Leeds Community Healthcare NHS Trust

Mortality Review and Responding to Deaths Policy	
Author (s)	Steph Lawrence Deputy Director of Nursing
Corporate Lead	**Leeds Community Healthcare NHS Trust** Dr Amanda Thomas Executive Medical Director
Document Version	1
Document Status	Final
Date approved by Clinical and Corporate Policies Group (CCPG)	July 2017
Date ratified by SMT	August 2017
Date issued	18 August 2017
Review date	August 2020
Policy Number	PL368

Executive summary

This policy explains the procedures to be followed within Leeds Community Healthcare NHS Trust (LCH) services in relation to mortality review and responding to deaths. This is applicable to all services within LCH and includes the specific processes to be followed in each business unit. The policy is based on National Guidance from the Quality Board around how trusts should investigate and learn from deaths. This should always include engaging with relatives to ensure all relevant aspects of care and delivery are investigated based on relatives experience as well as that of the trust.

Equality Analysis

Leeds Community Healthcare NHS Trust's vision is to provide the best possible care to every community. In support of the vision, with due regard to the Equality Act 2010 General Duty aims, Equality Analysis has been undertaken on this policy and any outcomes have been considered in the development of this policy.

Contents

1 Introduction

1.1 Death is one of, if not, the most significant event in a person's life and broadly falls into one of two sets of circumstances:

- Expected
- Unexpected

1.2 Mortality reviews are a key component of demonstrating effective and safe patient care.

1.3 Whilst mortality reviews have traditionally been held within acute NHS organisations, they have not been routinely held in NHS organisations outside of an acute trust, including NHS services delivered in the community. The Francis Report describes the process of mortality reviews as a key part of reviewing patient outcomes and working towards a high quality service. It is expected by the NHS Trust Development Agency (NTDA), Monitor and the Care Quality Commission (CQC) that NHS organisations have these processes in place.

1.4 The National Quality Board has issued National Guidance on Learning from Deaths and has said that for many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months and years leading up to their death. However, some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. Therefore it is essential we learn from deaths where systems or leadership issues have been a contributory factor to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

2 Aims and Objectives

The aim of this policy is to describe the framework for reviewing all incidents of death both expected and unexpected.

The principal objectives are:

- All incidents of mortality where the patient was under the care of Leeds Community Healthcare NHS Trust (LCH) services are appropriately reviewed to assess if patient mortality was avoidable and to review the quality of care at or near the time of death to ensure patient safety and high quality care.
- Where required actions are taken and learning shared to improve the safety and quality of patient care.
- Being open and transparent in line with our Duty of Candour policy to disclose incidents and poor care practices including avoidable deaths to commissioners and service users and or their relatives.
- Involving service users and or relatives in mortality investigations.
- Benchmarking incidents of mortality with similar NHS organisations to evaluate if LCH incidents of mortality are in keeping with comparable services.

3 Definitions

Expected death: An expected death is the result of an acute or gradual deterioration in a patient's health status, usually due to an advanced progressive incurable disease. The death is anticipated, expected and predicted.

Unexpected death: Unexpected death is a death that is not anticipated or related to a period of illness that has been identified as terminal. (Hospice UK, 2016).

4 Responsibilities

Chief Executive: The Chief Executive has ultimate responsibility for ensuring that the Trust has robust policies and procedures in place for reviewing all incidents of mortality.

Executive Medical Director: The Medical Director is responsible for ensuring that there is a comprehensive mortality and responding to deaths policy, ensuring that all incidents of mortality are appropriately reviewed and where required appropriate actions are taken and learning disseminated.

Clinical and Medical Leads: Are responsible for ensuring there are arrangements for reviewing all incidents of patient mortality. They are also responsible for ensuring each business unit has a Mortality Review Group and Meeting to oversee the management of all reviews which they will manage and oversee for the business unit.

Service Managers and Quality Leads: Are responsible for ensuring all staff are aware of this policy.

Clinical Staff in all Business Units: All staff are responsible for ensuring there is a completed incident report for all deaths unless the service is excluded from this process as determined by the business unit's local process or if this was an expected end of life pathway death and the information is on EPaCCs. The service reporting the death also needs to inform any other service the patient is under the care of that they have reported it, to prevent duplicate reporting. They are also responsible for ensuring they follow their business unit's procedure for escalation in response to reporting of deaths.

Business Unit's Mortality Review Meeting: The members of the Mortality Governance meeting in each business unit are responsible for:

- Attending bi-monthly Mortality Governance meetings
- Supporting the completion of all in-depth reviews.
- Discussing concerns raised by the case reviews.
- Identifying and feeding back learning and action points.
- When considered appropriate, escalating learning and actions points to the Mortality Surveillance Group.

Mortality Surveillance Group: The members of the Mortality Surveillance Group are responsible for:

- Ensuring the delivery of the Mortality Review and Responding to Deaths Policy on behalf of the Quality Committee.
- Attending monthly meetings and ensuring appropriate attendance by all relevant disciplines and professional groups.

- Identifying themes and areas of concern and putting corrective actions or preventative measures into place.
- Reviewing and monitoring quarterly trend figures. Ensuring that possible adverse trends are discussed and undertaking further investigation where this is indicated.

All staff employed by Leeds Community Healthcare NHS Trust must work in concordance with the Leeds Safeguarding Multi-agency Policies and Procedures and local guidelines in relation to any safeguarding concerns they have for service users and the public with whom they are in contact. See Associated Documents for Mortality Surveillance Group Terms of Reference.

