NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

# Responding to Deaths Policy

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| **Policy Number** | **CL/Pol/057** |
| **Target Audience** | **All Staff including Agency Workers, Volunteers, Contractors and Bank Staff** |
| **Approving Committee** | **Policy Approval Group** |
| **Date Approved** | **November 2017** |
| **Last Review Date** | **New Policy** |
| **Next Review Date** | **November 2020** |
| **Policy Author** | **Medical Director** |
| **Version Number** | **1** |

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| **Applicable Statutory, Legal or National Best Practice Requirements** | Care Quality Commission: Learning, candour and accountability<br>Coroners (Investigations) Regulations 2013<br>Department of Health: End of life care strategy: promoting high quality care for adults at the end of their life<br>Learning Disabilities Mortality Review (LeDeR) Programme: Guidance for the conduct of local reviews of the deaths of people with learning disabilities<br>National Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP): MBRRACE-UK<br>National Quality Board: National guidance on learning from deaths<br>NHS England: Serious incident framework<br>Royal College of Pathologists and Royal College of Paediatrics and Child Health: Sudden unexpected death in infancy and childhood |

The Trust is committed to an environment that promotes equality, embraces diversity and respects human rights both within our workforce and in service delivery. This document should be implemented with due regard to this commitment.

This document can only be considered valid when viewed via the Trust's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

## Version Control Sheet

| Version | Date | Reviewed By | Comment |
|---|---|---|---|
| 0.1 | August 2017 | Karen Slade | New Policy |
| 0.2 | September 2017 | Policy Approval Group | Amendments and resubmission to PAG required |
| 0.3 | November 2017 | T. Reid | Amendments completed |
| 0.4 | November 2017 | Policy Approval Group | Approved subject to minor amendments and chair approval |
| 0.5 | November 2017 | S. Edwards | References updated |
| 0.6 | December 2017 | T. Reid | Amendments completed |
| 1 | December 2017 | S. Arkwright | Approved by chair action |

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| Equality Impact Assessment completed | By: T. Reid | Date: November 2020 |

## Contents

# 1 Introduction

This policy has been developed in accordance with the National Quality Board's "Guidance on Learning from Deaths" (published in March 2017) as part of a national drive to implement the recommendations of the CQC's review "Learning, Candour and Accountability: a review of the way Trusts review and investigate the deaths of patients in England".

Mortality reviews are a key component of improving the quality and safety of patient care. Mortality governance is a key priority for Bridgewater Community Healthcare NHS Foundation Trust ("the Trust").

The policy also takes account of the Serious Incident Framework (NHS England, 2015) and existing national processes for reporting and investigating deaths including the (LeDeR) programme, Working Together to Safeguard Children (2015) and contributions to reports under Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013.

## 1.1 Objective

This policy sets out how the Trust responds to and learns from the deaths of patients who die under its management and care.

Specifically, this policy describes how the Trust:

- Determines which patients are considered to be under its care for the purpose of responding to deaths
- Determines which deaths to report as incidents for possible investigation and learning
- Reports deaths within the organisation and to other organisations who may have an interest
- Engages meaningfully and compassionately with bereaved families and carers
- Identifies and acts on learning from the investigation of deaths
- Responds to all deaths of patients including the following groups – patients with a Learning Disability, patients with mental health condition, children, infants, still births, perinatal or maternal death

## 1.2 Scope

This policy applies to all employees and contractors conducting work on behalf of the Trust.

## 2 Definitions

The definitions applicable to this policy are as follows:

**Death due to a problem in care** – a death that has been assessed (by case record review) as being more likely than not to have resulted from problems in healthcare, rather than due to the natural course of the service user's illness or underlying condition, and therefore to have been potentially avoidable.

**Avoidable death** – a death which could have been avoided if problems with the patient's care had not been present.

**Preventable death** – a death which could have been prevented if certain preventable factors (including patient lifestyle, problems with the patient's care and health care system failures) had not existed.

**Unexpected death of a patient** – a patient in whom death was not clinically considered to be a likely outcome at a specific point in time.

**Expected death** – a patient in whom death was clinically considered to be a likely outcome at a specific point in time. This could be a patient who was terminally ill.

