Wirral Community Health and Care NHS Foundation Trust

# Mortality Report: Learning from Deaths Framework Quarter 2: 01 July 2019 - 30 September 2019

| | | | |
|---|---|---|---|
| **Meeting** | Board of Directors | | |
| **Date** | 05/02/2020 | **Agenda item** | **16** |
| **Lead Director** | Nick Cross, Medical Director | | |
| **Author(s)** | Nick Cross, Medical Director | | |

**Action required** (please tick the appropriate box)

| | | |
|---|---|---|
| **To Approve** ☑ | **To Discuss** ☐ | **To Assure** ☐ |

## Purpose

The purpose of this paper is to provide assurance to the members of the Quality and Safety Committee in relation to the implementation of the Learning from Deaths framework. It is also seeking approval for the statutory report to be presented to Public Board along with its subsequent publication on the Trust website.

## Executive Summary

This quarterly report provides evidence that learning from deaths is firmly embedded as a priority across the Trust, ensuring full adherence to the NQB Learning from deaths framework. It provides anonymised details of the numbers of unexpected deaths which have occurred within the Trust throughout Q2 19/20, along with a summary of thematic learning identified during investigation into these cases. Attached as an appendix is a report detailing this information for purposes of publication of the Trust website.

**Risks and opportunities:**
Not applicable

**Quality/inclusion considerations:**
Quality Impact Assessment completed and attached No
Equality Impact Assessment completed and attached No
A QIA and EIA is not applicable in this particular case

**Financial/resource implications:**
Not applicable

**Trust Strategic Objectives**
*Please select the top three Trust Strategic Objectives that this report relates to, from the drop down boxes below.*

| | | |
|---|---|---|
| Our Populations - outstanding, safe care every time | Our Populations – provide more person-centred care | Our Populations - improving services through integration and better coordination |

## Committee action

The committee is asked to be assured that process are in place to meet our statutory obligations surrounding Learning From Deaths and to approve that the report in Appendix 1 can be presented in Public Board and subsequent publication on the Trusts website

## Report history

| Submitted to | Date | Brief summary of outcome |
|---|---|---|
| Mortality Review Group | 15/10/2019 | Report for QSC approved |

Wirral Community Health and Care NHS Foundation Trust

# Mortality Report: Learning from Deaths
# Quarter 2: 01 July 2019 - 30 September 2019

## Purpose

1. The purpose of this paper is to provide assurance to the members of the Board in relation to the implementation of the Learning from Deaths framework.

## Executive Summary

2. Wirral Community Health and Care NHS Foundation Trust (WCHC) Board recognises that effective implementation of the Learning from deaths framework (National Quality Board, March 2017), is an integral component of the Trusts' learning culture, driving continuous quality improvement to support the delivery of high quality sustainable services to patients and service users.

3. In December 2016, the Care Quality Commission (CQC) published its report: Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. The recommendations of this report were accepted by the Secretary of State and incorporated into a Learning from Deaths framework by the National Quality Board (NQB) in March 2017.

4. The Learning from Deaths framework aims to address the key findings of the CQC report, ensuring a consistent approach to learning from deaths across the NHS, assuring a transparent culture of learning by delivering a commitment to continuous quality improvement, particularly in relation to the care of vulnerable people.

5. The key findings of the CQC report were as follows:

   - Families and carers are not treated consistently well when someone they care about dies.
   - There is variation and inconsistency in the way that trusts become aware of deaths in their care.
   - Trusts are inconsistent in the approach they use to determine when to investigate deaths.
   - The quality of investigations into deaths is variable and generally poor.
   - There are no consistent frameworks that require boards to keep deaths in their care under review and share learning from these.

6. This quarterly report provides evidence that learning from deaths is firmly embedded as a priority across the Trust, ensuring full adherence to the NQB Learning from deaths framework.

7. WCHC compliance with the NQB framework has been self-assessed by an internal review of the Board Leadership requirements as outlined in the National Guidance on Learning from Deaths (NQB, March 2017). The RAG rating for this process has been included in the inaugural Learning from Deaths report.

## WCHC Learning from deaths governance framework

8. All reported deaths are discussed at the weekly Clinical Risk Management Group (CRMG). Further investigations are commissioned on the basis of the events surrounding the death and on the results of the Mortality Screening Tool. The principles around Duty of Candour are also overseen within this group.

9. Pending investigations are monitored against progress and timelines and expediated where necessary. Any reports (ie Root Cause Analysis - RCA) and associated action plans are quality assured at CRMG. This includes cases which are under investigation by the coroner.

10. Lessons learnt and learning themes from Learning from Deaths cases are reviewed at the Trust's quarterly Mortality Review Group which is chaired by the Executive Medical Director who is responsible for the Learning from Deaths agenda.

