East London NHS Foundation Trust

REPORT TO THE TRUST BOARD - PART 1
26 MARCH 2020

Title	Learning from Deaths Review Q3 October 2019 – December 2019
Author	Kim MacGillivray, Mortality Reviewer Abiola Ajayi-Obe, Associate Director Risk and Governance
Accountable Executive Director	Dr Paul Gilluley, Chief Medical Officer

Purpose of the Report:

This report covers the three month period from 1st October 2019 until 31st December 2019 (Q3) and provides:

- An analysis of service user deaths including expected and unexpected deaths, and coroner's inquests;
- Overview of the findings;
- Key themes from learning including triangulation of learning;
- Actions being taken to address the learning.

Summary of Key Issues:

The Trust reported a total of 569 deaths between 1st October 2019 and 31st December 2019.

A total of 464 expected deaths were reported in Q3, there were a total of 105 unexpected deaths as of 31st December 2019.

36 inquests were concluded within the period 1st October 2019 - 31st December 2019.

The 178 expected deaths subject to a Structured Judgement Review (SJR) in Q3 relate mainly to patients in the 66-100 years of age group. Overall, mortalities among males across the Trust was higher than for females.

Cancer was the most common cause of death in both males and females across the Trust.

Work had been developed by the Mortality Reviewer for Q3, gathering data which looked at patients on Gold Standard Framework (GSF) Pathway's. All of the patients on a GSF End of Life Pathway were cared for and died in their preferred place of care (PPC) and death (PPD).

During this period there was a total of 7 LeDeR reportable deaths across ELFT in Q3. Of these:

- 4 in Community Health Services;
- 1 in Beds and Luton LD service;
- 1 in Specialist Services across the Trust (CAMHs);
- 1 in Tower Hamlets LD Service.

There were no completed LeDeR investigation reports received during this period. All of the reported deaths are presently under investigation.

There were 105 unexpected deaths for the reporting period, 13 of which were investigated as Serious Incident Reviews. Of these, there were a total of 7 suspected suicides (this will be confirmed following the completion of a Coroner's inquest into these deaths). Suspected suicides at 54% is the highest cause of death category. Three main areas of completed SI in unexpected deaths for learning are:

- Sub optimal identification of deteriorating patients and failure to escalate physical health check findings;
- Poor communications;
- Poor compliance with policy requirements.

There were a total of 36 inquests concluded within Q. There were 10 verdicts of suicide and 5 narrative verdicts. The main lessons learnt from these verdicts were:

- Procedure/ protocol not followed (referrals);
- Poor record keeping;
- Delay/ Lack of communication between CMHT and GP;
- Poor communication between teams/clinicians;
- Lack of assessment/ assessments not being undertaken in a timely manner;
- Actions not being discussed during/ actions not being carried out following MDT meetings;
- Key individuals not invited to meetings.

Triangulating these themes will be conducted within the Trust's Risk and Governance Networks to ensure learning is shared across the Trust:

- Increase compliance with follow up protocols;
- Improve communications within in and out with the organisation.

Strategic priorities this paper supports (Please check box including brief statement)

Improved patient experience	☒	The purpose of this report is to update the Board on patient deaths and lessons learnt to improve the patients' safety.
Improved health of the communities we serve	☒	Summarises the investigations where the aim is to learn lessons to improve the health of the communities we serve.
Improved staff experience	☒	The purpose of this report is to update the Board on patients' death and lessons learnt by staff to improve their working experience.
Improved value for money	☒	Through full investigation of these incidents we aim to improve the quality of care we provide including improving efficiencies and providing value for money.

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
25/02/2020	Learning from Deaths Panel Meeting

Implications

Equality Analysis	The report does not include an equality analysis.
Risk and Assurance	Monitoring and understanding mortality and learning from deaths provides assurance that there is a robust approach to mortality.
Service User/Carer/Staff	The process for analysing and investigating deaths ensures that learning and improvement takes place, positively impacting on service users, carers and families.
Financial	There are financial implications associated with mortality reviews. NHS Quality Board national guidance requires case note review of mortality to be routinely undertaken.
Quality	The themes arising from serious incidents and the work being done to address them have clear quality implications and act as drivers for improvement.

Supporting Documents and Research material

1. Mortality Dashboard
2. The NHS Quality Board framework

Glossary

Abbreviation	**In full**
Datix	Trust incidents and complaints reporting and management system
RiO	Patient information recording system, ELFT Mental Health
EMIS	Patient information recording system, ELFT Community Health
SystmOne	Patient information recording system, Bedfordshire Community Health
ELFT	East London NHS Foundation Trust
HSMR	Hospital Standardized Mortality Ratio
LeDeR	Learning Disabilities Mortality Review
SJR	Structured Judgement Reviews
EoL	End of Life pathway
PPC	Preferred Place of Care
DNAR	Do not attempt resuscitation
StEIS	Strategic Executive Information System
CVA	Cerebrovascular Accident
CNS	Central Nervous System
BNF	British National Formulary

1.0 Background/Introduction

1.0 The report will provide an analysis of service user deaths over the three month period 1st October 2019 till 31st December 2019 (Q3).

