South Tees Hospitals
NHS Foundation Trust

GENERAL POLICY

Document No: G163
***All Sites**

Responding to Deaths

TITLE	Responding to Deaths policy
Version:	2
Approved by: Clinical Standards Sub Group **Date:** **Final Approval by: Delegated Authorising Officers of SLT/CPG** **Date:**	 20 October 2020 20 November 2020
Author/lead responsible for policy:	Medical Director Deputy Director (Clinical Effectiveness) (Tony Roberts)
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Target audience:	All staff
Amendments and Additions	N/A
Replaces/supersedes:	Version 1
Associated Policies:	G36 Handling and Caring of the Deceased Patient Policy G29 Mortuary Policy CG39 Do not attempt cardiopulmonary resuscitation: DNACPR (Adults) policy CG49 Post-Mortem consent and the retention and disposal of tissues and organs thereafter policy CG56 Advance decisions (living wills) policy CG60 Incident Reporting and Investigation Policy G140 Care in the last days of life & after death (Adult) policy G154 Nurse verification of expected death policy
Equality Impact Assessed Y/N	**Y**

Issued by:

Chief Executive

Contents

I Version Control

Date	Version	Author	Reason
31.03.2017	1	Tony Roberts	NQB draft regulations published in March 217 require all NHS FTs to produce a Responding to Deaths policy by September 2017
28.08.2020	2	Tony Roberts	Due review date

II Table of Revision

Date	Section	Details	Reason
28.08.2020	Front page ands section 5	Responsibility for policy lies with the Medical Director	The previous policy identified the Director of Quality.

28.08.2020	Introduction	Changes to wording to bring up to date	Medical Examiners Service has been established since version 1 of this policy was written.
28.08.2020	Definitions	Updated to improve clarity	Use of ‘first stage’ and ‘second stage reviews’ reviews has been removed to improve clarity of Medical Examiner examination of case notes as the first stage in Trust Mortality Reviews, when required.

1. Introduction

The National Quality Board published National Guidance on Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. The First Edition was released in March 2017. One of the regulations set out in this guidance (Chapter 1 sections 6, 12 and Annex C – Responding to Deaths) states that "Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under their management and care." This policy closely follows the detailed guidance set out in Annex C. NHS Improvement and the Care Quality Commission stipulate that the Responding to Deaths Policy should be approved and in place in Trusts by September 2017. The policy was in place by this deadline and has been reviewed by the due date of September 2020.

Learning from deaths is important to our trust as it exemplifies the trust's ethos of putting patients, families and carers at the centre of everything we do. The Trust was at the forefront, both in the North East and nationally, of developing a centralised mortality review system, and this allowed the Trust to build on this history by being the first trust in the North East to establish a Medical Examiner Service, from May 2018.

The trust board has received detailed information about statistical measures of hospital mortality for many years and since 2013 from the centralised case record mortality review process. This has helped emphasise the importance of the work carried out in the trust in this area, supporting the clinical governance arrangements in place to guide this work. The Board provides visible and effective leadership to ensure the organisation addresses significant issues identified by Medical Examiners, mortality reviews and investigations.

The trust welcomes and encourages feedback from staff, patients, families and others which raise questions or concerns about the policy and how it is implemented. This can be done by patients and families either through the existing PALS, complaints or other patient experience forums and specifically in this area through the Medical Examiner and Bereavement Service. Staff may also use existing staff feedback mechanisms for general concerns but may also specifically raise concerns through their relevant professional or organisational routes and may also have direct contact with the Medical Examiners who contact the staff who cared for a patient who has died.

2. Scope

This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust's behalf.

3. Purpose

The purpose of the Responding to Deaths Policy is to describe the process by which all deaths in care are identified, reported and investigated. It aims to strengthen arrangements, where appropriate, to ensure learning is shared and acted upon. It seeks to ensure the Trust engages meaningfully and compassionately with bereaved families and carers and supports staff to find all opportunities to improve the care the NHS offers by learning from deaths.

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which may include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

4. Definitions

Death certification: The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. The process includes identifying cases for referral to the Coroner and links to the Medical Examiner role.

