Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**Wednesday 5 May 2021**		

Title of Report:	**Learning from Deaths and Inquest Report**
Status:	**To discuss and approve**
Board Sponsor:	**Bernie Marden Medical Director**
Author:	**Heather Boyes, Lead for Claims and Inquests**
Appendices	**None**

1. Executive Summary of the Report

The Trust is required to report quarterly on its activity relating to Learning From Deaths as mandated by Secretary of state for Health and Social Security and monitored by NHSI and the CQC.

This is a report to summarise the mortality review process and learning from completed SJRs.

This report splits the mortality process for those patients who died before the introduction of the Medical Examiner role and those who died post introduction to allow clearer assessment of the impact of the procedural changes that have been identified.

One SJR raised the possibility of issues with care contributing to the patient's death; this have been the subject of divisional scrutiny.

Where an SJR outcome reports that there are identified care problems likely to have contributed to death, it is important to remember that this is an individual's subjective assessment. A further stage of review or SI investigation is undertaken to establish any detailed concerns and to identify any additional appropriate actions.

2. Recommendations (Note, Approve, Discuss)

To discuss and approve

3. Legal / Regulatory Implications

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

The Secretary of State for Health accepted the report's recommendations and in a Parliamentary statement made a range of commitments to improve how Trusts learn from reviewing the care provided to patients who die. This includes regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action

that is happening as a consequence of that information in Quality Accounts from June 2018.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
What are the risks arising or identified in the report. Risks need to be added to the risk register in advance of submitting the report and the risk number stated.	

5.	Resources Implications (Financial / staffing)
The learning from deaths case review process is relatively resource intensive for clinicians.	

6.	Equality and Diversity
All services are delivered in line with the Trust's Equality and Diversity Policy.	

7.	References to previous reports
Q2 Learning From Deaths Report	

8.	Freedom of Information
Public	

Learning from Deaths Dashboard

Quarter 3 2020/21

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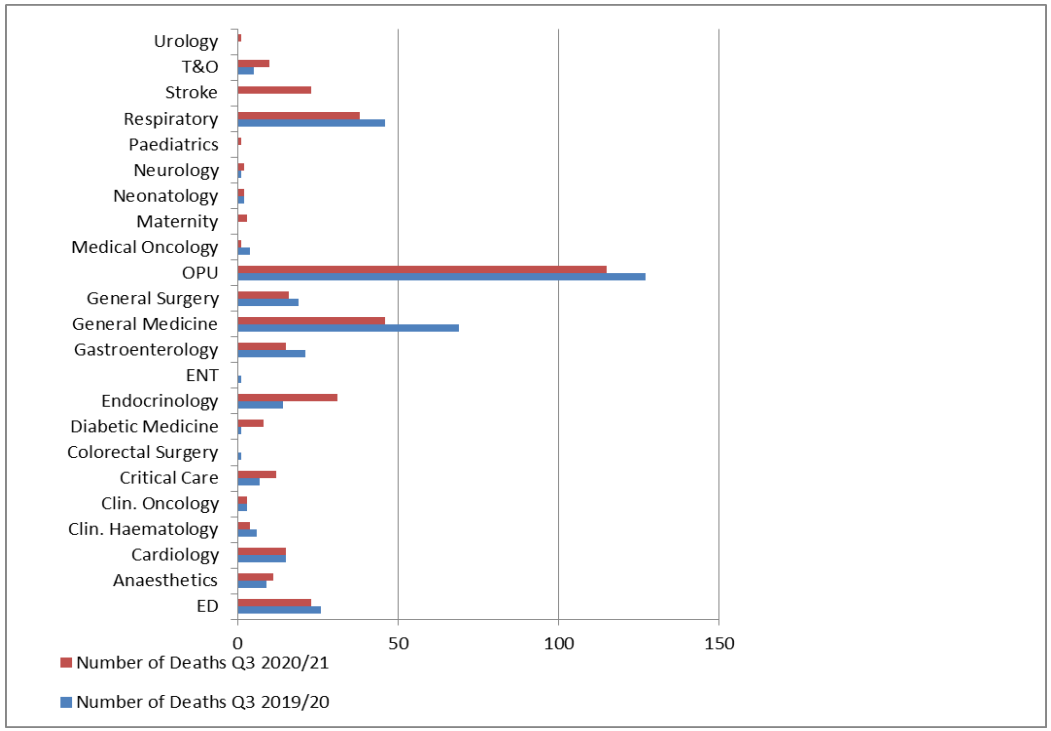
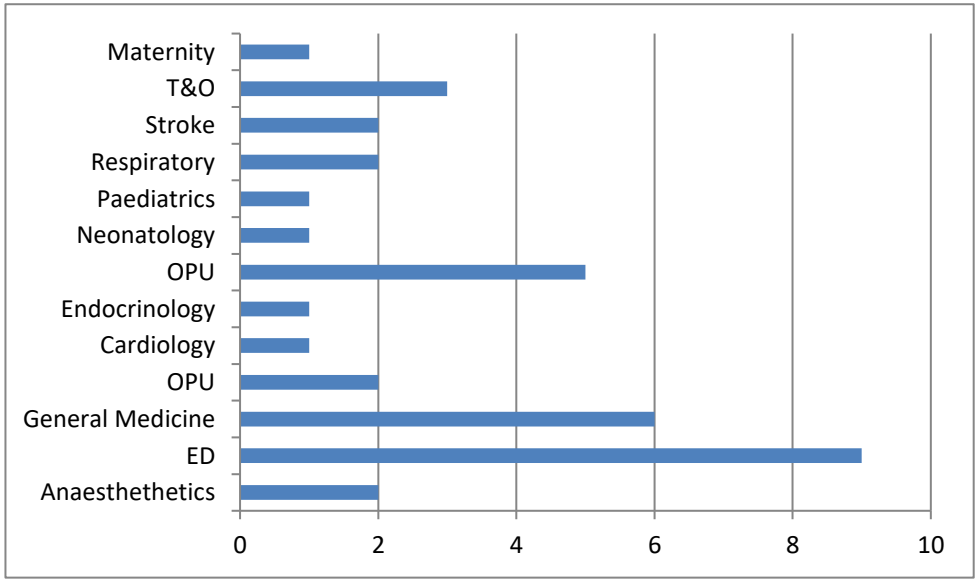
2019/20: 1511	2019/20: 404	2019/20: 230	2019/20: 61	Target: 100%	Target: 0
939	380	34	71	37%	1
Total number of deaths 2020/21 (cumulative)	Total number of deaths this quarter	Outstanding checklists (death post-01/04/2020	Total number of SJRs complete this quarter	SJRs completed within two months of death	SJRs identified care problems likely to have contributed to death