1.1 Reported deaths are divided into expected and unexpected deaths.

1.2 Expected deaths are dealt with through the mortality review process. 100% of those deaths where the service user is being managed by ELFT services at the time of their death are reviewed using a Structured Judgement Review (SJR) tool. 25% of expected deaths which take place in hospital or in care/nursing home are also reviewed using SJR tool.

1.3 Unexpected deaths, where appropriate, will usually be dealt with through formal investigation processes and Serious Incident Reviews. The outcomes and recommendations of these reports are then reviewed as themes from which the organisation can learn from.

1.4 There is a summary of the Coroner's hearings of service users that took place in this quarter and a review of the themes of the outcomes of these.

2.0 Presentation and Analysis of Mortality Data for Q3

2.1 The total number of patients who died Trust-wide in Q3 was 569. 464 were expected deaths and 105 were unexpected deaths.

3.0 Summary of deaths and scope of review: Q3

3.1 100% of reported expected deaths where ELFT was managing care were reviewed under the SJR process. 25% of the deaths where care was not being managed by ELFT, or where the patient died in hospital or in a care home were also reviewed.

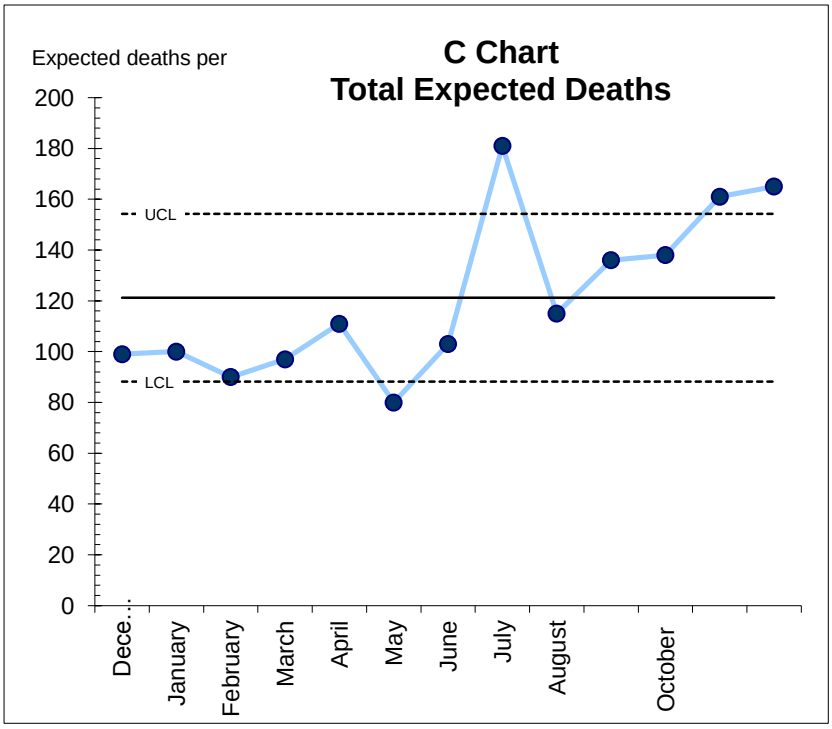
3.2 SJRs have been conducted using patient information (recording) systems: EMIS; RiO; SystmOne and the Incident Reporting System DATIX. The SJRs look at the six months of case notes prior to the patient's death.

3.3 All unexpected deaths are not necessarily reviewed via the Serious Incident Review process as they may not meet the threshold for an SI investigation. *An SI Review is required when the cause of death is related to severe harm, is unknown and / or the potential for learning is so great or the consequences to patients, families and carers or staff or organisations that these incidents require a formal investigation.* (NHSE SI Framework 2015)

3.4 The overall data reported runs from December 1st 2018 until December 31st 2019. The presentation of data during this period has been with the use of Control Charts. Mortality data collection has been continuous over 2018 and 2019.

4.0 Expected Deaths between 1st October and 31st December 2019 against population

C Chart (Trust Wide) rate 100,000 population



2018 - 2019	Expected deaths	population
December	99	1,659,900
January	100	1,659,900
February	90	1,659,900
March	97	1,659,900
April	111	1,659,900
May	80	1,659,900
June	103	1,659,900
July	181	1,659,900
August	115	1,659,900
September	136	1,659,900
October	138	1,659,900
November	161	1,659,900
December	165	1,659,900

4.1 The baseline for the report is from December 2018 until 30 September 2019. The mean for this period is 6.4 deaths per 100,000 populations. The data reported for Q3 is from October 2019 to December 2019.