Medical Examiner: Reforms enacted by the government include the requirement for NHS Trusts to employ Medical Examiners by April 2019. The Trust established this service, in line with national reforms, in May 2018. The Medical Examiner is involved in the certification and registration of deaths, has contact with bereaved families and staff in the immediate period after a death, improves the recording of cause of death, referral of cases to the Coroner, reviews the case notes and identifies any concerns that suggest a case should receive a Trust Mortality Review or investigation.

Trust Mortality Review: The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. The process begins when the Medical Examiner reviews the notes but a Trust Mortality Review can be requested where a more in-depth review might potentially identify whether the death is due to a problem in care. Medical Examiners are in a good position to identify when a problem may have occurred but Trust Mortality Reviewers have more time to use a structured recognised methodology for case record review, such as the Structured Judgment Review developed by the Royal College of Physicians or the PRISM[1] methodology. In this Trust the form used is an adaptation of both methods, but is closer to the PRISM data collection tool.

Death due to a problem in care: A death that has been clinically assessed using a recognised methodology of case record review and judged more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable. The 6-point scale used in the PRISM study is recorded for Trust Mortality Reviews and deaths at the avoidable half of this scale are reported, through the public Boar papers, as judged to be potentially preventable. Where a Medical Examiner is satisfied that no problems in care have potentially contributed to a death, a Trust Mortality review is not required and the case is recorded as not preventable.

Investigation: The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may

[1] Hogan Helen, Zipfel Rebecca, Neuburger Jenny, Hutchings Andrew, Darzi Ara, Black Nick et al. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis *BMJ* 2015; **351** :h3239

need to change in service provision in order to reduce the risk of future occurrence of similar events. The Serious Incident Policy details the process of investigation, including the different levels of investigations required in specific circumstances.

Duty of Candour: Health and Social Care Act 2008 Regulation 20. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

5. Roles and Responsibilities (Duties)

Role	Responsibilities
Chief Executive	Overall responsibility for the implementation of this policy.
Medical Director	To be the Board lead for Learning from deaths; to take responsibility for the Responding to Deaths policy; to publish, through a quarterly paper to the public Board meeting, estimates of the number of avoidable deaths; to ensure that from June 2018 the annual Quality Account summarises the data published by the Board, including learning and action as a result of this information and an assessment of the impact of actions that the Trust has taken. To ensure all doctors are supported to fulfil their duty to engage in responding to deaths; to identify specific doctors to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.
Director of Nursing	To ensure all nurses and midwives are supported to fulfil their duty to engage in responding to deaths; to identify specific nurses and midwives to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.
Director of Finance	To ensure adequate resources are made available to enact the Responding to Deaths policy and other requirements such as set out in the Quality Account regulations.
Director or Human Resources	To ensure HR policies make it clear that clinical staff have a duty to engage in learning from deaths, to contribute to case record review and investigations when required and to fulfil Duty of Candour requirements.
Medical Examiner(s)	To be involved in the certification and/or registration of a death in the immediate period following a death of a person ins receipt of services form the Trust. To

	discuss with bereaved families and staff whether there are any concerns and to review the medical records. To identify cases that require referral to the Coroner. To advise on the appropriate completion of cause of death on the death certificate. To identify cases that require stage two case record review or investigation.
Clinical Directors	To ensure all doctors in their Clinical Directorate are supported to fulfil their duty to engage in responding to deaths; to identify specific doctors to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.
All Staff	To ensure all staff with clinical roles have a duty to engage in responding to deaths; to be involved in case record reviews and investigations as required and to meet the Duty of Candour requirements.

The Trust is working with the North East and North Cumbria Regional Mortality Group to share best practice and to develop more integrated working with other Trusts. This is particularly important for reviewing the case records who have received care in a number of other organisations which need to be involved in a review.