5 Mortality Review Process

5.1 All deaths that occur whilst a patient is under the care of LCH services and on an active caseload both expected and unexpected will be reported via Datix®. The only exceptions to this will be if it is already recorded in the Electronic Palliative Care Coordination Systems (EPaCCs) or if the death occurs whilst a patient is under the care of a service that is excluded from this process and as identified in the local process for that business unit (refer to local processes in appendix 3, 4, 5 for exceptions). In addition if a person has been in hospital for more than 24 hours at the point of death this does not need to be reported via LCH.

5.2 Every death reported on Datix® will be specialist reviewed by the Quality Lead on behalf of each business unit to ensure the correct process is instigated in terms of Level 1 and 2 below. The responsibility for completing the Level 1 paperwork rests with the person reporting the death and the case manager will support this with oversight from the cluster case manager and clinical quality lead in the team as appropriate and as per each business unit's process.

.

5.3 All deaths where a patient is on an active caseload across LCH services will be subject to a review as per the local process as defined above. This will include patient deaths reported on Datix®, on EPaCCs or reported via the SUDIC process.

5.4 The mortality review process will be a two level process.

Level 1: All deaths both expected and unexpected will be reviewed via the Level 1 assessment tool (Appendix 1). This will determine whether a more in depth review is required.

Level 2: If a Level 2 investigation is required a Mortality Review Tool must be undertaken (Appendix 2).

5.5 Each business unit will ensure they follow the mortality reporting flowchart for their business unit (Appendix 3, 4, and 5).

5.6 If a number of services are involved in a patient's death these will be considered via the complex deaths investigation SOP. (Appendix 6)

5.7 All services must ensure where a death has occurred that the Duty of Candour process is enacted and all relatives are kept informed regarding investigations etc. and are consulted on what they may want from the investigation.

5.8 Some deaths may fall into the category of serious incidents requiring investigation (SIRI) e.g. a death in custody and where this is the case the SIRI process will be the process used to investigate the death.

5.9 Where the death of a patient with a Learning Disability has occurred whilst under the care of the Trusts services the death will be reported via the Learning Disabilities Mortality Review Programme (LeDeR) and will be subject to that review process which will contribute to the internal LCH review process. These cases will be reported specifically in the quarterly data.

5.10 Where the death of a patient with a mental health condition has occurred whilst under the care of the Trust's services the death will be reported and recorded as such and reported specifically in the quarterly data. The exception to this is a patient with dementia which for the purposes of this policy will not class as a mental health condition.

5.11 Where the unexpected death is a child the death will be reported via the Sudden Unexpected Death in Infants and Children (SUDIC) route and follow that process.

5.12 Expected death in a child who has been under the care of an LCH service in the past 6 months will be reported on Datix and the process for expected death in a child will be followed.

6 Learning from deaths

6.1 The Trust's Mortality Review Process will ensure that where a death has occurred if there are omissions or lapses in care from LCH services the learning is identified and shared appropriately.

6.2 All deaths that are reviewed at Level 2 will be considered by the local Mortality Governance meeting. Where the learning goes beyond the local level this should be escalated to be discussed at the organisation's Mortality Surveillance Group.

6.3 Learning will be shared across the organisation as required and utilising a variety of methods e.g. learning events, workshops etc.

6.4 Learning and actions to be taken by the Trust to prevent a recurrence will be shared with relatives as appropriate.

7 Risk Assessments

Risks identified with the implementation of this policy (and procedure) have been assessed and mitigated as far as possible, in line with the Trust's risk appetite. Should any further risks be identified following implementation, these will be assessed and consideration will be given to an urgent review/revision of the policy (and procedure).

8 Training Needs

The leadership team and Quality and Professional Development will facilitate briefing sessions in each Business Unit to support staff embedding this policy into clinical practice.

9 Monitoring Compliance and Effectiveness

Minimum requirement to be monitored / audited	Process for monitoring / audit	Lead for the monitoring/audit process	Frequency of monitoring / auditing	Lead for reviewing results	Lead for developing / reviewing action plan	Lead for monitoring action plan
Review of quality assurance process and data collection process	Review of Business Unit SOPs	Chair of Business Unit Mortality Group	Annual	Chair of Business Unit Mortality Group	Chair of Business Unit Mortality Group	Chair of Business Unit Mortality Group
	Audit of random sample of Level 1 and Level 2 documentation	Quality Lead	Annual	Clinical Leads from each Business unit	Chair of LCH Mortality Surveillance Group	Chair of LCH Mortality Surveillance Group
Review of process for sharing lessons learnt	Telephone audit of staff regarding understanding of lessons learnt and changes made	Quality Lead	Annual	Chair of LCH Mortality Surveillance Group	Chair of LCH Mortality Surveillance Group	Chair of LCH Mortality Surveillance Group
	Review effectiveness of mechanisms used to share lessons learnt	Clinical Leads	Annual	Chair of LCH Mortality Surveillance Group	Chair of LCH Mortality Surveillance Group	Chair of LCH Mortality Surveillance Group

10 Approval and Ratification process

The policy has been approved by the Clinical and Corporate Policy Group and ratified by SMT on behalf of the Board.

11 Dissemination and Implementation

Dissemination of this policy will be via the Clinical and Corporate Policy Group to services and made available to staff via the intranet.

12 Review arrangements

This policy will be reviewed by the author in three years following ratification or sooner if there is a local or national requirement.

13 Associated documents

PL245 Being Open and Duty of Candour Policy

Mortality Surveillance Group, Terms of Reference:

Mortality Surveillance Group ToR V7 FINAL.