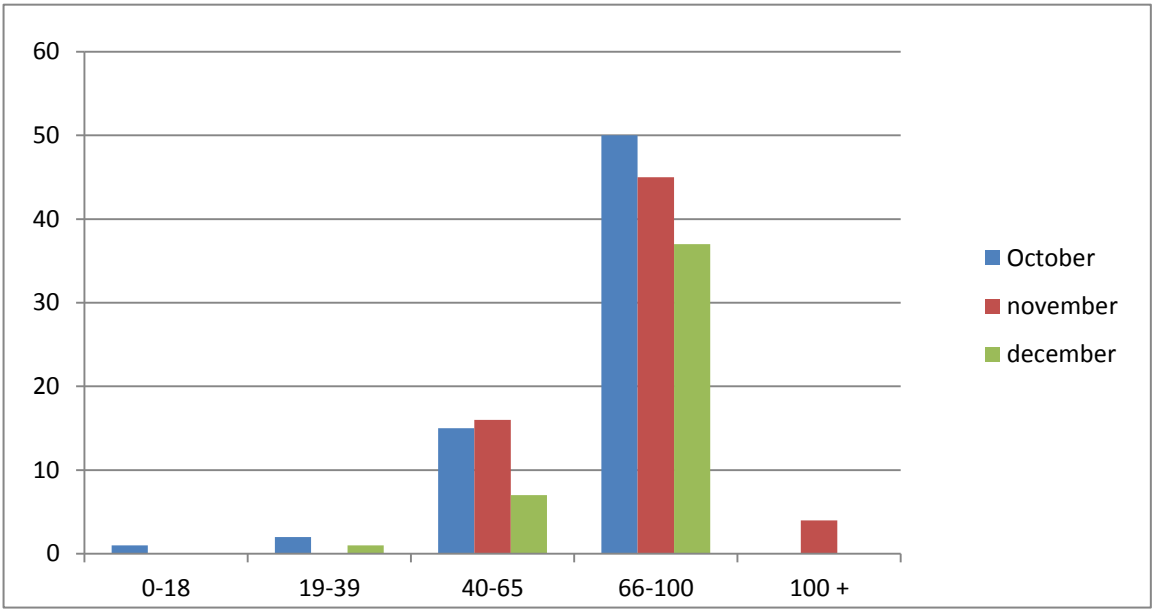
4.2 Expected deaths showed steady increases in October, November and December 2019. The increase over this 3 month period was due to podiatry and foot health services reporting mortalities figures when updating case records; Additionally, Newham Community Health Services reported deaths that had previously been unreported.

5.0 Structured Judgement Reviews

5.1 Of the 464 expected deaths which occurred in Q3, all 120 (expected) deaths of patients who were under the care of the Community Health Services at the time of their deaths were reviewed under the SJR process. There were 58 patients who died expectedly in a hospital/care home and whose care was not being managed by ELFT but who were also reviewed via the SJR process, this is due to the Trust being required to complete 25% of SJR where care is not managed by ELFT. Resulting in a total of 178 SJR's of expected deaths which were completed.

5.2 **Age Ranges between 1st October 2019 and 31st December 2019**

Column Chart (Trust Wide) rate 100,000 population



5.3 The chart accounts for the ages of the 178 deaths reviewed via the SJR process.

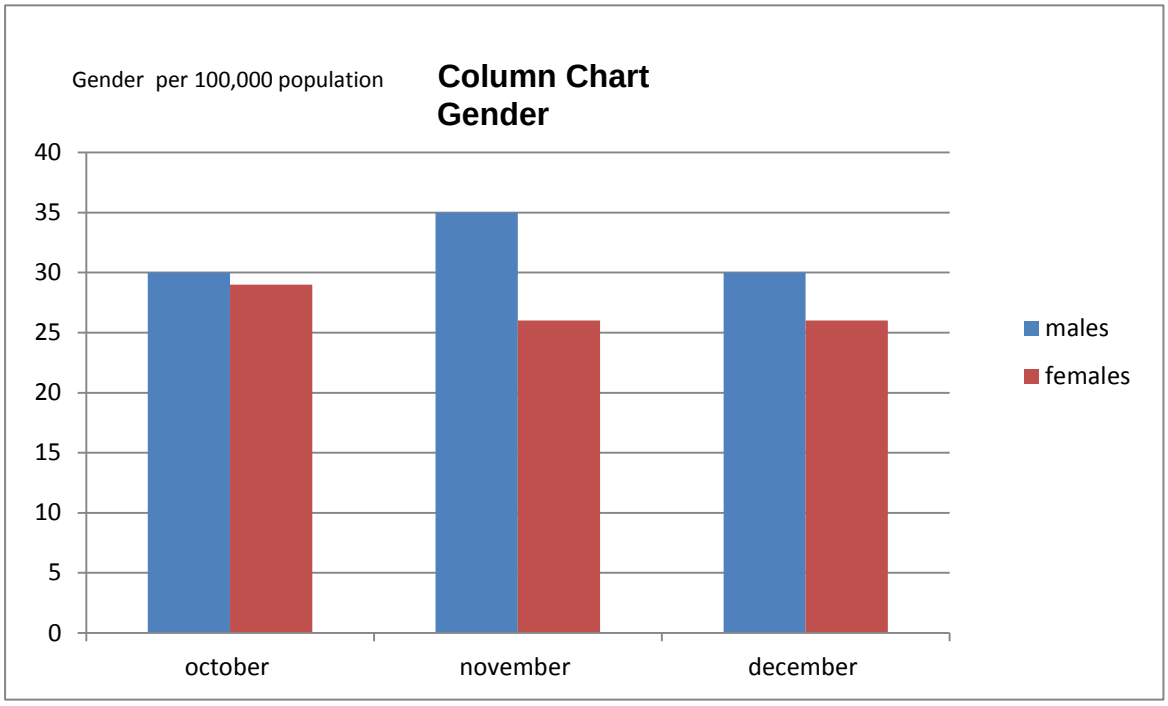
5.4 74.1% (132) of the total 178 deaths reviewed occurred in the 66-100 years age group.