6. Responding to deaths in care

6.1 Deaths in care

All patients who die following admission to the any of the Trust's sites are regarded as 'deaths in care' and will be subject to this policy. Some deaths occur in patients who are under the care of the Trust but who are not admitted and over time more of these groups have been included under the remit of this policy. These groups include: patients who die before arrival in Accident and Emergency or who die in the department prior to admission. The majority of these cases are seen by the Medical Examiners. Deaths within a short period following discharge (future versions of this policy will determine whether this includes deaths within 30 days or another period to be determined), deaths under the care of community services but not whilst the patient is admitted. This will require a permanent change in national regulations around the requirement, by Medical Examiners, to review the body of the deceased and also for access to Medical Record not held by the Trust to be available.

6.2 Certification and registration of a death

When a death occurs the consultant responsible for care (as either the "Attending Practitioner" or that doctor's supervisor) has a duty to decide whether the coroner needs to be informed and to oversee the process of completing the Medical Certificate of the Cause of Death (MCCD). The MCCD should be completed within 24 hours for all deaths as circumstances allow. The Medical Examiner can provide guidance.

Cremation forms Part 1 - for all deaths within the hospital Part 1 of the Cremation Form (Cremation form 4) should be completed by the medical practitioner who attended the deceased at the same time as the MCCD within 24 hours as circumstances allow.

In normal circumstances, there is an opportunity for the Medical Examiner to discuss with the bereaved family the cause of death and at this stage the family are asked whether they have any concerns about the care of the deceased patient. A second opportunity to

identify any concerns about care will arise in many cases when a second doctor completes the confirmatory (Part 2) medical certificate for cremation.

Cremation forms Part 2 - this section may only be completed by a registered practitioner of at least 5 years' standing who is not either a relative of the deceased, the medical practitioner who issued the part 1 (Cremation form 4) or a relative or a partner or a colleague in the same practice or clinical team as the medical practitioner who issued that certificate. The Trust's Medical Examiner will normally complete this function and will undertake proportionate scrutiny of the case. This will usually involve examination of recent medical records and a discussion with a doctor who attended the deceased. It may involve an external examination of the body or conversations with other people, depending on the case. In every case the medical examiner will try to contact a representative of the family to ask whether they understand the proposed cause of death and whether they have any concerns that might justify further investigation. If the medical examiner concludes that the proposed cause of death is incorrect, s/he will contact the attending doctor and require that a replacement certificate is produced and that the incorrect certificate is cancelled.

When the medical examiner is satisfied that a natural cause of death has been correctly identified to an acceptable level of confidence, and that there is nothing to suggest that investigation by the coroner is justified, he/she signs a form to that effect and sends it to the Registrar. The attending practitioner is asked to add the date of this confirmation to the MCCD, making the MCCD ready for registration of the death.

The 'prescribed information about the deceased', supplied by the Attending Practitioner, should include any information about hazards associated with the body of the deceased, such as infections or implants (the latter being potentially hazardous during cremation). If the medical examiner becomes aware of such a hazard there is a duty to inform those concerned, such as funeral directors and crematorium staff.

A representative of the family takes the certificate of the cause of death to the Registrar, to register the death. The registrar checks that the information on the MCCD and the medical examiner's confirmation is all congruent.

If at any point during this process the Medical Examiner forms the opinion that the death should be investigated by a coroner, the Medical Examiner process must be stopped and the Medical Examiner must provide details of the case to the appropriate senior coroner.

At the James Cook site, the bereaved family will normally attend the Bereavement Office to register the death and this provides a further opportunity for any concerns about care to be raised.

The UK government intends to continue to reform the process of death certification which they began with the non-statutory appointment of Medical Examiners, in NHS Trusts, in April 2019. The Trust will continue to implement national reforms as the statutory scheme is introduced by government.

Until the statutory reforms are implemented the Trusts Medical Examiner(s) will support clinical teams in their duties by advising on the completion of the Medical Certificate of Cause of Death (MCCD) which is needed in order for the registrar of births deaths and marriages to issue a death certificate, advising on cases that should be referred to the Coroner, reviewing the case records, speaking to bereaved families and staff and identifying cases that require stage two case record review or investigation. The Trust's

Medical Examiner and Bereavement Service has developed a process to inform bereaved families that the Trust reviews all deaths; that this does not mean that there has been a problem in care, but if a significant problem is identified that was not known about at the time of death that they can chose to be informed about this. Any family concerns and preferences about how much they would like to be involved in future will be recorded by the Bereavement Office team.