14 References

Care After Death: Registered Nurse Verification of Expected Death Adult Death guidance, Hospice UK, 2016

National Guidance on Learning from Deaths, National Quality Board, first edition March 2017

The Mid Staffordshire NHS Foundation Trust Inquiry: Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005 to March 2009, Volume 1, Chaired by Robert Francis QC, Published 24 February 2010.

Appendix 1:

Leeds Community Healthcare NHS Trust

The purpose of this tool is to perform an initial assessment of the quality of care delivered for the patient. Tool to be completed within 72 hours of receiving notification of the patient's death.

Level 1: Assessment Tool for all Deaths	
Business Unit:	
Service or Team:	
Date of death:	
Patient's age:	
Sex:	
NHS Number:	

Completed by	
Name:	
Designation:	
Date:	

Cause of death from death certificate (if known):	
1 a	
b	
c	
2	

Appendix 2:

Leeds Community Healthcare NHS Trust

	Yes	No	N/A
1. Was the death unexpected?			
2. If the death was *expected*, was there an **absence** of end of life care planning and did this impact negatively on the deceased? Consider evidence of: DNACPR decision making, patient wishes and preferences including Preferred Place of Death.			
3. Were there any concerns about the healthcare that impacted negatively on this patient's death? A concern in healthcare is defined as 'any point where the patient's healthcare fell below an acceptable standard and led to harm' e.g. healthcare associated infection, acquired pressure ulcer, failure to respond in a timely manner to deterioration			
4. Is this case subject to an investigation e.g. Sudden Unexpected Death in a Child (SUDIC), Learning Disability Mortality Review Programme (LeDeR (internal or external)?			
5. Was a complaint made regarding the patient's care?			
6. Will this death be subject to a coronial investigation?			
7. Did the patient have mental health issues? And was this relevant to the cause of death?			
8. Did this patient have a learning disability?			
9. Was a safeguarding concern raised either adult or child relevant to the death?			
If yes to any of the above then a Level 2: Mortality Review Tool must be undertaken			
If a Level 2 Mortality Review is not required, list the identified areas of good practice and compliments received			

Appendix 2:

Leeds Community Healthcare NHS Trust

Level 2: Mortality Review Tool	
Business Unit:	
Service or Team:	
Date of death:	
Patient's age:	
Sex:	
NHS Number:	

Cause of death from death certificate (if known):	
1 a	
b	
c	
2	

Completed by	
Name:	
Designation:	
Date:	

1: Why was this case chosen for a Level 2 review?
Outline reasons for a Level 2 review e.g. issue identified through Level 1 assessment, audit or other.

	Yes	No
2: Have the relatives been invited to contribute to the review/set terms of reference?		
3. Has the member of staff involved been offered relevant support?		

3: Review the patient's background, admissions care and events leading to death. Consider the following but this is not an exhaustive list

- Concerns regarding assessment, diagnosis and management, including whether the patient had appropriate senior medical input
- Timeliness of diagnosis, investigations, delivery of care/treatment
- Appropriate monitoring and response to e.g. early warning scores, abnormal test results
- Harms including (but not limited to) hospital acquired VTE/MRSA infection/C.difficile infection/inpatient fall/pressure ulcer/allergic reaction/incorrect medication
- Appropriate escalation of care.
- If Learning Disability Mortality Review Programme (LeDeR (internal or external) or mental health issues notify Deputy Director of Nursing.
- Communication between healthcare professionals and/or with family
- Quality of end of life care, including timely and appropriate DNACPR decision, where appropriate

Areas of good practice identified

Concerns regarding care

	Yes	**No**
Have these issues been incident reported via Datix? e.g. an adverse incident that has not previously been reported		
Has there been an error or omission in care which would invoke duty of candour?		