**Serious Incident (SI)** – a health care event where the potential for learning is so great, or the consequences to patients, families, carers, staff and the organisation is so significant, that a comprehensive response is warranted. These include acts or omissions occurring as part of care that result in unexpected or avoidable death.

Serious Incident Framework, NHS England Patient Safety Domain, March 2015 acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

- Unexpected or avoidable death of one or more people. This includes:
    - Suicide/self-inflicted death; and
    - Homicide by a person in receipt of mental health care within the recent past.
- Unexpected or avoidable injury to one or more people that has resulted in serious harm
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
    - The death of the service user; or
    - Serious harm.
- Death of a prisoner while serving a custodial sentence (expected or unexpected)
- Within Maternity Services:
    - Postpartum Haemorrhage

- Unplanned maternal transfers to Intensive Therapy Unit (ITU)
- Hysterectomy.

Actual or alleged abuse; sexual abuse, physical or psychological ill- treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:

- Healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
- Where abuse occurred during the provision of NHS-funded care. This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident.

**Never Event** – a wholly preventable serious incident which occurred due to a failure to implement national safety recommendations.

**Patient Safety Incident** - any unintended or unexpected incident that occurred in respect of a service user during the provision of care that appears to have resulted in the death, severe harm, moderate harm or prolonged psychological harm to the service user. Patient safety incidents are notifiable to the CQC via the National Reporting and Learning Service (NRLS).

**Duty of Candour** – a legal duty on the Trust to inform and apologise to patients (or, in the case of a patient's death, their families/carers) if there may have been mistakes in their care that led to harm.

**Strategic Executive Information System** - a national database that all NHS bodies upload details of SIs into, for the attention of the relevant commissioner, NHS England, and Care Quality Commission to observe.

# 3 Abbreviations

The abbreviations applicable to this policy are as follows:

LeDeR - Learning Disabilities Mortality Review programme

CQC - Care Quality Commission

SI – Serious Incident

STEIS – Strategic Executive Information System

NRLS - National Reporting and Learning Service

CGsC - Clinical Governance Sub-Committee

ACNs - Associate Chief Nurses

MNI-CORP - Maternal, Newborn and Infant clinical Outcome Review Programme

CDOP - Child Death Overview Panel

SMI - Severe Mental Inness

GP - General Practitioner

ITU - Intensive Therapy Unit

SCR - Serious Case Review

SAR - Safeguarding Adult Review

# 4 Other Relevant Procedural Documents

This policy should be read in conjunction with the following documents:

- Incident Reporting Policy
- Compliments, Comments, Concerns and Complaints Handling Policy and Procedures
- Duty of Candour (Being Open) Policy and Procedure
- Investigation Procedure
- Adult Safeguarding Policy
- Safeguarding Children Policy

# 5 Roles and Responsibilities

## 5.1 The Chief Executive Officer

The Chief Executive Officer is accountable to the Board for ensuring that resources, policies and procedures are in place to respond to deaths. For practical purposes, the Chief Executive Officer has delegated responsibility for this to the Medical Director.

## 5.2 Medical Director/Caldicott Guardian

The Medical Director is the nominated director with accountability for developing and implementing this policy. The Medical Director is responsible for providing assurance to the Board with respect to mortality governance arrangements. This includes the provision of a quarterly report to the Quality and Safety Committee of the Board on the numbers of deaths of patients who were under the care of the Trust and the Trust's response to these, including any resultant learning.

The Medical Director, together with the Chief Nurse, has responsibility for monitoring and improving the quality of clinical services. They must ensure that systems are in place to identify opportunities for service improvement, including as an outcome of investigation of deaths or serious incidents.

The Medical Director is responsible for chairing the Deaths Review Panel. They are responsible for notifying the Board of Directors of any deaths which may attract media attention.

The Medical Director also holds the post of Caldicott Guardian for the Trust.

### 5.3 Chief Nurse/Director of Quality

The Chief Nurse/Director of Quality is the nominated director with accountability for ensuring that appropriate systems are in place for reporting incidents and patient safety incidents, including uploading SIs to the STEIS and Patient Safety Incident details to the National Reporting and Learning Service (NRLS).