If any concerns are identified at any stage of the certification or registration process, Clinical Directorates need to inform the Medical Examiner or the Bereavement Office so that they are able to capture this on the Medical Examiner Database and to ensure that these deaths are referred to the Trust Mortality Review team for further review (see below).

Appendix A sets out the Standard Operation Procedure (SOP) for completion of Medical Death Certification and Cremation Forms.

6.3 Medical Examiner case record review

The Medical Examiner reviews case records as part of the process of either certifying a death or referring to the Coroner. Their review is recorded in the Trust's mortality system (Assure RCR). They will identify whether there is any reason to conduct a more in-depth second stage review or investigation. It is intended that all deaths that occur whilst a patient is in receipt of care from the Trust also receive a case record review from the specialty team responsible for their care at the time of death. In most cases, this will involve the wider specialty team, rather than just those directly responsible for the patient at the time of death. In many specialties (and all surgical specialties) the number of deaths is small and so cases can be discussed in a Mortality and Morbidity meeting. In medical specialties with larger numbers of death the case records should be reviewed briefly to see whether there is any reason why a more in-depth review would be potentially useful. The brief review should seek to identify any areas where there could be a problem in the care of the patient, such as a fall, potentially hospital-acquired infection, acute kidney injury, blood clot or other adverse event, problems in the recognition of deterioration, or in the care delivered as part of the end of life process (this list is indicative, it is not intended to be exhaustive – clinical judgement will always be required to identify when a more in-depth review would be potentially helpful). Details of the review should be recorded in the Trust's case record review system (see below). Wherever possible reviews should include completion of the preventability grading scale. Only in cases with in-depth review should the reviewer judge whether it is more likely than not (ie greater than 50:50 chance) that the death could have been prevented.

6.4 Trust Mortality Review

An in-depth review of the notes will be carried out by the Trust Mortality Review team (and be identified for priority review in Centre or Specialty Mortality and Morbidity meetings) when:

- Any concerns have been raised by the Medical Examiner review of case notes
- Any concerns have been raised by the bereaved family
- Any concerns have been raised by staff involved in the patients care
- Any death where any incident was reported during the patients stay (see section on investigations below)
- A specialty review suggests a more in-depth review by the central team may be helpful or where the death is judged by the specialty team to have greater than 50:50 chance of being preventable.

- Death within 30 days of a procedure in theatres (a process for identifying this group is run by the Anaesthetists)
- A patient has a Learning Disability (in-line with the national LeDeR process, detailed in Appendix Y)
- A patient has a severe mental illness (patients are identified by the Mortality Surveillance team)
- Deaths in patients aged between the ages of 18 and 50.
- Any mortality alert from Care Quality Commission, via benchmarking systems including the HED system (for SHMI and HSMR) or the CRAB Clinical Informatics system (any death identified with 4 or more medical triggers are reviewed).

Maternal and neonatal deaths are reviewed in a robust process detailed elsewhere, as are deaths in children and young people. There is a section later in this policy concerned with cross-system reviews and investigations.

6.5 The Trust's case record review system: Assure RCR

The Trust is using a secure, on-line database (called Assure RCR) to facilitate the process of case record review. This system was developed with the help of colleagues across the region and with funding from the Academic Health Science Network for the North East and North Cumbria. The system is linked to the CaMIS system so that the Trust can reliably identify all deaths of patients in its care. The Information department regularly (currently on a daily basis) interrogates the Spine (the NHS central information system) to ensure that patients who have received care from the trusts but have died elsewhere are identified. As review systems develop more of these deaths, particularly those within 30 days of discharge from the Trust, can be included in the review process. The database allows deaths to be allocated (and re-allocated where necessary) to clinical specialties for review and to clinical specialties and/or the Trust Mortality Review team as appropriate. The link to CaMIS also allows basic factual information about a patient to be pre-populated into the review, saving time for clinical reviewers. The system records reviewers' judgements of the preventability of deaths (as required for publication – see section on Mortality Surveillance Team) and qualitative elements of the review that are suitable for identifying problems in care and opportunities for improving care. All case record reviews will, in time, need to be recorded in the system. The process for accessing the system is managed by the Mortality Surveillance Team (see Appendix F).