Learning points

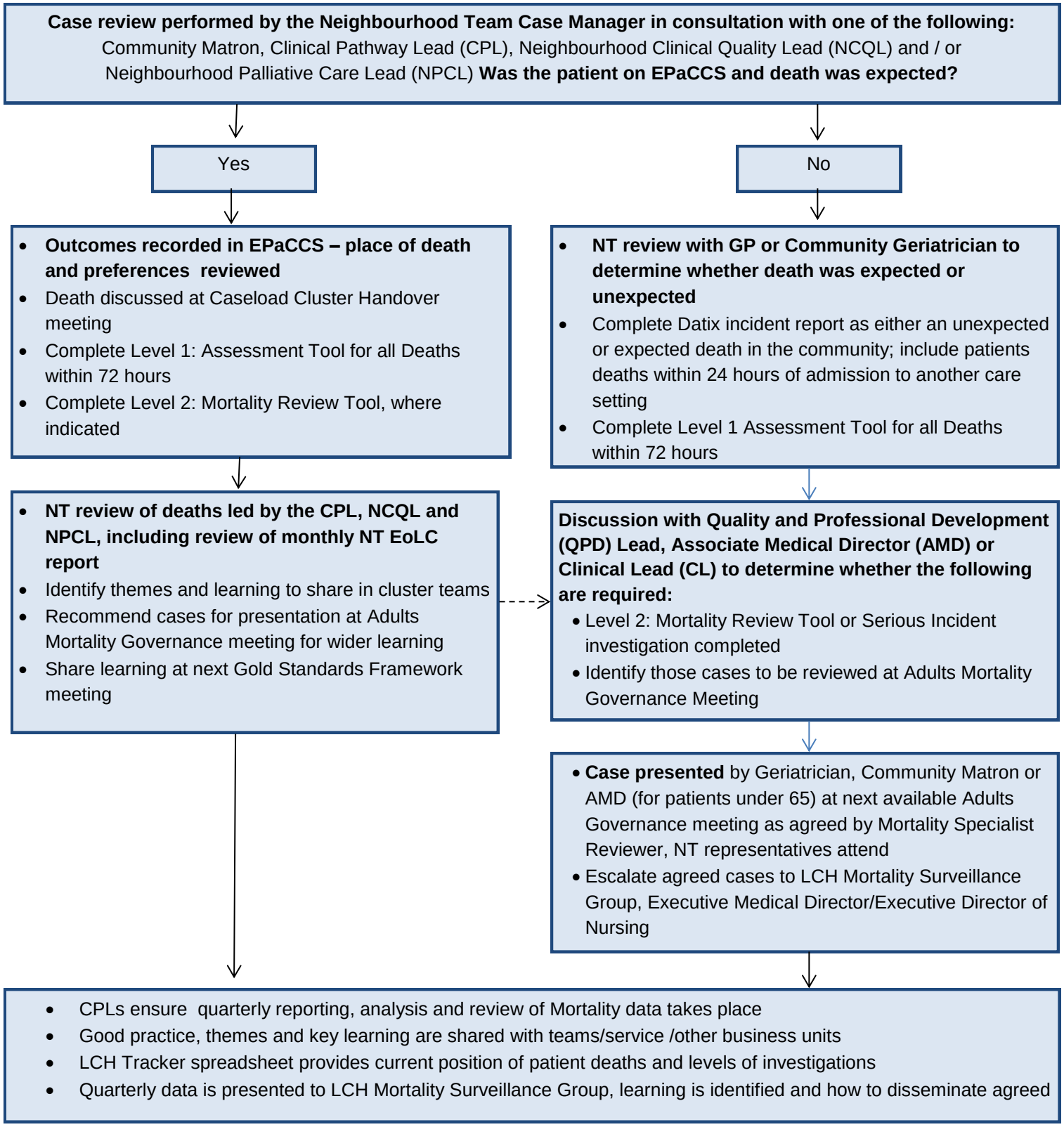
Action Points

	Yes	No
Are there areas of learning that need to be shared across the Trust and reported to the LCH Mortality Surveillance Group? Outline below		
Does this case require escalation to the LCH Mortality Surveillance Group? Use Business Unit Reporting SOP to determine this and follow procedure for escalation		

Appendix 3

Revised Mortality Review Process for Adult Neighbourhood Teams (NT)

This flowchart supports the review process for investigating patient deaths, where required, identifying good practice and areas for further improvement; the findings and actions are shared in cluster/team meetings



Definitions

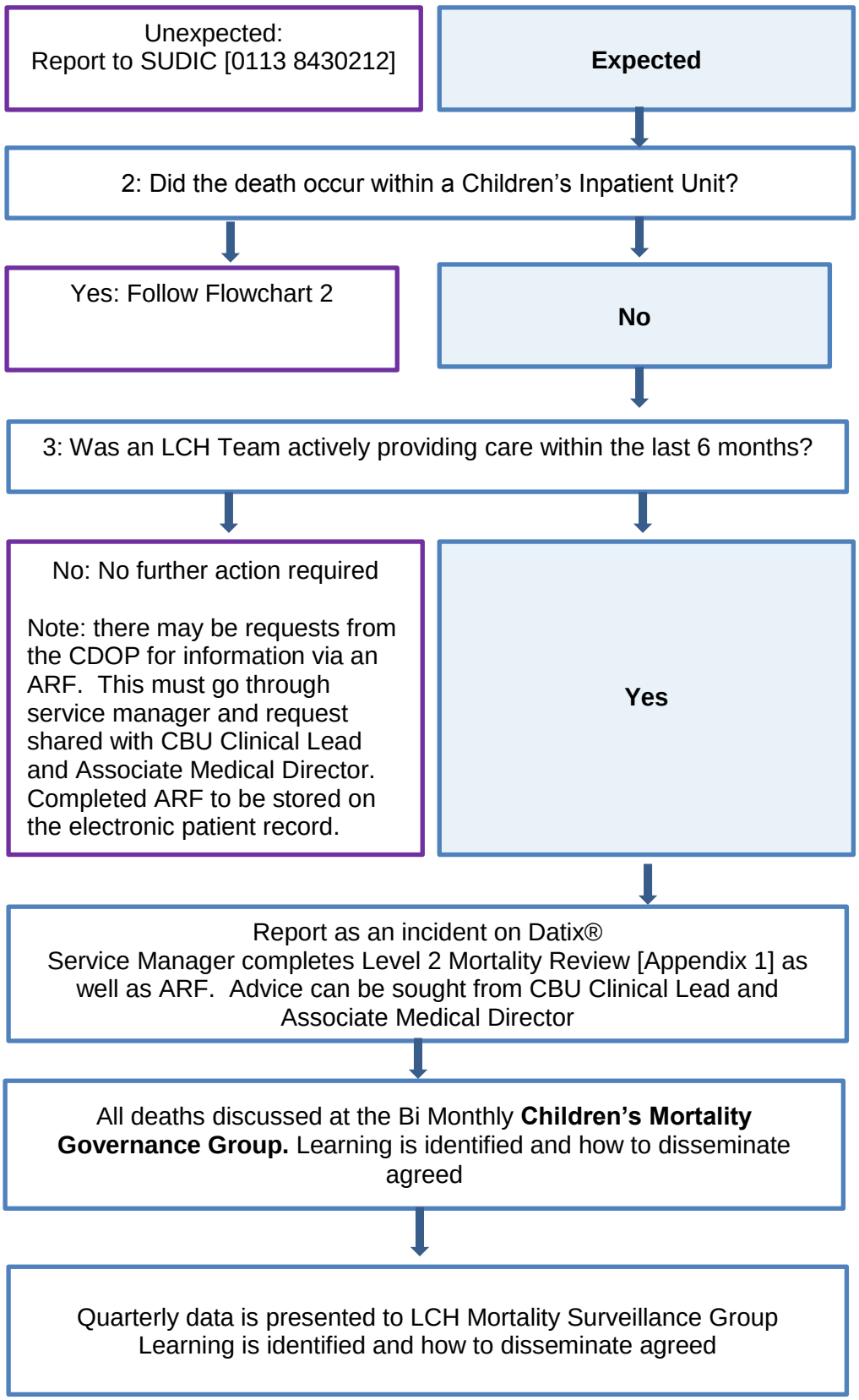
Expected death is the result of an acute or gradual deterioration in a patient's health status, usually due to advanced progressive incurable disease. The death is anticipated, expected and predicted.