The Chief Nurse/Director of Quality is also responsible for ensuring that systems are in place for investigating incidents and learning from them.

The Chief Nurse/Director of Quality is also the nominated director with accountability for patient experience and duty of candour.

The Chief Nurse/ Director of Quality is also responsible for ensuring that systems are place for LeDeR - Learning Disabilities Mortality Review programme.

### 5.4 Non–Executive Lead for Learning from Deaths

The Non-Executive Director Lead for Learning from Deaths will provide constructive challenge to the effectiveness of mortality governance arrangements.

### 5.6 Director of Operations

The Director of Operations is responsible for ensuring that all staff report deaths in accordance with this policy. They will promote a learning culture within clinical teams and a willingness to implement service changes resulting from learning from deaths. They will ensure that local structures enable reporting of deaths, engagement in investigations and support for bereaved families and carers. They may discharge these responsibilities through the Assistant Directors of Operations.

### 5.7 Clinical Managers

The clinical managers are responsible for directing the undertaking of review within 72 hours in the event of a reported death. Based on the findings of this review, the clinical manager is responsible for determining whether further investigation is required and for setting out the terms of reference for the investigation. They should seek advice from the Associate Chief Nurse in this respect.

In the case of a child death, the clinical manager is responsible for notifying the Safeguarding Team.

The clinical manager is also responsible for determining whether Duty of Candour is applicable. They should seek advice in this respect from the Associate Chief Nurse.

The clinical manager must document their decisions at every stage of the process. They are responsible for ensuring that documentation in relation to the investigation of deaths is submitted in a timely manner. They are responsible for attending the Deaths Review Panel as required or arranging for a suitable deputy to attend.

The clinical manager is responsible for ensuring that any lessons arising as an outcome of the investigation of a death are implemented within the service and shared with the Quality Governance Team for wider communication via the Lessons Learned Hub, as appropriate.

### 5.8 Safeguarding Team

The Safeguarding Team are responsible for reviewing all child deaths within the Trust.

### 5.8 All Clinical Staff

All clinical staff must act in accordance with this policy in respect of responding to deaths of patients under their care. Clinical staff must engage meaningfully and compassionately with bereaved families and carers.

Clinical Staff are responsible for reporting all incidents (including deaths) on the Ulysses Risk Management System and informing their clinical manager. They are responsible for undertaking a review within 72 hours, uploading the review onto Ulysses and undertaking further investigation as instructed by their clinical manager.

Clinical Staff must document their decisions at every stage of the process.

### 5.9 Associate Chief Nurses

The Associate Chief Nurses (ACNs) are responsible for advising clinical managers in relation to the need for further investigation and the applicability of duty of candour following the reporting of a death of a patient under the care of the service.

The ACNs will attend the Deaths Review Panel to challenge the investigation findings and identify lessons to be learned. They are responsible for informing clinical managers of the lessons to be learned.

### 5.10 Associate Director of Safeguarding

The Associate Director of Safeguarding will provide a quarterly report to the Clinical Governance Sub-Committee on the status of serious case reviews (including reviews of child deaths) from Children's Safeguarding Leads for each locality. This includes the numbers of open case reviews during the quarter as well as any learning for the Trust from Serious Case Reviews which have been closed in the previous quarter.

### 5.11 Trust Secretary

The Trust Secretary will provide a written monthly report to the chair of the Clinical Governance Sub-Committee on the status of coroner's investigations. This includes the number of open investigations that the Trust is contributing to and any learning for the Trust from case investigations which have been closed during the previous month.

### 5.12 Trust Board

The Board will be apprised of mortality governance arrangement and will receive quarterly "Learning from Deaths" reports, via its Quality and Safety Committee. These will include the numbers of deaths of patients who were under the care of the Trust, the Trust's response to these and any resultant learning.

### 5.13 Clinical Governance Sub-Committee (CGsC)

The CGsC will review and approve quarterly "Learning from Deaths" reports prior to their presentation to the Quality and Safety Committee. These will include the numbers of deaths of patients who were under the care of the Trust, the Trust's response to these and any resultant learning.