5.5 In November 2019 a 101 year old male died in hospital from prostate cancer. The service user was not on an End of Life Plan until he was admitted to hospital and was given a diagnosis.

5.6 A five year old female died in hospital with a diagnosis of Sandhoff's Disease and a neurometabolic condition.

5.7 **Mortalities by Gender between 1st October to 31st December 2019**

Column Chart (Trust Wide) rate 100,000 population



5.8 A total of 81 female deaths and 95 male deaths were reviewed in Q3. Male mortalities were higher than females in Q3 and the highest number was in November 2019 with 36.8% (35) of the total 95 male deaths reviewed.

5.9 **Causes of Death**

5.9.1 Cancer was the highest cause of death (CoD) throughout October, November and December 2019. Cancer was the highest CoD in all age groups and in both males and females, accounting for 46% (82) of the total reviewed mortalities. One patient died at the age of 56 from b-cell lymphoma developing into septic shock.

5.10 Findings from Expected Deaths

5.10.1 All cases reviewed in Q3 showed good standards of care delivery. A total of 164 patients (92.1%) had a Gold Standard Framework plan of care. The remaining 14 (7.9%) patients had insufficient information on Datix; RiO; EMIS or SystmOne. These patients were either on palliative care, where death was premature and an End of Life care plan had not been created; 0had been admitted to a care home or hospital and died, or had been referred to the Trust but died before being discharged from hospital.

5.10.2 The Trust aims to ensure that all patients who are involved in Gold Standards Framework and End of Life Pathways have their preferred place of care (PPC) and death (PPD) recorded. During Q3, all (100%) of the 164 patients receiving a Gold Standard Framework were cared for and died in their PPD.

5.10.3 Do Not Attempt Resuscitation (DNAR) was in place for all the patients that were on an End of Life Pathway. One patient had requested that he be resuscitated and taken to a hospice or hospital if he required Cardiopulmonary Resuscitation (CPR). This did not happen as he suffered a cardiac arrest and after discussion with his family it was decided that it would not have been in his best interest to attempt resuscitation.

5.10.4 127 (77.4%) patients from the total 164 with a GSF were cared for and died with family or carer involvement. The same number had family members or their carers present at the time of death. The 37 patients where family members or carers were not involved either had no traceable relatives or they had not yet been seen by the Trust.