Sudden or unexpected death is a death that is not anticipated or related to a period of illness that has been identified as terminal.

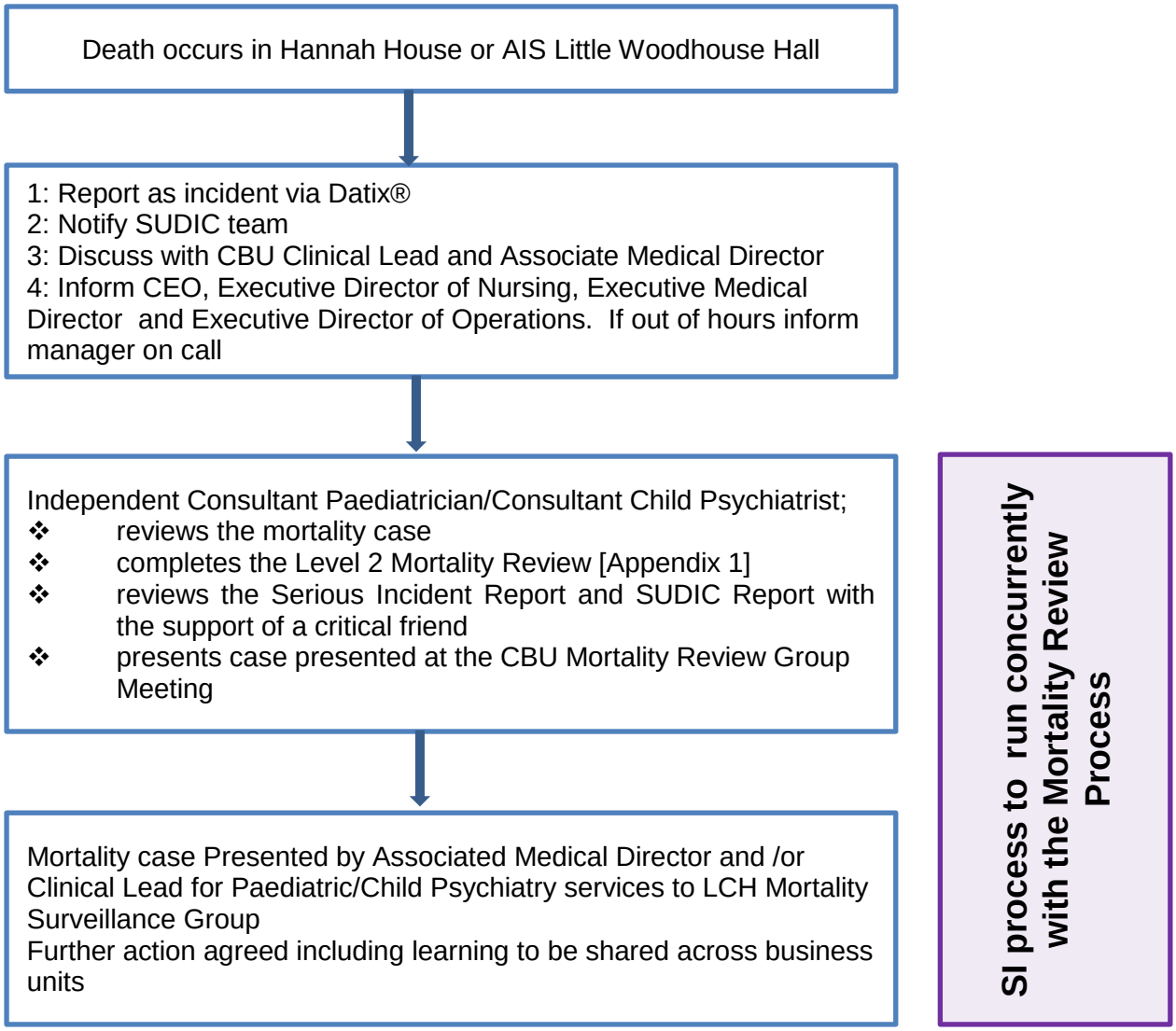
Reference 2017 Hospice UK *Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance*

Appendix 4: CBU Mortality Reporting Process

Flowchart 1: Reporting and Review Process for a Child Death by LCH Practitioners



Flowchart 2: Reporting and Review Process for a Child Death in a Children's Inpatient Unit



Appendix 5: SBU Mortality Reporting Process

Service informed of patient death.