The Clinical Governance Subcommittee will also receive quarterly reports from the Assistant Director of Safeguarding which include the numbers of serious case reviews (including reviews of child deaths) for each locality and any resultant learning for the Trust. The Clinical Governance Sub-Committee will also receive monthly updates from the Trust Secretary on the number of coroners' investigations that the Trust is contributing to and any resultant learning for the Trust.

### 5.14 Risk Team

The Risk Team, led by the Head of Risk Management and Patient Safety on behalf of the Medical Director, is responsible for monitoring the information uploaded onto Ulysses and providing the quarterly Learning from deaths report to the CGsC. This report includes numbers of deaths of patients who were under the care of the Trust, the Trust's response to these and any resultant learning.

They will monitor the status of investigations into deaths and provide intelligence for the Deaths Review Panel in respect of deaths investigations. This includes working with clinical managers to ensure that accurate and relevant documentation is submitted in a timely manner and that the clinical manager, or their deputy, attends the panel as required. They will also offer training to staff on reporting and learning from incidents, including deaths.

The Risk Team will support staff in accessing the Ulysses Safeguard Risk Management System and offer reports that allow directorates to gauge the level of staff engagement with this process.

### 5.15 Deaths Review Panel

The Deaths Review Panel reviews the investigation of deaths and identifies any lessons learned and actions required to implement the learning. The Deaths Review Panel is chaired by the Medical Director and its membership includes the Associate Chief Nurses and the Head of Risk Management and Patient Safety.

The panel receives its intelligence from the Risk Team.

## 6 Equipment List

The Trust uses the Ulysses Risk Management System for the recording of incidents (including deaths).

## 7 Response to Deaths

### 7.1 Deciding which Patients are "Under our Care"

The Trust offers services that are often part of a care system involving more than one provider, e.g. primary care, social care, acute care. For the purpose of this policy the following groups of patients are considered to be "under our care".

- Patients who are being cared for in an inpatient bedded unit by staff who are employed by the Trust
- Patients who are in custody in a prison where healthcare is provided by the Trust
- Patients who have received care from staff who are employed by the Trust within the last month*.

*The Trust will not routinely undertake care record review for patients who die in hospital under the care of a different provider but were under the care of the Trust prior to admission (e.g. a prisoner who was admitted and died in hospital, a patient who died following admission to hospital from GP Out of Hours service). It is expected that these deaths will be reported and investigated through the current provider's own mortality reporting system. However, the Trust will consider investigating the death if the provider suggests that it would be appropriate to do so.

### 7.2 Immediate Response following death

If a patient dies under our care, the first priority for the organisation is to ensure the needs of individuals affected by the death are attended to.

A safe environment should be re-established, all equipment or medication retained and isolated, and all relevant documentation copied and secured to preserve evidence to facilitate the investigation and learning. If there is a suggestion that a criminal offence has been committed, the police should be contacted immediately.

In accordance with a culture of openness and a general duty of candour, information and support should be provided to relatives and carers, and staff affected by the incident in accordance with the Being Open Policy and Duty of Candour requirements as relevant.

Local documentation should be available regarding PALs, Complaints, Occupational Health or counselling services and referrals made on behalf of staff made by their manager.

If the death is a potential Safeguarding concern, staff should immediately contact the Trust's Safeguarding lead in accordance with the Safeguarding policies for children and for vulnerable adults.

### 7.3 Criteria for reporting a death on Ulysses

If a patient dies whilst under our care (as defined above), an assessment should be made within 48 hours of the death of whether any of the following criteria apply:

- The death was unexpected
- The bereaved family have expressed a concern about the care their relative received from the Trust
- Staff employed by the Trust have expressed a concern about the quality of care received by the deceased
- The death occurred whilst the patient was under the care of a service where concerns have previous been raised (e.g. through audit or CQC inspection)
- The deceased patient had a learning disability
- The death was a maternal death, neonatal death or still birth
- The deceased patient was a child aged <18 years
- The deceased patient was in custody.

The assessment should be made regardless of whether the death was expected (e.g. a patient is terminally ill) or unexpected.

If any of the above criteria apply, the death should be reported as an incident, in accordance with the Incident Reporting Policy, using the online Ulysses Safeguard Risk Management System within 48 hours of the death. A review should be completed within 72 hours of the death and uploaded onto Ulysses.

