Birmingham and Solihull Mental Health NHS Foundation Trust

Learning from Deaths Policy

Policy number and category	**C58**	**Clinical**
Version number and date	**4**	**July 2025**
Ratifying committee or executive director	**Trust Clinical Governance Committee**	
Date ratified	**August 2025**	
Next anticipated review	**August 2028**	
Executive director	**Executive Medical Director**	
Policy lead	**Head of Patient Safety**	
Policy author *(if different from above)*	**As Above**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

This policy sets out how the Trust will comply with the "National Guidance on Learning from Deaths", March 2017.

The Trust is committed to service improvement and acknowledges that systematic mortality review has a crucial part in delivering the clinical quality agenda and providing assurance of quality improvement.

Policy requirement

The main purpose of this policy and the content is to promote learning and improve how the Trust supports and engages with the families and carers of those who die in our care.The Trust strives to improve the care provided to all of our its service users; the overall aim is to identify, understand and implement improvements where any issues are related to the provision of quality care. It is considered that if such improvements are initiated effectively and embedded, then the mortality statistics will naturally show improvement.

This policy provides details of how the Trust will ensure compliance with the requirements set out in the NQB guidance (2017).

Policy Summary

This policy sets out a framework describing how the Trust and its staff will respond to and learn from deaths that occur under our care.
It will provide guidance for all staff involved in the mortality review process ensuring clarity on roles, responsibilities and expectations.
Reviewing mortality can help make improvements to the quality of care received by patients at the Trust by identifying care related issues. This enables the identification of learning themes and provides evidence of a high standard of care.
Mortality is a fundamental component of clinical effectiveness, one of the three dimensions of quality described by Lord Darzi in High Quality Care for all (2008)

The Trusts aims are to:

- Improve learning from mortality reviews.
- Ensure robust and timely governance processes regarding mortality outcomes and reviews.
- Provide assurance of mortality processes in the Trust.

Change Record

Date	Version	Author (Name & Role)	Reasons for review / Changes incorporated	Ratifying Committee
March 2025	4	Sam Munbodh, Head of Patient Safety	Three yearly review. Inclusion of the medical examiner role PSIRF national requirements	Trust CGC

CONTENTS

1. INTRODUCTION

1.1. RATIONALE

The policy sets out the Trust's approach to applying the National Guidance on Learning from Deaths (2017) which builds on the recommendations made by the Mazars investigation into Southern Health (Dec 2015), the CQC report 'Learning, Candour and Accountability publication' (Dec 2016) and the Learning Disabilities Mortality Review (LeDeR) process managed by NHS England.

Under the National Guidance on Learning from Deaths, published by the National Quality Board in March 2017 trusts are required to:

Publish a policy on how their organisation responds to and learns from deaths of patients who die under their management and care, including:

- how their processes respond to the death of an individual with a learning disability or autism, severe mental illness, an infant or child death
- their evidence-based approach to undertaking reviews
- the categories and selection of deaths in scope for case record review (and how the
- organisation will determine whether a full investigation is needed)
- how the Trust engages with bereaved families and carers, including how the trust supports them and involves them in investigations
- how staff affected by the deaths of patients will be supported by the trust.

The learning from deaths framework states that trusts must collect and publish via a quarterly public board papers on information on:

1. number of deaths in their care
2. number of deaths subject to case using a structured review
3. number of deaths reviewed/investigated and as a result considered more likely than not due to problems in care
4. themes and issues identified from review and investigations
5. actions taken in response, actions planned and an assessment of the impact of actions taken

This policy should be followed in conjunction with:

- Patient Safety Incident Response Framework Policy (RS24)
- The Management of Incidents (RS02)
- Duty of Candour (C25)
- Complaints Policy (CG06)
- NQB Guidance (2017)
- Enforcement Act (2018)

1.2. SCOPE

This policy informs the organisation of staffs' roles and responsibilities relating to learning from deaths and how we identify learning opportunities and applies to all staff whether they are

employed by the Trust permanently, temporarily though an agency or bank arrangement, students on placement or are joint working through contract arrangements

1.3. PRINCIPLES

The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

2. THE POLICY

The policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in receipt of care from the Trust or had been discharged within the last six months.

