score is 2 or 3, please include details in the "comments" box | | |
| Reported on Datix? | | |
| If yes, Datix reference | | |
| Root cause analysis done? | | |
| SI declared? | | |
| If no, should an SI have been declared? | | |

## Details of Death

| Details of death | |
|---|---|
| Does the narrative record include death? | |
| Place of death | |
| If **ward** or **other,** please specify: | |
| Withdrawal of active treatment? | |
| Evidence of end of life care planning in notes? | |
| Evidence of symptom management plan in notes? | |
| Patient referred to Palliative Care? | |
| Could care have been received outside the hospital? | |
| Died in patient's/family's preferred place of care? | |
| If not for resuscitation, was this clearly documented? | |
| Was the patient referred to a SNOD for organ/tissue donation? | |
| If yes, documented discussion about organ/tissue donation? | |
| Completed death checklist on the notes (sticker) or in CareVue? | |
| Comments: | |
| | |

## Analysis of Death

| | | | | |
|---|---|---|---|---|
| **Main underlying cause of death:** | 1 - Deliberately inflicted injury, abuse or neglect | ☐ | 6 – Chronic medical condition | ☐ |
| | 2 – Suicide or deliberate self-inflicted harm | ☐ | 7 – Chromosomal, genetic and congenital anomalies | ☐ |
| | 3 – Trauma and other external factors | ☐ | 8 – Perinatal/neonatal event | ☐ |
| | 4 - Malignancy | ☐ | 9 – Infection | ☐ |
| | 5 – Acute medical or surgical condition | ☐ | 10 – Sudden unexpected, unexplained death | ☐ |

| | | | | |
|---|---|---|---|---|
| **Mode of death:** | Withholding, withdrawal or limitation of life-sustaining treatment | ☐ | Failed cardiopulmonary resuscitation | ☐ |
| | Planned palliative care | ☐ | Witnessed event | ☐ |
| | Brainstem death | ☐ | Found dead | ☐ |

| | | | | |
|---|---|---|---|---|
| **Expectation of the death** | Unexpected | ☐ | Expected | ☐ |

Unexpected = "where the death was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death" (Department for Education, 2013)

| | | | | |
|---|---|---|---|---|
| **Area of service failure** | Mismanagement of deterioration | ☐ | Equipment related errors | ☐ |
| | Failure of prevention | ☐ | Other | ☐ |
| | Deficient checking and oversight | ☐ | None/Not applicable | ☐ |
| | Dysfunctional patient flow | ☐ | | |

| | | | | |
|---|---|---|---|---|
| **Modifiable factors** | Modifiable factors identified at GOSH | ☐ | No Modifiable factors | ☐ |
| | Modifiable factors identified elsewhere | ☐ | Inadequate information to make a judgement (very rare use) | ☐ |
| | Modifiable factors identified at GOSH and elsewhere | ☐ | | |

**modifiable factors** are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths

**Where any modifiable factors are identified:**

* Write a comment in the relevant box(es) below which are sufficiently detailed to standalone
* Ensure at least one action is identified to address the issue in the action plan

| **Influence score** | |
|---|---|
| 0 – Information not available | 2 – Factors may have contributed to vulnerability, ill health or death |
| 1 – No factors, or unlikely to have contributed to death | 3 – Factors provide a complete and sufficient explanation for death |

| Modifiable factor 1 | Influence score: | |
|---|---|---|
| | | |

| Modifiable factor 2 | Influence score: | |
|---|---|---|
| | | |

| Modifiable factor 3 | Influence score: | |
|---|---|---|
| | | |

| **Were there any relevant factors that contributed to the child's death?** | Yes | ☐ | No | ☐ |
|---|---|---|---|---|