The following services are exempt from the process below. (Any deaths as a result of care provided by these services would be picked up in the SI process or through another service)

- Podiatry
- Dental
- Community Gynaecology
- Leeds Sexual health Service
- Musculoskeletal / Spine fit
- Speech and Language Therapy Adult learning difficulties. (These fall into the LYPFT mortality review process)
- Police Custody and Youth offender institute would follow the death in custody Policy /process.

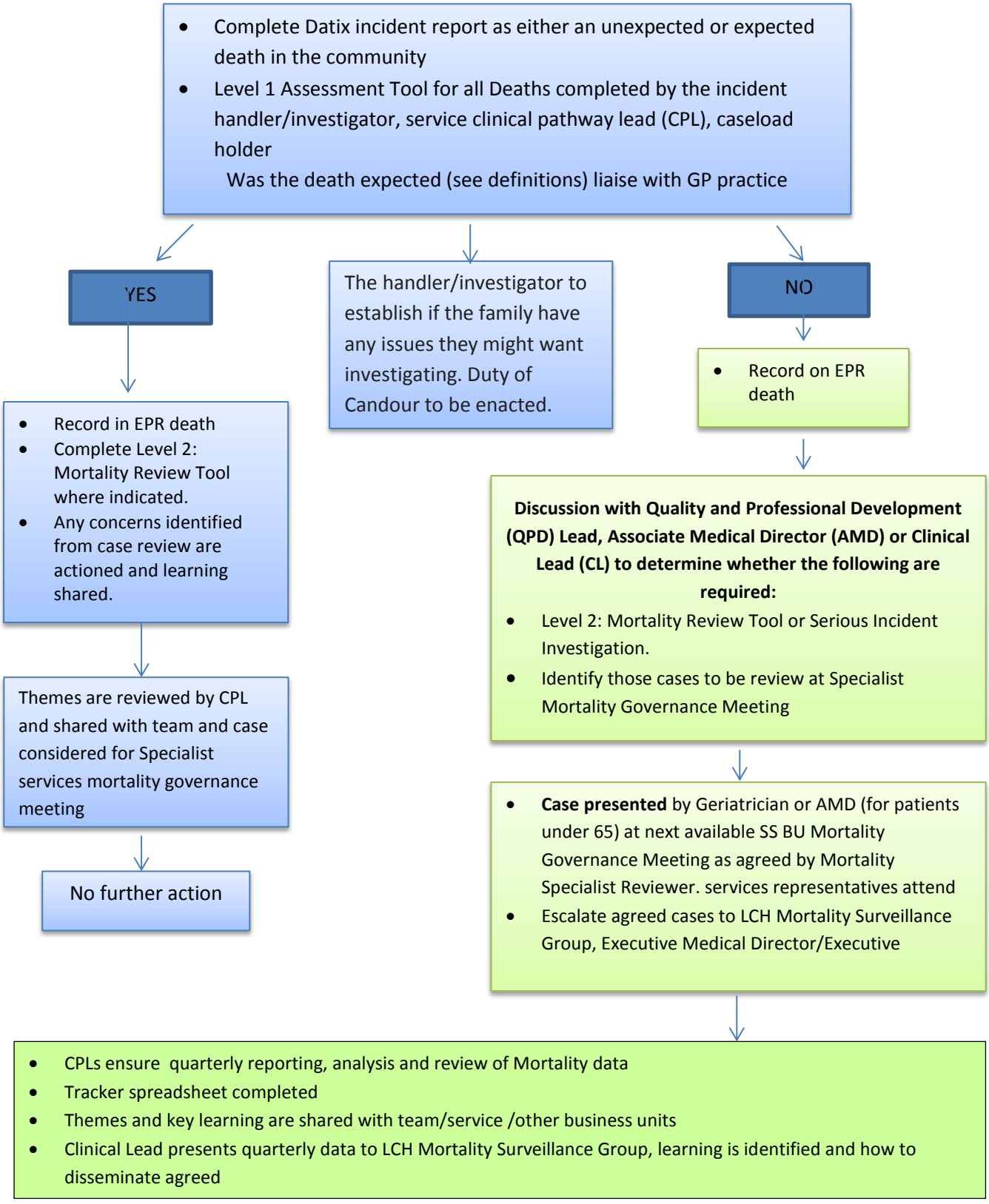
All other services would follow the process below. The exemptions being:

- Patient is under the neighbourhood team or children's services are involved. (They would take the lead and the specialist services would provide information and participate in the investigation as requested).
- Patient is on the Electronic Palliative Care Coordination Systems (EPaCC)
- Patient has been in hospital for **more** than 24 hours at the point of death

Inclusion:
All other patient deaths that occur whilst a patient is under the care of LCH services and on an active caseload (this includes patients on a waiting list where there has been a clinically relevant contact) both expected and unexpected will be reported on Datix® and the process below followed.

Service reporting death

- The service reporting the death to inform any other service that the patient is under their care and they have reported the death to prevent duplicate reporting.
- If a number of services are involved in a patient's death these will be considered via the complex deaths investigation SOP. (Appendix 6)



Definitions **Expected death** is the result of an acute or gradual deterioration in a patient's health status, usually due to advanced progressive incurable disease. The death is anticipated, expected and predicted **Sudden or unexpected death** is a death that is not anticipated or related to a period of illness that has been identified as terminal.