6.6 Investigations

All deaths are cross referenced, by the Mortality Surveillance Team to the Trust's incident and complaints reporting system (Datix) to identify any death in which an incident was reported during the patient's hospital stay. Where an incident has been recorded, a Trust Mortality Review will be carried out in order to judge whether the incident was part of a problem in care that contributed to the patient's demise.

Case record review is not a replacement for investigation, which includes root cause analysis (RCA). RCA involves reviews of case records reviews but goes beyond this by utilising other evidence (see definitions section) including discussions with staff. Second stage case record reviews may identify the need for incident reporting and subsequent investigation, in line with CG60 Incident Reporting and Investigation Policy which describes the different levels of investigation appropriate to the different levels of risk identified using the Datix Risk Scoring System (see Appendix 5 of CG60).

6.7 Cross-system Reviews and Investigations

In many circumstances organisations other than the Trust are involved in the care of a patient who dies whilst in the care of the Trust, with the most common ones being primary

care, ambulance services, other acute Trusts and mental health services. In the past, case record review has largely been restricted to review of records held by the Trust however it is sometimes possible to identify problems in care at earlier stages of care. Where this is the case, in the last few years, it has been possible to ask for reviews to be carried out by other organisations, however this has largely been restricted to other acute Trusts and the National Quality Board's regulations make it clear that the NHS needs to substantially strengthen arrangements. As these arrangements come into place, it is expected that Trust staff will engage with cross-system reviews and investigations as required.

6.8 Duty of Candour

In most cases, problems of care are known to the team managing the care of a patient at the time of their death and suitable discussions have been held with the bereaved family at the time. However case record review or investigation can identify problems that were not known about at the time and where it would be appropriate to inform families.

6.9 Learning from deaths

The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon. It is beyond the scope of this policy to outline all the organisational and educational mechanisms that can be employed to do this. However, it is clear that case record reviews and investigations must include summaries of the lessons that need to be learnt and disseminated. The Trust will collate themes and report on action taken as a result.