6.0 Learning Disability Deaths

6.1 During this period there was a total of 7 LeDeR reportable deaths across ELFT in Q3. Of these:

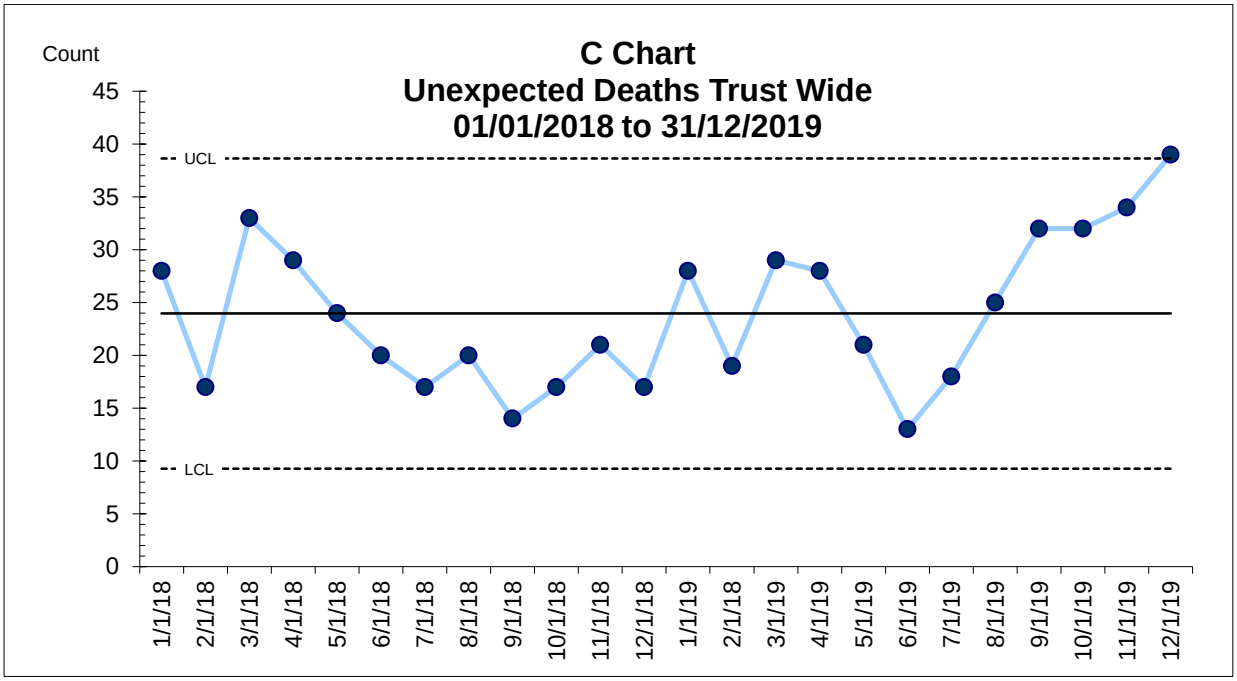
- 4 in Community Health Services;
- 1 in Beds and Luton LD service;
- 1 in Specialist Services across the Trust (CAMHs);
- 1 in Tower Hamlets LD Service.

6.2 There were no completed LeDeR investigation reports received during this period. All of the reported deaths are presently under investigation.

7.0 Unexpected Deaths between 1st October 2019 and 31st December 2019

7.1 The chart for Unexpected Deaths shows data for Q3 from 1st October 2019 until 31st December 2019.

C Chart (Trust-wide) Unexpected Deaths

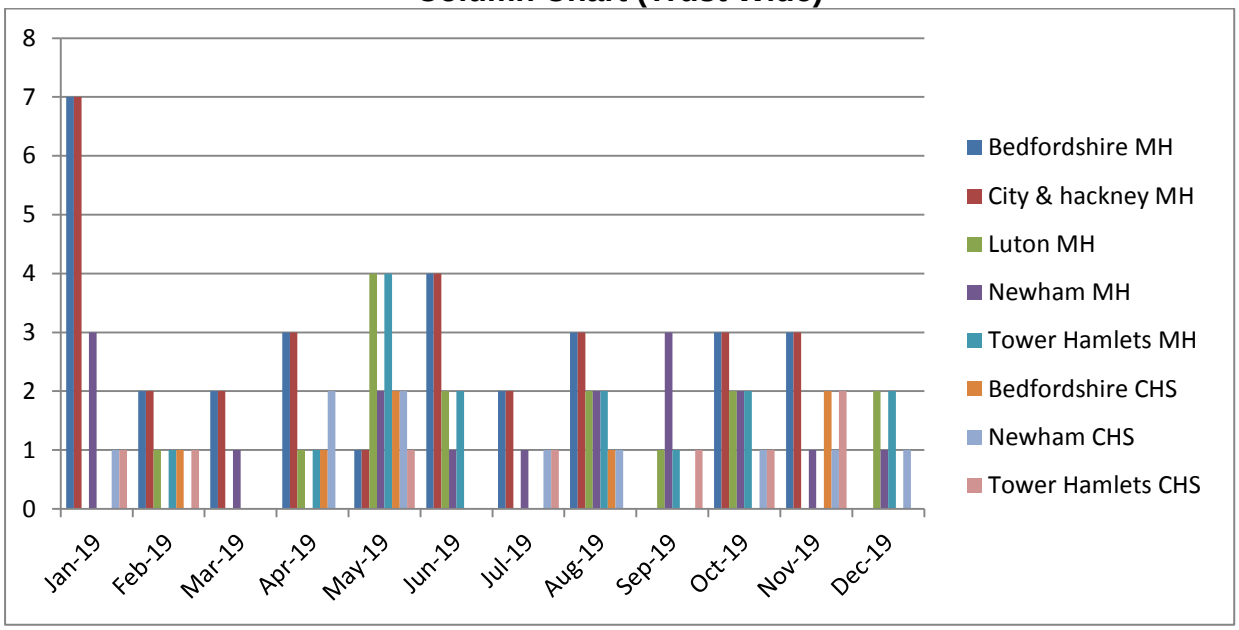


7.2 The baseline for reporting is from January 2018 until January 2019. The mean for this period is 19.9. Q3 data runs from October 2019 until December 2019