Reference

2016 Hospice UK and National Nurse Consultant Group: Palliative Care (2016) *Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance*

Appendix 6:

Standard Operating Procedure (SOP) Complex Deaths Investigation	
Author (s)	Stephanie Lawrence Deputy Director of Nursing
Service and Clinical Lead	**Leeds Community Healthcare NHS Trust** Quality and Professional Development Marcia Perry, Executive Director of Nursing
Applies to	All staff in LCH clinical services
Document Version	1
Document Status	
Date approved by service	1 June 2017
Date issued	
Review date	June 2019 or sooner if: learning points identify a required change in the SOP e.g. following a serious incident
SOP Number	To be inserted by service

1 Introduction

This SOP is intended for the use of all clinical services where an unexpected death needs to be investigated and there are several services involved with the persons care.

2 Scope

Relevant for all clinical services where an unexpected death requires investigation and there is complexity due to the number of services involved in the persons care.

3 Definitions

An unexpected death is one where the death was not expected by a service.

A case that would be classed as complex for the purpose of this SOP is where there is more than one service involved in a person's care and the investigation requires coordination.

4 Responsibilities

All staff employed by Leeds Community Healthcare NHS Trust, must work in concordance with the Leeds Safeguarding Multi-agency Policies, Procedures and local guidelines in relation to any safeguarding concerns they have for children or adults they are in contact with.

The Business Unit Quality Leads are responsible for ensuring any unexpected deaths where the investigation is complex are escalated to the Deputy Director of Nursing to enable a joint investigation with all services involved chaired by the Deputy Director of Nursing.

The service leads will be responsible for ensuring that all reports are written and submitted as required.

5 Training Needs

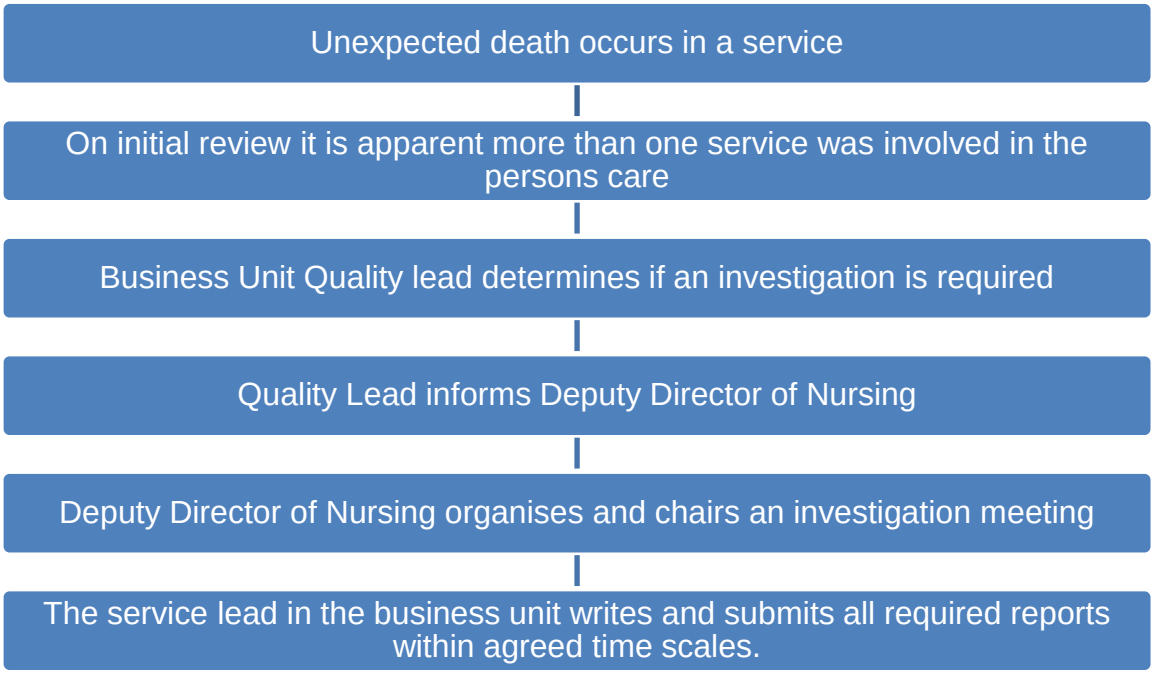
Refer to the Statutory and Mandatory Training Policy including Training Needs Analysis. Up to date information is available on the Intranet for course details.

Awareness and access to SOPs will form part of staff induction, and awareness will be raised with existing staff, including when changes have been made.

6 Risk Assessments

As per usual LCH policy, nothing specific relating to this SOP.

7 Operating Procedure



All unexpected deaths within LCH are reported on Datix®. If a death involves more than one service and there is a need to pull together a meeting for an investigation of the issues this SOP will apply.

The Business Unit Quality Lead will identify unexpected deaths requiring investigation and where this involves more than one service and an investigation is required this will be escalated to the Deputy Director of Nursing who will be responsible for organising and chairing the investigation meeting.

The service leads will attend the meeting and will be responsible for writing all required reports within the requested time scales.