6.10 Governance and Accountability arrangements

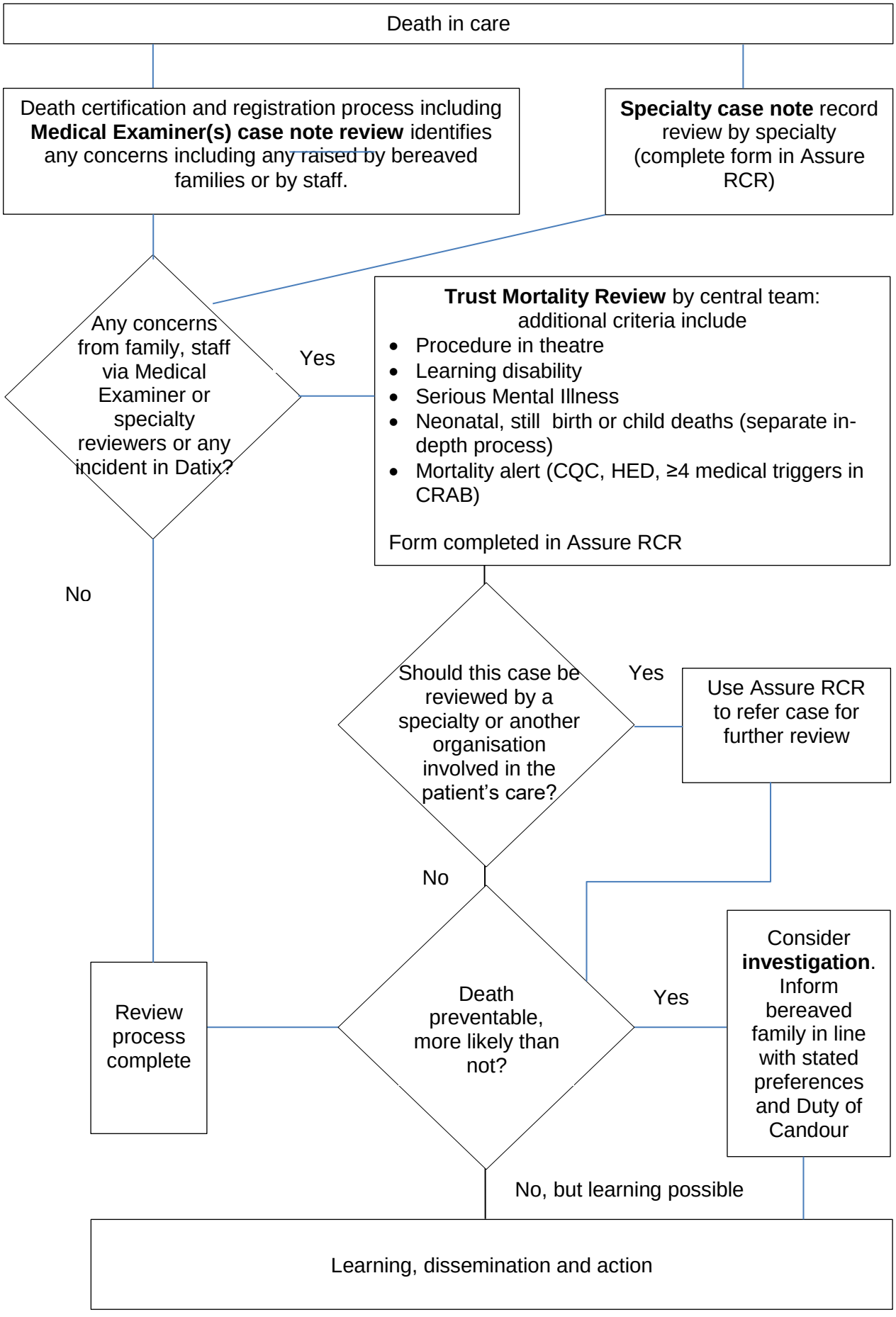
Board Leadership will be provided by a Non-Executive Director and the Medical Director, with support from the Director of Nursing.

The public section of the Trust Board receive a quarterly report detailing the implementation of this policy in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge. Specifically, the paper includes a dashboard, based on the requirements set out by the National Quality Board regulations, detailing for the previous year and quarter, the number of deaths, the proportion reviewed and the percentage where a problem in care was identified and where reviewers judged that the death had a greater than 50/50 chance of being preventable. Patients with Learning Disabilities and patients with severe mental illness who die are reported separately from other deaths.

All aspects of the Trust's approach to learning from deaths are overseen by the Patient Safety Sub Group to the Quality Assurance Committee of the Board.

The annual Quality Account, from July 2018, contains a section reporting how the Trust ensures that learning from reviews and investigations is acted on to sustainable change clinical and organisational practice and improve care.

Summary of Process



7 Associated Policies

G36	Handling and Caring of the Deceased Patient Policy
G29	Mortuary Policy
CG39	Do not attempt cardiopulmonary resuscitation: DNACPR (Adults) policy
CG49	Post-Mortem consent and the retention and disposal of tissues and organs thereafter policy
CG56	Advance decisions (living wills) policy
CG60	Incident Reporting and Investigation Policy
G140	Care in the last days of life & after death (Adult) policy
G154	Nurse verification of expected death policy

References

CQC Learning, Candour and Accountability: http://www.cqc.org.uk/content/learning-candour-and-accountability

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

National reporting dashboard: https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-learning-from-deaths-dashboard.xlsx

Reforming death certification: Introducing scrutiny by Medical Examiners
Lessons from the pilots of the reforms set out in the Coroners and Justice Act 2009

Appendix A

STANDARD OPERATING PROCEDURE (SOP)

Clinical Diagnostic and Support Services

Completion of Medical Death Certificates and Cremation forms

MANDATORY

SOP NUMBER: **DATE:**
(Trust-wide(TW)
AUTHOR: **Jacqui Richards/Paula Taggart** **REVIEW DATE: May 2018**