It sets out how the Trust will seek to learn from the care provided to service users who die, as part of its work to continually improve the quality of care it provides to all its service users.

The Trust will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all service users.

The Trust will continue to develop ways to hold effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.

Dealing respectfully, sensitively and compassionately with families and carers when someone has died is crucially important. At times families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received but do not always want to make a complaint.

3.0 PROCEDURE

3.1 Recording Deaths

The Trust will be informed of a service user's death in a variety of ways. This could be by contacting to arrange an appointment or attending a planned visit, family contacting staff to inform them of the death, coroner's requests, medical examiner, NHS Spine and, other care providers.

All deaths of service users expected and unexpected who currently receive care from BSMHFT services including HMP Birmingham, are to be reported on the Trust's incident

management system Eclipse. Additionally, deaths of patients up to 6 months post discharge are also reportable. How to report an incident can be found in the Management of Incidents Policy (RS02).

Staff should engage compassionately with bereaved families and carers as outlined in the Patient Safety Incident Response Framework (PSIRF) Compassionate Engagement standards and where appropriate the support of the Family Liaison Officer to be offered.

3.2 Selection of Deaths for Review

In accordance with the requirements for Learning from Deaths, the Trust will systematically screen deaths through the daily Patient Safety Team incident huddle**.**

To support continuous improvement, the Trust will use a recognised tool called Structured Judgement Review, referred to as a Safety and Quality Review. However, this will not be true to the model, of a case note review. Instead, the approach will focus on open, honest and inclusive conversations with staff to ensure meaningful learning and development.

As guided by the Royal College of Psychiatrists (November 2018) the following criteria will automatically require review:

- Family, carers or staff have raised concerns about the care provided.
- Psychiatric inpatient at the time of death or discharged from inpatient care within
- the last month.
- All patients under the Crisis Resolution and Home Treatment Team (or equivalent)
- at the time of death,
- Primary diagnosis of psychosis or eating disorder during the last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death.

The Royal College of Psychiatrists also note Trusts can locally determine 'Red Flags' on a regular or adhoc basis.

It has been an agreed that suspected suicide will be a regular ‘Red Flag’ and additional ad-hoc Red Flags will be agreed by the Learning from Deaths Group.

Safety and Quality Reviews will be completed by those with the appropriate training. An assessment of the Quality of Care using the Royal College of Physicians scoring system should be recorded (Appendix 2) and an assessment of avoidability of the death, using the 6-point Hogan avoidability scale (Appendix 3), will be recorded. Reviews will be completed within 60 working days after allocation and be completed by a person who has received the appropriate training.

These will be reviewed by the Local Safety Panels who will identify the appropriate actions from any learning identified.

The Patient Safety Incident Framework (PSIRF) outlines the following review processes:

Event	Action Required	Lead
Deaths thought more likely than not due to problems in care	Locally Led PSII	The organisation in which the event occurred
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally Led PSII	The organisation in which the event occurred
Incidents meeting the Never Events criteria 2018, or its replacement.	Locally Led PSII	The organisation in which the event occurred
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	As decided by the RIIT
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Maternity and Newborn Safety Investigations (MNSI)	MNSI
Child deaths	Children under the age of 18 must be notified to the Child Death Overview Panel via the local Child Death Review Refer for Child Death Overview Panel review	Child Death Overview Panel

	Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel.	
Deaths of persons with learning disabilities or autism	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	LeDeR programme
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Refer to your local designated professionals for child and adult safeguarding
Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where	PPO or IOPC

	required to do so	
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case	CSP

3.3 Reviewing Findings and Actions to Inform Quality Improvement

Learning from deaths is central to improving care and this will be achieved in the following ways:

- By involving and listening to the family/ carers in the Patient Safety Incident Review process
- By undertaking an analysis of deaths and other incidents, complaints, claims, inquests and surveys from the previous year to inform priority areas for the following year
- By learning from inquests and Prevention of Future Deaths which is reported through the Learning from Deaths Group
- By the Learning from Deaths Group overseeing strategic recommendations and escalate where necessary if progress is slow or limited to the relevant Executive
- The Leaning from Deaths Group will analyse incidents and good practice findings to share as an improvement activity.
- By clinical teams holding regular meetings to share learning from incidents and Structured Judgement Reviews (Quality and Safety Reviews)
- Sharing reviews through the Clinical Governance Committee
- Sharing learning through a range of mechanisms, such as learning events, ‘Learning from Deaths Matters’ bulletin
- The Learning from Deaths Group will monitor outputs for improvements based on safety actions implemented, these will be reported to, Clinical Governance Committee, QPES and Trust Board as outlined in the assurance schedule.