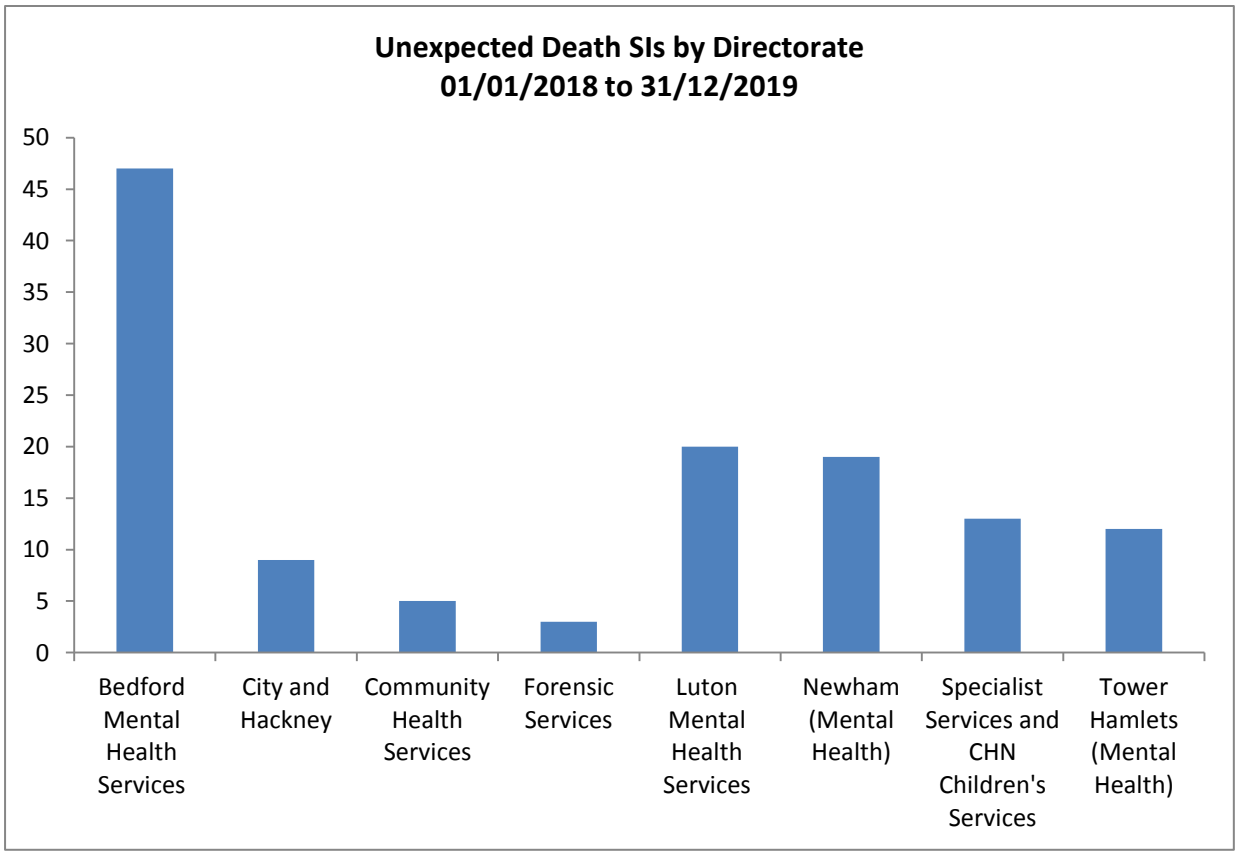
7.3 During Q3 there was an increase in the number of unexpected deaths which were reported on Datix. This is explained by the new categorisation of deaths introduced in September 2019 providing for reporters to record deaths with more accuracy. Previous to September 2019, some cases were recorded as unexpected but with the cause known, where the patient may have been on palliative care and died outside the expected timeframe.

Serious Incidents by Directorate from January 2019 - December 2019

Column Chart (Trust Wide)



Unexpected Deaths by Directorate from January 2019 - December 2019



7.4 There were a total of 105 unexpected deaths which occurred during the Q3 reporting period, of which 13 were ELFT patient safety related unexpected deaths.

7.5 Notably, not all deaths which are reported on the Trust's Incident Reporting system, Datix, have occurred as a result of Trust-related patient safety incidents. However, for completeness, particularly in the case of Community Health Services - all deaths are reported on Datix by Community Staff, to ensure the closing down of patient records and for learning purposes.

7.6 **Q3 Thematic Review of Unexpected Deaths**

7.6.1 Of the unexpected deaths for the reporting period, there were a total of seven suspected suicides (this will be confirmed following the completion of a Coroner's inquest into these deaths).

7.6.2 The completed SI Reviews into unexpected deaths, which have occurred during this reporting period, have indicated the following themes:

- Sub optimal levels of understanding regarding when physical health checks findings should be escalated or recognising a deteriorating patient and accurately recording baseline observations;
- Poor quality communications relating to; handover records / patient documentation / mental state assessments, safety huddles, levels of risk and management plans;
- Poor compliance with policy requirements including the use of the Dual Diagnosis Policy and the Care Programme Approach Policy, which has been identified within the community teams, particularly regarding discharge and transfer where no risk assessment, recovery plan or agreed discussion with patient and/or family about follow-up plans prior to or at time of discharge.