MANDATORY	
OBJECTIVES	Timely completion of Medical Certificate of Cause of Death (MCCD, death certificate) and part one of Cremation forms to enable body release from the mortuary. To create capacity within the mortuary. To ensure that family can register deaths within the required legal time frame of 5 days.
SCOPE	To ensure that all medical death certificates and cremation forms are provided swiftly to enable the bereaved family to register the death within the required legal timeframe and that funeral arrangements can proceed.
TARGET GROUP	All Medical staff completing Medical Certificate of Cause of Death and part one and part two of the cremation forms

SEQUENCE OF CLINICAL PROCEDURE	**RATIONALE / ADDITIONAL INFORMATION**
1) Where the cause of death is known a **medical certificate of cause of death (MCCD)** is issued by the medical practitioner attending during the last illness of the patient. If the medical practitioner did not attend the deceased during his or her last illness they ***must not*** complete the death certificate.	Prompt and accurate certification of death is essential. It provides legal evidence of the fact and the cause(s) of death, thus enabling the death to be formally registered.
2) The **medical certificate of cause of death** should be completed within **24 hours** for all deaths as circumstances allow.	Reducing delay and distress to the bereaved family
3) When the cause of death is not known or the death is reportable to the coroner. The coroner's officer should be contacted as soon as possible. There is a coroner's officer on call 7 days a week	This is a statutory duty for the medical practitioner
4) **Cremation forms Part 1** - for all deaths within	It is a statutory requirement for this

the hospital Part 1 of the Cremation Form (Cremation form 4) should be completed by the medical practitioner who attended the deceased at the **same** time as the medical death certificate within **24 hours** as circumstances allow.	certificate to be completed before a cremation can take place – delay in completion of cremations forms delays funerals from taking place. Whilst it is recognised that not all funeral arrangements will be cremations, the majority are, and the prompt completion of part 1 at the same time as the death certificate minimises hold ups further along the process
5) The **medical certificate of cause of death (MCCD) and the cremation form** will be collected from the ward by the bereavement team	There is a central point for co-ordination
6) JCUH - The relatives will then be offered the opportunity to make an appointment to come to the bereavement service in order to collect the Medical certificate of Cause of Death (MCCD) , collect any remaining property and then to register the death with the on- site registrar.	The bereavement service offer comprehensive support to families during this process
7) Once the wishes of the relatives are known as to cremation or burial the bereavement team will, for cremations, contact the ward to arrange for part 2 of the cremation form to be completed, for burials the ward will be informed and the Part 1 of the cremation form destroyed as it is no longer required.	Bereavement Services can arrange for a medical practitioner meeting the above criteria to complete the part 2 or the doctor completing the part 1 can arrange this himself with a colleague
8) Cremation forms Part 2- this section may only be completed by a registered practitioner of at least 5 years' standing who is not either a relative of the deceased, the medical practitioner who issued the part 1 (Cremation form 4) or a relative or a partner or a colleague in the same practice or clinical team as the medical practitioner who issued that certificate.	It is a statutory requirement for this certificate to be completed before a cremation can take place – delay in completion of cremations forms delays funerals from taking place.
9) The bereavement team will ensure the completed cremation form should be sent to the mortuary. The form can be left in the mortuary by the medical practitioner completing part 2 or the form will be collected from the ward by the mortuary team	It is suggested that the medical practitioner attend the mortuary to complete section 6 – Once all other sections are fully completed cremation form can be left in the mortuary.
10) FHN - the arrangements for collection of the medical certificate of cause of death by the family and the completion of the cremation form are the responsibility of each individual ward. If the certificate is not available immediately families should be advised to telephone the ward the day following the death to arrange collection of the death certificate and any remaining belongings 11) PCH's- the arrangements for collection of the medical certificate of cause of death by the family are the responsibility of each individual ward. If the certificate is not available	

immediately families should be advised to telephone the ward the day following the death to arrange collection of the death certificate and any remaining belongings. Completion of cremation forms should be discussed with the Mortuary at JCUH	
VERSION:	