Leeds Community Healthcare NHS Trust

LEEDS COMMUNITY HEALTHCARE NHS TRUST

Mortality Surveillance Group Terms of Reference

Version: **7.0 – FINAL**

Approved by: **QUALITY COMMITTEE**

Date approved: **20 FEBRUARY 2017**

Date issued:

Review date:

Document History:

Version:	7.0 Final
Approved by and date:	Quality Committee 20 February 2017
Ratified by and date:	Quality Committee 20 February 2017
Name of author:	Amanda Thomas – Executive Medical Director Carolyn Nelson - Head of Medicines Management
Name of responsible committee/individual:	Leeds Community Healthcare NHS Trust Board through the Leeds Community Healthcare NHS Trust Quality Committee
Date issued:	
Review date:	
Target audience:	Leeds Community Healthcare NHS Trust Board Quality Committee Mortality Surveillance Group

1. Overall aim/purpose

1.1 The overall aim of the Mortality Surveillance Group (MSG) is to review all data on inpatient and community deaths, the quality of care provided, identify learning and consider strategies to reduce avoidable mortality.

2. Membership

2.1 The membership of the Mortality Surveillance Group will comprise:

- Executive Medical Director – Chair of the group
- Deputy Director of Nursing – Deputy Chair
- Head of Medicines Management (deputy to be Medicines Management Pharmacist)
- Associate Medical Directors
- AHP Lead and Head of Patient Experience
- Clinical Lead – Adults, with deputies to be the Clinical Leads from Children's or Specialist
- York Street Homeless Practice to April 2017
- Palliative Care Lead

2.2 In addition to the membership, co-opted members can be invited, as required.

3. Quorum

3.1 The Chair will preside at all meetings. In extraordinary circumstances where the Chair cannot attend, the Deputy Chair shall preside.

3.2 A quorum shall be four people, including at least one executive or deputy and at least one from each of the following professional groups:

- Doctor
- Nurse
- Pharmacist
- AHP

3.3 If the Group is not quorate the meeting may be postponed at the discretion of the Chair. If the meeting does take place and is not quorate, no decision shall be made at that meeting and such matters must be deferred until the next quorate meeting. In the case of non-agreement or no decision reached by the majority, the issue is to be escalated to the Quality Committee for discussion.

4. Frequency of meetings

4.1 The Group will meet at least quarterly per year.

4.2 Special meetings of the Group can be arranged for specific purposes as necessary.

4.3 Members are expected to attend all meetings. All members are required to identify a suitable deputy to attend meetings in their absence.

4.4 If any member has an interest, pecuniary or otherwise, in any manner and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the Group's consideration has been completed.

4.5 The Chair of the Mortality Surveillance Group may also act on urgent matters arising between meetings of the Group, in line with the organisation's *Chair's Action Procedure.*

5. Duties

5.1 To act as the strategic Trust mortality overview group with the purpose of reviewing all inpatient and community deaths and reducing all avoidable inpatient deaths.

5.2 To review data, analyse trends, identify themes and learning.

5.3 To receive information on trends from deaths outside of inpatient areas.

5.4 To provide a high level report of any trends identified from mortality reviews.

5.5 To report on mortality performance to the Trust Board through the Quality Committee.

5.6 To develop data collection systems to ensure the Trust's mortality data is timely, robust and in line with national best practice.

6. Roles & responsibilities

6.1 The Mortality Surveillance Group will:

6.1.1 Review all available data on inpatient and LCH community services deaths and ensure appropriate governance processes are in place.

Inpatient units for the purpose of the MSG will include:

- CICU
- SLIC
- CRU
- Little Woodhouse Hall
- Hannah House.

6.1.2 To review the information on trends from deaths outside of in-patient areas and identify learning.

6.1.3 Consider the mortality data in conjunction with other qualitative clinical data and identify areas for future investigation.

6.1.4 Investigate or review information, policy, reports and notifications from regulatory bodies.

6.1.5 Advise on the development of data collection systems to ensure the Trust's in-patient mortality data is timely, robust and in line with national best practice.

6.1.6 Ensure local business unit learning is co-ordinated and shared.

6.1.7 Identify raised mortality, themes and trends in particular clinical services and initiate further action with reports back to the group.

6.1.8 To review and monitor compliance with relevant Trust guidelines.

6.1.9 Identify potential Trusts to develop benchmarked mortality rates.

7. Record keeping

7.1 The Group will be supported by a nominated secretary who will:

- Prepare the agenda and papers with the Chair and circulate;
- Maintain accurate records of attendance, key discussion points and decisions taken, and issue necessary action logs within five working days of the meeting;
- Draft minutes for circulation to members within five working days of the meeting;
- Maintain a database of any documents discussed and/or approved and recall them to the Group when due;
- Organise future meetings; and
- File and maintain records of the work of the Group.

8. Review

8.1 The purpose, function, responsibilities and duties of this Group will be reviewed on an annual basis.

Policy Consultation Process

Title of Document	Mortality Review and Responding to Deaths Policy
Author (s)	Steph Lawrence, Deputy Director of Nursing
New / Revised Document	New
Lists of persons involved in developing the policy	Dr Amanda Thomas
List of persons involved in the consultation process	Julie Mountain, Head of Neighborhoods Service Caroline McNamara, Clinical Lead Adult Services Sarah McDermott, Service Lead Palliative Care Gill Armstrong, Quality Lead Adult Services Elaine Goodwin, Clinical Lead Specialist Services Philip Boynes, Quality Lead Specialist Services Karen Worton, Clinical Lead Childrens Service Helen Rowland, Quality Lead Childrens Services Carolyn Nelson, Head of Medicines Management Maureen Drake, Professional Lead Allied Health Professionals Charles Stanley, Associate Medical Director, CAMHS Florence McDonagh, Associate Medical Director, Community Paediatrics Rachel Howitt, Incident and Assurance Manager