**Where any contributory factors are identified:**

* Write a comment in the relevant box(es) below which are sufficiently detailed to standalone
* Determine the level of influence, using the influence score
* Ensure at least one action is identified to address the issue in the action plan

| **Influence score** |
|---|

| | |
|---|---|
| 0 – Information not available | 2 – Factors may have contributed to vulnerability, ill health or death |
| 1 – No factors, or unlikely to have contributed to death | 3 – Factors provide a complete and sufficient explanation for death |

| **Domain A - Child's needs** | | |
|---|---|---|
| **Factors intrinsic to the child**<br>Include any known health needs; factors influencing health; development/educational issues; behavioural issues; social relationships; identity and independence; abuse of drugs or alcohol; note strengths and difficulties.<br><br>**Please enter the relevant information in the box below** | Influence score: | |
| | | |

| **Domain B – Social environment including family and parenting capacity** | | |
|---|---|---|
| **Factors in the social environment**<br>Include family structure and functioning: provision of basic care; health care (including antenatal care where relevant); safety; any evidence of current or previous abuse or neglect; emotional warmth; stimulation; guidance and boundaries; stability; parental abuse of drugs or alcohol; wider family relationships; employment and income; social integration/support; nursery/pre-school or school environment<br><br>**Please enter the relevant information in the box below** | Influence score: | |
| | | |

| Domain C – Physical environment | | |
|---|---|---|
| **Factors in the physical environment**<br>Include known hazards relating to the external environment in relation to common childhood injuries: burns, falls, road traffic accidents; issues relating to housing and home safety measures<br><br>**Please enter the relevant information in the box below** | Influence score: | |
| | | |

| Domain D – Service Provision | | |
|---|---|---|
| **Factors in relation to service provision**<br>Include any identified services (either required or provided); any gaps between child's or family member's needs and service provision; any issues in relation to service provision, access or uptake<br><br>**Please enter the relevant information in the box below** | Influence score: | |
| | | |

## Actions and learning

| Date of Meeting raised | Patient name | Patient number | Issue identified | Action for MRG | Level of recommendation (Specialty, Division, Trust, London, National) | MRG action lead |
|---|---|---|---|---|---|---|
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| Learning for dissemination what's the one - three learning points you think should be shared widely across the Trust? These must be standalone learning points |
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| |

| Communication following review - MRG to complete jointly | | Feedback for MD/Risk Team |
|---|---|---|
| Should this death be discussed as a teaching case? | | |
| Should this death be referred for review to: | | |
| Local team | | |
| Medical Director | | |
| Risk Team | | |
| Other (e.g. Police, Coroner, HSE, Serious Case Review panel) | | |
| Details of referral | | Follow up plans for the family, if relevant |
| | | |

**Appendix ii Equality Analysis Form – Learning from Deaths policy**

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|---|---|
| **Title of Document:** | Learning from Deaths policy |
| **Completed By:** | Andrew Pearson, Clinical Audit Manager |
| **Date Completed:** | March 2018 |
| **Summary of Stakeholder Feedback:** | |

| **Potential Equality Impacts and Issues Identified** | | |
|---|---|---|
| **Protected Group** | **Potential Issues Identified** | **Actions to Mitigate / Opportunities to Promote** |
| Age | Policy and process only applies to GOSH patients | GOSH will contribute to reviews held by other organisations where the care of the patient when at GOSH is relevant. This may result in review of patients aged over 21 years. |
| Disability (Including Learning Disability) | There are additional review requirements for children/young people with LD | This is a nationally mandated additional review requirement so outside the purview of GOSH to influence. |
| Gender Re-Assignment | None Identified | |
| Marriage or Civil Partnership | None Identified | |
| Pregnancy and Maternity | It is recognised that the MRG process requires reviews of neonatal and baby deaths, and the MRG are sensitive to those members of the group who have a declared pregnancy or are returning to work | Members are given the option to refrain from participation |

| | | |
|---|---|---|
| | following maternity leave | |
| Race | None Identified | |
| Religion or Belief | None Identified | |
| Sex | None Identified | |
| Sexual Orientation | None Identified | |