MANDATORY		
Developed By:	**AUTHOR TITLE (NAME)**	**JOB TITLE**
	Jacqui Richards/Paula Taggart	
	APPROVAL GROUP NAME	**DATE**
Approved By:	Operational Management Board	

Appendix B

Responding to the death of an individual with a Learning Disability: using the LeDeR process

The Trust follows the national LeDeR process:

http://www.bristol.ac.uk/sps/leder/

For further information please contact Tony Roberts, Deputy Director (Clinical Effectiveness) t.roberts@nhs.net

Appendix C

Responding to the death of an individual with Mental Health Needs

Patients are identified by the Mortality Surveillance Team for Trust Mortality Review.

For further information please contact Tony Roberts, Deputy Director (Clinical Effectiveness) t.roberts@nhs.net

Appendix D

Responding to the death of an infant or child

Infant or child (under 18) death reviews should be undertaken in accordance with national guidance, Working Together to Safeguard Children. The Department for Education's 'Form C' should be used as a reporting template. This includes the small number of children who die on adult wards.

The Department of Health, Department for Education and NHS England are currently developing new national guidance on reviewing child deaths, and will publish this towards the end of 2017.

A collaboration led by MBRRACE-UK has been appointed by the Healthcare Quality Improvement Partnership (**HQIP**) to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'. The PMRT, which is currently being developed, will be piloted over summer 2017 with the roll-out planned by the end of the year. Funded by the Department of Health (England) and the Scottish and Welsh Governments, he tool will be free to all NHS maternity and neonatal units in England, Wales and Scotland.

The PMRT tool will be wholly integrated within the **MBRRACE-UK** programme of work.

The PMRT is being designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

https://www.npeu.ox.ac.uk/pmrt/programme

For further information please contact Tony Roberts, Deputy Director (Clinical Effectiveness) t.roberts@nhs.net

Appendix E

Responding to a stillbirth or maternal death

The Trust has a robust process in relation to responding to stillbirths or maternal deaths. Links will be made to the written policies in this area in due course.

For further information please contact Tony Roberts, Deputy Director (Clinical Effectiveness) t.roberts@nhs.net

Appendix F

Accessing the Trust mortality review system

The Trust maintains a centralised secure, on-line system for recording case record reviews. The system is called Assure RCR and is provided by Clarity Informatics Ltd.

The system is used by the Mortality Surveillance Team and the Trust has made the system available to specialties for recording their reviews. Over time, all specialties will move to this system.

To gain a login and secure access to the system please contact j.raine@nhs.net

For further information please contact Tony Roberts, Deputy Director (Clinical Effectiveness) t.roberts@nhs.net

Appendix G

Policy checklist from Appendix C of National Guidance:

Annex C - Responding to Deaths
Trusts should have a policy in place that sets out how they respond to the deaths of patients who die under their management and care.

POLICY FOR RESPONDING TO DEATHS - KEY POINTS

The policy should include how providers:
• **determine which patients are considered to be under their care and included for case record review if they die** (it should also state which patients are specifically excluded);

• **report the death within the organisation and to other organisations who may have an interest** (including the deceased person's GP), including how they determine which other organisations should be informed;

• **respond to the death of an individual with a learning disability** (Annex D) or **mental health needs** (Annex E), **an infant or child death** (Annex F) **and a stillbirth or maternal death** (Annex G) and the provider's processes to support such deaths;

• **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**;

• **review the care provided to patients whose death may have been expected**, for example those receiving end of life care;

• **record the outcome of their decision whether or not to review or investigate the death**, which should have been informed by the views of bereaved families and carers;

• **engage meaningfully and compassionately with bereaved families and carers** - this should include informing the family/carers if the provider intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that they wish to be involved. Initial contact with families/carers are often managed by the clinicians responsible for the care of the patient. Given that providers must offer families/carers the opportunity to express concerns about the care given to patients who have died, then the involvement of clinicians who cared for the patient may be considered a barrier to raising concerns. Providers should therefore offer other routes for doing this;

• **offer guidance, where appropriate, on obtaining legal advice for families**