7.6.3 One of the issues noted and discussed has been the communication between organisations on who is responsible for a service user's needs. Disputes between Mental Health Trusts or lack of communication had led to service users not receiving the care they required. This has contributed to negative outcomes in some of the cases investigated. This has been addressed through an agreement between ELFT and NELFT which now not only covers inpatient but also covers community service users. This is consistent with the Mental Health Compact agreement which has come into force across London. Within ELFT, staff are aware at times of crisis the priority has to be given to the treatment of the service users rather than a dispute on responsibility between Trusts.

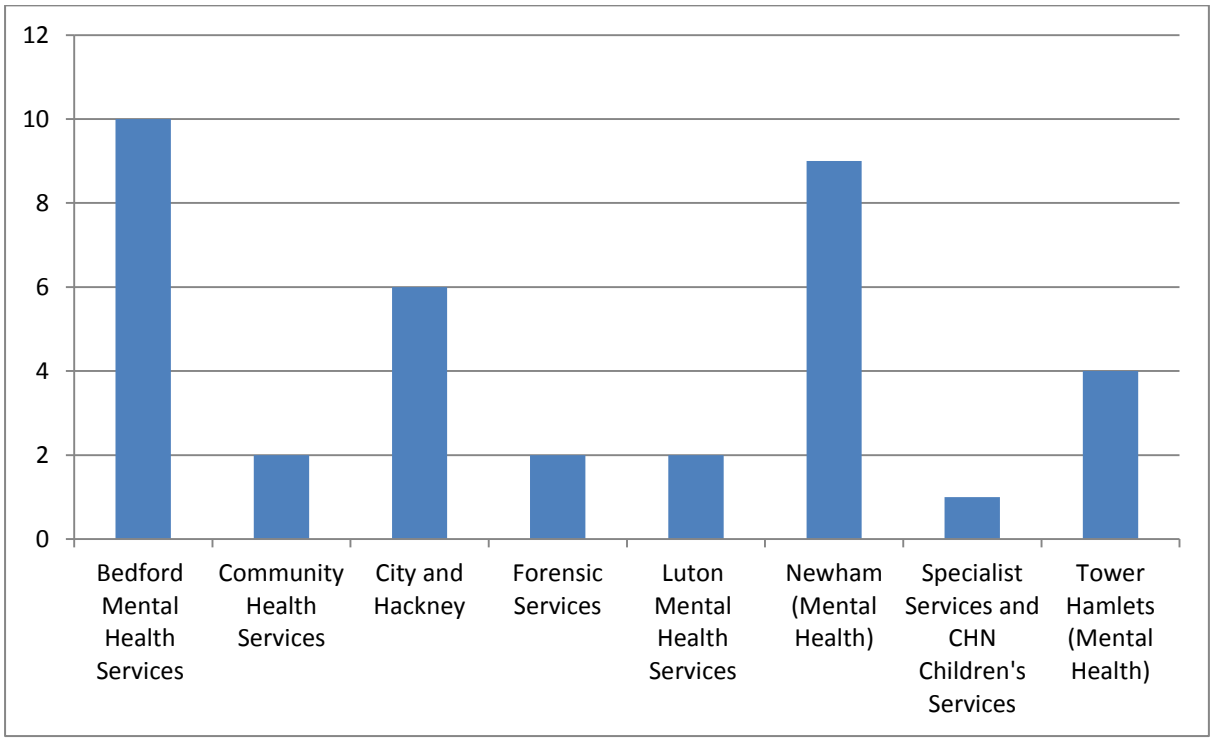
7.6.4 Observations has also been noted to be a theme in SI reviews. It was noted more work is required with clinical staff on the purpose of observations, whilst respecting the service user's right for privacy and dignity.

7.6.5 These findings have been identified together with mechanisms, for them to be addressed in completed SI Reviews. These will be followed up via monitored

Action Plans and also at Risk and Governance Directorate reviews via rolling SI Review implementation programmes to be agreed with the Risk and Governance department commencing from March 2020.

8.0 Quarter 3 Inquests

8.1 36 inquests were concluded within the period 1 October 19 – 31 December 19. The graph below shows the number of Inquests by Directorate:



8.2 Coroner's conclusions

8.2.1 The table below provides details of the Conclusions returned by the Coroner:

Short Form Conclusions:	
Accident	6
Alcohol/Drug Related	1
Drug Related	5
Alcohol Related	2
Natural Causes	2
Open	5
Suicide	10
Narrative Conclusions:	5
"The [Deceased] died from a combination of two terminal conditions, together with an excess of morphine. She was in pain and she had used non prescribed and prescribed drugs for recreational purposes for most of her adult life - her intention in taking the morphine was not to end her life."	