3.4 Training

The reviewers should be trained in undertaking the Structured Judgement Reviews.
All staff will complete the NHSE education Patient Safety e-learning level 1 and where identified clinical staff to complete level 2.

3.5 Learning from Deaths Group

The Learning from Deaths Group is held once a month and is there to provide direction and formally report on progresses against the key work-streams relating to mortality and learning from deaths across the Trust.

The group will consider national guidance to ensure the implementation of best practice standards across the trust. The group will also consider the implications arising out of national reports and enquiries, making recommendations as required to the Trust Clinical Governance Committee.

The objectives of the group are to:

- Receive assurances that all local safety panels within the Trust are reviewing deaths and taking the opportunity to learn from these experiences and that the learning is disseminated amongst the multi-disciplinary team
- Receive assurances regarding learning points gained from inquests and notifications of any Regulation 28 notices received.
- Identify, co-ordinate and track mortality work streams within the Trust to reduce the avoidable mortality and increase the quality of care
- Monitor and review mortality across the Trust and initiate learning gained from mortality

3.6 Reporting

- A quarterly report on themes, trends and analysis for Learning from Deaths will be produced for Trust Clinical Governance Committee and QPES.
- Local reports will be produced for local Clinical Governance Committee.
- The learning form deaths dashboard will be used for monitoring and reporting purposes.

4. RESPONSIBILITIES

Post(s)	Responsibilities	Ref
All Staff	All staff regardless of role have responsibility to recognize, report and engage in the systems for learning from deaths and patient safety incidents	
The Board of Directors	The Trust Board has a responsibility for ensuring there are: • Robust systems for recognising, reporting and reviewing or investigating deaths where appropriate • Systems for learning from outcome of reviews. Learning means taking effective, sustainable action related to the number of deaths where causal factors are the same or similar on review,	

	not in response to one example only • Visible and effective leadership to support staff to improve what they do • Means by which the needs and views of service users, families, carers and the public are central to how the Trust operates	
Non Executive Directors	Non-Executive Directors have the responsibility of being the Trust's 'critical friend', this means testing the assurance the Trust provides of safe and effective systems, providing challenge when needed and holding the Trust Board to account. The responsibility includes understanding the review processes, ensuring they are robust; championing actions that improve patient safety and assuring published information is fair and accurate reflecting the Trust's approach, achievements and challenges.	
Medical Director	The Medical Director has executive responsibility for the application of the learning from deaths systems in place and to ensure there is learning from the outcomes of reviews with measurable actions.	
Learning from Deaths Group	This group, under the chairmanship of the Deputy Medical Director For Quality and Safety, will be responsible for the review and monitoring of Trust learning from avoidable deaths This group has the required multi-disciplinary and multi-professional membership and will meet monthly to oversee the process.	
Local Safety Panel	The Panel will be responsible for ensuring that deaths are reviewed.	
Mortality Lead	Responsible for implementing the Learning from deaths policy and ensuring that opportunities to learn from the deaths and prevent repeat causes are maximised. Work within the Trust's quality governance structure to ensure that the Trust has timely, robust processes in place to assess avoidable harm and its underlying causes and to involve families appropriately. • Work with the Medical Director for Safety & Quality to identify the most impactful actions to reduce avoidable deaths and harm. To inform the Trust's annual quality and safety priorities of the learning and facilitate Quality Improvement programmes to support. • Develop a structure for trust wide learning and sharing of learning across the organisation.	

	• Work with teams to support improvement work and ensure they are embedded and sustainable.	
Medical Examiner	Scrutinise every death not requiring a Coroner investigation, provide expert advice and to confirm the doctor's Medical Certification of Cause of Death ensuring the cause of death is accurate; b) Discuss the cause of death with the family and address any concerns they may raise; c) Identify patterns of causes of death; where indicated refer the death of any patient for review by the most appropriate provider organisation(s).	