Patient Deaths by Specialty



Outstanding Checklists by Specialty



Phase of Care Ratings

Rating Type	Average	Number of	Number Of 1s	Number Of 2s	Number Of 3s	Number Of 4s	Number Of 5s
Initial Admission	4.14	70	0	4	7	34	25
Ongoing Care	4.11	61	0	3	9	27	22
Care During	4.18	17	0	0	5	4	8
Return To Theatre	5.00	3	0	0	0	0	3
Perioperative Care	4.43	7	0	0	2	0	5
End Of Life	4.16	62	0	1	12	25	24
Overall	3.94	70	0	4	14	34	18
Patient Record	3.96	68	0	0	24	23	21

SJRs Raising Concerns

Date of Death	Specialty	Overall Score	Summary of Concerns	Incident Already Reported?	Matter already an SI?	Action Taken
Oct-19	Acute Stroke	2 - Care Problems identified but unlikely to have contributed to death	Delay in performing CTG. Once performed, changes not detected. Cardiac arrest.	Yes - 78523	Yes	Shared with Risk Team to ensure nothing missed. SI already complete.
Mar-20	Orthopaedics	2 - Second Review required	Concern deterioration was due to opiate toxicity	No	No	Reported on datix - 87859. Not an SI.
Aug-20	Diabetic Medicine	2 - Care problems identified but unlikely to have contributed to death	Delay in treating paracetamol toxicity	Yes - 86001	Yes	SJR shared but SI investigation already completed
Oct-20	Acute Stroke	2 - Care problems identified which most likely contributed to death	Undiagnosed stroke	No	No	Reported on datix - 90439. SJR added to datix. Awaiting division review.

Subjects and Themes

Good/Excellent Care (12)

High level care throughout

Excellent communication and documentation

Good care

Good level of care throughout

Excellent senior involvement

Team did their best

Lack/Quality of Documentation (3)

No documented examinationfor injuries post fall

Documented patient possibly had learning disabilities but no further detail

Poor documentation

Delays

Delay in initial medical assessment, could have contributed

Delay in initial medical assessment although unlikely to have changed outcome

Delay in treatment of overdose

Delay in responding to morphine toxicity

Communication (2)

Missed opportunity for better communication between private and NHS team

TEP could have been discussed earlier

No Additional Learning (45)

Inquest Dashboard

Quarter 3 2020/21

NHS
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2019/20: 53	2019/20: 8	2019/20: 29	Target: 0	Target: 0	Target: 0
30	8	2	5	1	Zero
Total Number of Inquests opened 2020/21	Number of Inquests Opened this Quarter	Number of Inquests Concluded this Quarter	Number of Inquests without an SJR	Number of Inquests with SJR Score of 1 or 2	Number of Regulation 28 Reports this Quarter

Inquests Opened

Specialty	Description (Policies)	Incident date	Incident or Complaint?	SJR Completed?	SJR Rating
Orthopaedics	Cause of death has been confirmed as: 1a Acute myocardial ischaemia b Soft tissue haematoma c Fractured neck of femur (senile osteoporosis)II Coronary artery atheroma and aortic stenosis	23/11/2020	No	No	
Stroke	The cause of death has been confirmed as: 1a Haemorrhagic stroke b Thrombolysis of right basal ganglia infarct c II Hypertension, atrial fibrillation. There are no family concerns.	07/12/2020	No	No	
Anaesthesia	Suicide attempt/self hanging. Cardiac arrest, admitted to ICU. Cause of death as 1a Hypoxic brain injury 1b Cardiac arrest 1c Hanging. Wiltshire Coroner's case.	14/10/2020	No	No	
Emergency Department	Cause of death has been confirmed as: Cause of death 1a Acute toxicity of Methylenedioxymethamphetamine (MDMA)	19/08/2020	Incident	No	
Diabetes & Endocrinology	Admitted to RUH after paracetamol overdose and pneumonia following long lie. Cause of death has been confirmed as 1a Aspiration pneumonia II Liver damage due to paracetamol toxicity	17/08/2020	No	Yes	2
Orthopaedics	Patient died at home, cause of death 1a Sepsis, b Chronically infected thigh wound following fixation of a right peri-prosthetic femur fracture II Ischaemic heart disease. The patient had an operation at RUH in March 2020 and has then had several admissions to RUH and Paulton Hospitals to deal with infections.	30/11/2020	No	Died at home	
Emergency Department	Cause of death: 1a Cardiac arrest b Propranolol overdose. There are no concerns with the Trust.	20/10/2020	No	Yes	4
Orthopaedics	Cause of death has been confirmed as: 1a Vascular dementia II Fractured neck of femur (operated) No post mortem was performed. There are family concerns directed at care centre.	23/11/2020	No	No	