The decision should be documented, along with any criteria which were considered to be met.

### 7.4 Engaging meaningfully and compassionately with bereaved families and carers

If a patient dies under the care of Bridgewater services and any of the above criteria are met, the following steps should be followed to ensure meaningful engagement with bereaved family and carers:

- Inform bereaved families/carers about the process for reporting and investigating the death

- Inform bereaved families/carers that the purpose of reporting and investigating is to establish whether there is anything that can be learned from the death of their loved one which could help to prevent a future death

- Offer to inform bereaved families/carers of the outcome of any investigation.

### 7.5 Reporting deaths to other providers who may have an interest

#### 7.5.1 Patients who die within 30 days of discharge from hospital

If a patient who is under our care dies within 30 days of being discharged from another hospital provider, the Trust will notify the hospital provider that the patient has died, as the provider may wish to report and investigate the death through their own mortality reporting system. The death will still need to be reported onto Ulysses if the above criteria are met.

#### 7.5.2 Shared care arrangements

If the deceased patient's care was shared between Bridgewater and another provider (e.g. primary care), the Trust will notify the other provider of the patient's death. If the criteria in section 7.3 apply, the death must still be reported as an incident using the Trust's online Ulysses Safeguard Risk Management System within 48 hours of the death.

### 7.6 Identifying and acting on learning from the internal investigation of deaths

If, in accordance with the Incident Reporting Policy, a death which has been reported as an incident triggers an investigation, the findings of the investigation will be presented to the Deaths Review Panel (see section 5.15). The panel will identify any learning from the investigation and determine what action is required as a result.

The panel will also identify any learning which may be relevant to other organisations (e.g. primary care, Acute Trust) and determine how that learning will be shared.

The panel will seek assurance from the appropriate Clinical Manager that bereaved families have been invited to engage with the investigation process and that the outcomes are shared with them if they have expressed a wish for this.

### 7.7 Contributing to external investigation of deaths

#### 7.7.1 Coroner's inquests

The Trust will fully cooperate with the investigation of a death as requested by the coroner. Any learning which is identified will be included in the Trust Secretary's monthly report to the Clinical Governance Sub Committee.

#### 7.7.2 Deaths in Custody

For Deaths in Custody, the Trust will support the investigation of any death at the request of the prison and probation ombudsman or independent police complaints commissioner. Any learning which is identified will be included in the Trust Secretary's monthly report to the Clinical Governance Sub-Committee.

#### 7.7.3 Serious Case Reviews for Children's Safeguarding Deaths

The Trust will contribute to serious case reviews as directed by Children's Safeguarding Teams in each locality. Any learning which is identified will be discussed and managed through the Safeguarding Team Assurance Group and escalated to the Clinical Governance Sub Committee in the Assistant Director of Safeguarding's quarterly report.

### 7.8 Specific requirements for responding to deaths of patients with a Learning Disability

Reports and case studies have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities.

The National Quality Board has specified that all inpatient, outpatient and community patient deaths of people with learning disabilities should be reviewed in order that learning from these deaths can contribute to service improvements.

The national Learning Disabilities Mortality Review (LeDeR) programme commenced in June 2015 and is rolling out a review process for the deaths of people with learning disabilities. The Trust will notify all deaths of people with learning disabilities to the LeDeR programme. When undertaking investigation into the death of a patient with learning disability, the Trust will follow the national guidance:

http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf

### 7.9 Specific requirements for responding to deaths of patients with Mental Health condition

The National Quality Board guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) should be subject to case record review.

In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

### 7.10 Specific requirements for responding to deaths of infants or children

Infant or child (under 18) death reviews should be undertaken in accordance with national guidance: Sudden Unexpected Death in Infancy and Childhood – Multi-Agency Guidelines for Care and Investigation

https://www.rcpath.org/asset/874AE50E-C754-4933-995A804E0EF728A4

The Child Death Overview Panel (CDOP) should be notified whenever a child dies. The CDOP will gather appropriate intelligence, investigate the death and make recommendations for lessons learned.