5 DEVELOPMENT AND CONSULTATION

Consultation summary		
Date policy issued for consultation	March 2025	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	**Date(s)**	
Learning From Deaths Group		
PDMG		
CGC		
Patient Safety Advisory Group		
Local Safety Panels		
Where received	**Summary of feedback**	**Actions / Response**

6. REFERENCE DOCUMENTS

- Care Quality Commission (2016) "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England
- National Quality Board (2017) "National guidance on Learning from Deaths", National Quality Board, 2017
- Royal College of Physicians mortality review materials**.**
- Patient Safety Incident Response Framework (2022)

7. GLOSSARY

Structured Judgement Review (SJR)

This is a review that blends traditional, clinical judgement-based review methods with a standard format compiled by the Royal College of Physicians, for a retrospective case review. These are completed by trained clinicians using explicit statements to comment on the quality of healthcare and holistic care provided in a way that allows a judgement to be made that is more reproducible.

8. BIBLIOGRAPHY

Thank you to Suffolk and Norfolk NHS Trust for the inspiration from the policy.

9. AUDIT AND ASSURANCE

Element to be monitored	Lead	Tool	Freq	Reporting Arrangements
Criteria for reviews are adhered to	Head of Patient Safety	LFD Dashboard	Yearly	Learning from Deaths Group

10. APPENDICIES

Appendix 1 - Equality Analysis Screening Form

Appendix 2 - Avoidability scoring (Hogan)

APPENDIX 1

EQUALITY ANALYSIS SCREENING FORM

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	Learning from Deaths Policy		
Person Completing this proposal	Samantha Munbodh	**Role or title**	Head of Patient Safety
Division	Governance	**Service Area**	Corporate
Date Started	03/03/25	**Date completed**	03/03/25

Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.

The policy sets out the purpose of Learning from Deaths within BSMHFT, who falls within the scope of LfD and how these will be monitored / reviewed.

Who will benefit from the policy?

All staff employed by BSMHFT and service users

Does the policy affect service users, employees or the wider community?
Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward

We will collect and review data related to protective characteristics to help inform service improvement

Does the policy significantly affect service delivery, business processes or policy?
How will these reduce inequality?

No

Does it involve a significant commitment of resources?
How will these reduce inequality?

No

Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)

No				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*			*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*	
Please click in the relevant impact box and include relevant data.				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age			X	Data analysis will be undertaken to identify is any age groups are disproportionately represented
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			X	Data analysis will be undertaken. For those families affected communication needs to be taken into consideration
a				
Gender			X	Data analysis will be undertaken to identify any disproportionate representation
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships			X	Data analysis will be undertaken to identify gaps in representation
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity			X	Data analysis will be undertaken

This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity			X	Data analysis will be undertaken and for those families affected this will be taken into consideration as part of compassionate engagement
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief			X	Data analysis to be undertaken and taken into consideration with those affected through compassionate engagement to identify how we learn
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation			X	Data analysis to be undertaken to identify over representation
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment			X	Data analysis to be undertaken to identify trends of representation
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights			X	Applies to all
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
		No		

What do you consider the level of negative impact to be?	High Impact	Medium Impact	Low Impact	No Impact
				X

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.

If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

Action Planning:

Learning from deaths will form part of service improvement plans through a quality management system approach

How will any impact or planned actions be monitored and reviewed?

Plans will be monitored through the Learning from Deaths Group

How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.

Quarterly bulletin

Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at **bsmhft.edi.queries@nhs.net**. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix 2

Avoidability scoring (Hogan)

Hogan Avoidability Scale

Scores	Avoidabilty descriptor
Score 1	Definitely Avoidable
Score 2	Strong Evidence of Avoidability
Score 3	Probably Avoidable (More than 50:50)
Score 4	Possibly Avoidable, but not very likely (less than 50:50)
Score 5	Slight Evidence of Avoidability
Score 6	Definitely NOT avoidable

Quality of Care Scoring

1. **Very poor Care** – involves acts of neglect, abuse or incompetence which occur for any reason other than error
2. **Poor Care** – minimal care given to the patient
3. **Adequate care** – Enough or satisfactory care received by the patient
4. **Good care** – Where no cause for concern is found – Standard of care which is expected from PHU
5. **Excellent care** – Where care is exceptional and is gold standard