"The [Deceased] died in his cell F1-21 at HM Prison Pentonville, between the hours of 11pm on 28 November 2018 and 1.05am in the morning of 29 November 2018. We (the jury) find the cause of death was suicide by hanging. A contributory factor to his death by suicide was his chronic depression.	
"The Deceased jumped to her death from the top floor of a multi-storey car-park whilst receiving treatment for a mental disorder under S3 Mental Health Act 1983 and shortly after she had been informed that she was to be discharged from the Crisis Team's services. It is probable that the management and communication of this discharge contributed to her death."	
The Decease died from a fatal dose of sodium nitrate; although this was procured by the Deceased and self-administered, her intentions in doing so were unclear.	
"The [Deceased] suffered from emotionally unstable personality disorder; anxiety; depression and mood congruent psychosis. Her mental state had been deteriorating over the ten months leading up to her death. Her presentation was characterized by overwhelming voices telling [deceased] to harm herself. The [deceased] was under the mental health services throughout this period of time, but no overarching care plan was in place and she had no keyworker assigned to her. There was no assigned member of the mental health team with responsibility to ensure that [deceased's] care plan was actioned. The [deceased] was deemed to be at moderate to high risk of suicide in early January 2018. It was considered that her anti-psychotic medication needed to be changed as a priority. The change of medication was not communicated to the GP and no steps were taken to ensure that the medication change took place. On Friday 2 February 2018, the [deceased] presented to the mental health team, after taking an overdose of medication and self-harming by cutting. She was deemed to be a low risk of suicide by the assessing nurses and discharged home with no mental health support offered over the weekend. On Saturday 3 February 2018 the [deceased] ingested a fatal combination of alcohol and tablets. The [deceased] took the action that led to her death. Her intention at the time of this action is unknown due to the effect of the overwhelming voices upon her ability to form an intention.	

8.3 **Themes**

8.3.1 A review of all Inquests concluded in the quarter has been undertaken and the following themes identified:

- Procedure/ protocol not followed (referrals);
- Poor record keeping;
- Delay/ Lack of communication between CMHT and GP;
- Poor communication between teams/ clinicians;
- Lack of assessment/ assessments not being undertaken in a timely manner;
- Actions not being discussed during/ actions not being carried out following MDT meetings;

- Key individuals not invited to meetings.

8.3.2 All of the issues detailed above were identified during Serious Incident Reviews with associated recommendations/actions.

8.4 **Prevention of Future Deaths (PFD)**

8.4.1 The Trust did not receive any PFDs during the period:

8.5 **Non-Trust PFD**

8.5.1 The Coroner issued 1 non-Trust PFD during this period.

Background:	**Coroner's concerns**	**Trust's response**
Following concerns regarding the welfare of service user father called the emergency services on two occasions. There was a delay in the arrival of the ambulance. Deceased died having taken sodium nitrate.	*That the categories provided to call handlers to guide the appropriate response did not include the involvement of mental health street triage at the appropriate stage.* *Coroner issued a PFD to DoH for categories to be reviewed.*	N/A

8.6 **Non PFD concerns raised by the Coroner**

8.6.1 The Coroner raised some non PFD issues in 2 cases concluded during this period.

Background	**Coroner's concerns**	**Trust's response**
The deceased was found deceased in the River Thames. The plan to refer to the CMHT following discharge from inpatient admission had not been actioned.	Coroner concerned that the Trust did not have appropriate systems in place to identify where actions had been missed and that this would not have come to light if the service user had not died. He expressed concerns at standard of SIR which he felt had made no effort to understand why the failure to refer had not been identified prior to the death. Coroner agreed not to issue a PFD but wished to receive written assurance that appropriate systems were now in place.	Service users are now issued follow up appointments at discharge The follow up plan is then checked during 72 hour follow up for which a script/prompt is now provided. Figures provided on monitoring of 72 hour follow up.

Background	Coroner's concerns	Trust's response
The deceased was on leave from a Ward under the care of the Home Treatment Team. Three days later, the deceased was pulled out of the River Thames in Woolwich having drowned.	Family raised concerns in the days before Inquest that information used in the SIR was incorrect and may adversely influence the Coroner's conclusion. The information had been used in the formulation of the Root Cause section. It was necessary for the original report to be withdrawn on the eve of the inquest following consultation with the Medical Director. The Coroner asked for a letter from CMO setting out the steps being taken by the Trust to avoid a recurrence.	Trust's Associate Director of Risk and Governance will use the case as a learning exercise for the central team of Serious Incident Reviewers. There has recently been a change in the quality assurance process with Reviewers providing tabular timelines which identify the sources of evidence and enables senior guidance to be provided where necessary. The Trust is also considering formal report writing training for all SI Reviewers in order to further support the quality to reviews.

9.0 Recommendations and actions

9.1 The Board is recommended to **RECEIVE** and **NOTE** this report**.**