Stillbirths, perinatal deaths and infant (<1 year) deaths should be reported to the National Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP) via the MBRRACE-UK online reporting system available at www.mbrrace.ox.ac.uk. The national programme conducts surveillance and investigates the causes of maternal deaths, stillbirths and infant deaths. Guidelines for using the system can be downloaded here: MBRRACE online data entry guidebook (release April 2013 v101).

### 7.11 Specific requirements for responding to maternal deaths

If maternal deaths occur within the community setting this should be reported by Head of Midwifery to the national Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP) which conducts surveillance and investigates the causes of maternal deaths, stillbirths and infant deaths.

Notifications of maternal deaths should be made by ringing the Oxford MBRRACE-UK office on 01865 289715.

## 8 Consultation

Key individuals/groups involved in the development of the document to ensure it is fit for purpose once approved.

| **Name** | **Designation** |
|---|---|
| David Lewis | Medical Director |
| Anne Doyle | Assistant Director of Children's Services |
| Stephen Edwards | Librarian |
| Corina Casey-Hardman | Head of Midwifery |

| Name | Designation |
|---|---|
| Kristine Brayford-West | Associate Director for Safeguarding |
| Jeanette Hogan | Associate Chief Nurse |
| Sarah Martin | Named Nurse, Safeguarding |
| Berni Hardman | Associate Director for End of Life Care |
| Trish Reid | Business Manager to the Executive Medical Director |
| Sharan Arkwright | Associate Director: Quality Governance |

# 9 Dissemination and Implementation

## 9.1 Dissemination

The Medical Director is responsible for disseminating this policy via the Trust intranet and the bulletin.

## 9.2 Implementation

Managers are expected to actively communicate the contents of this policy to their staff using the most appropriate mechanism(s) available; including management meetings and recording this in their minutes or meeting notes.

A series of step by step procedures and flowcharts for quick reference support this document for staff to access on the intranet together with a standard operating procedure.

The Risk Team will hold a series of training sessions over the year which will include responding to deaths.

# 10 Process for Monitoring Compliance and Effectiveness

The Quality and Safety Committee and the Clinical Governance Sub Committee will receive quarterly “Learning from Deaths” reports which will include the numbers of deaths of patients who were under the care of the Trust, the Trust’s response to these and any resultant learning.

## 11 Standards/Key Performance Indicators

The Quality and Safety Committee and CGsC will receive a quarterly "Learning from Deaths" reports which will document the following indicators:

- Number of deaths which were reported as an incident
- Number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- Themes and issues identified from review and investigation (including examples of good practice)
- Actions taken in response, actions planned and an assessment of the impact of actions taken.

## 12 References


Care Quality Commission (CQC) (2016) Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England [online]. Available at: https://www.cqc.org.uk/publications/themed-work/learning-candour-and-accountability

Coroners (Investigations) Regulations 2013, SI 2013/1629 [online]. Available at: http://www.legislation.gov.uk/uksi/2013/1629/contents/made

Department of Education (2015) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children [online]. Available from: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2#history

Department of Health (2008): End of life care strategy: promoting high quality care for adults at the end of their life [online]. Available at: https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life

Learning Disabilities Mortality Review (LeDeR) Programme (2016) Guidance for the conduct of local reviews of the deaths of people with learning disabilities [online]. Available from: http://www.bristol.ac.uk/sps/leder/resources/

MBRRACE-UK (2013) MBRRACE-UK Confidential Survey: guidelines for perinatal and infant death data entry (version 1.0.1) [online]. Available from: https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/MBRRACE-online-data-entry-guidebook--release-April-2013-v101-.pdf

National Quality Board (2017) National guidance on learning from deaths: a framework for NHS trusts and NHS foundation trusts on identifying, reporting, investigating and learning from deaths in care [online]. Available from: https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/

NHS England (2015) Serious incident framework: supporting learning to prevent recurrence [online]. Available at: https://improvement.nhs.uk/resources/serious-incident-framework/

Royal College of Pathologists and Royal College of Paediatrics and Child Health (2016) Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation. 2nd edition.[online]. Available at: https://www.rcpath.org/asset/874AE50E-C754-4933-995A804E0EF728A4

### 12.1 Possible additional resource

NHS Improvement (2017) Learning from deaths in the NHS [webpage]. Available at: https://improvement.nhs.uk/resources/learning-deaths-nhs/

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