11. Minutes from the Mortality Review Group are submitted to the Standards Assurance Framework for Excellence (SAFE) Steering Group, which in turn reports directly to the Quality and Safety Committee and finally to the Board.

12. A report is produced which summarises the details of the deaths which have occurred within the preceding quarter, along with details of any thematic learning. This is ratified by the Quality and Safety Committee prior to being presented to Public Board, again on a quarterly basis.

13. In accordance with the Learning from Deaths framework, the Trust ratified and published a Learning from Deaths Policy during September 2017.

14. The policy provides a framework for how the Trust will evaluate those deaths that from part of our mortality review process, the criteria for review and quarterly and annual reporting mechanisms.

15. The Trust's Datix incident reporting system has been aligned to the Learning from Deaths Policy to ensure prompt communication to the Executive Medical Director, Director and Deputy Director of Nursing for all reported unexpected deaths. This includes integrating the Mortality Screening Tool with Datix.

16. The Incident Management Policy - GP08 has been updated during January 2018 and cross references the newly implemented Learning from Deaths Policy, ensuring a consistent approach to implementation. The revised policy contains arrangements for staff to follow in the event of an unexpected death of an adult and in the event of an unexpected death of a child.

17. The Trust continues to work with our system partners to devise systems whereby Learning from Deaths can take place in a consistent way across all major health and social care providers.

18. The Learning from Deaths report is based on the template devised by the National Quality Board. This report will be published on the Trust's website in keeping with our statutory obligations.

19. The Learning from Deaths Framework is aligned to the Trust's Duty of Candour Policy.

**Q2 2019/20 WCHC Reported deaths (Datix incident reporting)**

20. During Q2 there were a total of 16 reported deaths within scope.

21. During Q2 no deaths met the criteria for StEIS reporting.

22. In all cases Duty of Candour was carried out in keeping with Trust Policy.

| **Recording data on Structured Judgement Reviews:** | | |
|---|---|---|
| Total Number of Deaths in scope | 16 | |
| Total number of deaths reviewed through Structured Judgement Review methodology | 16 | W30593 – 0-19 – child death, 72h, Suicide, no learning<br>W30875 – 0-19 – child death, SUDiC/CDOP, no learning<br>W31024 – ICCT – RCA, coroner case, no learning<br>W31246 – ICCT – Sepsis, 72h, learning noted<br>W31509 – ICCT – 72h, S42, coroner, learning noted<br>W31521 – Child death, no learning<br>W31508 – Child death, SUDiC, no learning<br>W31550 – ICCT, 72h, good practice, no learning<br>W31572 – Child death, SUDiC, no learning<br>W31704 – ICCT, S42, no learning |

| | | |
|---|---|---|
| | | W31872 – ICCT, fall, natural causes, no learning<br>W31915 – ICCT, no learning<br>W32149 – ICCT, S42, no concerns, no learning<br>W31919 – ICCT, RCA, learning noted<br>W32073 – Community nursing, RCA in progress<br>W32251 – Safeguarding, suicide, 72h, no learning |
| Total Number of Deaths considered to have more than 50% chance of being avoidable | 0 | |
| | | |
| **Recording data on LeDeR reviews:** | | |
| Total Number of Deaths in scope | 0 | |
| Total Deaths reviewed through LeDeR methodology | 0 | |
| Total Number of deaths considered to have been potentially avoidable | 0 | |
| | | |
| **Recording data on SUDIC reviews:** | | |
| Total Number of Child Deaths | 5 | |
| Total Deaths reviewed through SUDIC methodology | 4 | |

**Summary of Thematic Learning**

23. Each unexpected death reported during Q2 has been analysed and investigated as appropriate, to identify any relevant learning points for the Trust and the wider health and social care system.

24. Of the 16 cases reported, after investigation, three had lessons which the Trust could learn from.

25. The themes from the learning included:

- The need to adhere to the Comfort Calling Policy as an important part of safety netting processes during the Out of Hours period. As a result, a staff communication was circulated to all operational staff with the Urgent Care service and it was also raised as a point of discussion during the Senior Leadership Team meeting.
- Following one death involving potential safeguarding concerns, there was a delay in communication with the police. This was discussed with the coroner and communication pathways were reviewed, revised to add clarity and communicated to teams.
- Following one death, a review of processes surrounding fire risk assessment was undertaken. As a consequence, an action plan was devised to share learning and raise awareness of the importance of risk assessments in high risk people. Home fire risk assessment forms and tools were added to the clinical system and also a fire safety guidance pack was devised in partnership with Merseyside Fire and Rescue.

**Update of Outstanding cases from Previous Reports**

26. There was one outstanding case from the previous Q1 report, relating to W30537. This case was STEIS reported, with the RCA being approved via CRMG and reviewed by the CCG.

27. The following learning was identified along with outcomes:

- The importance of completing assessments and scoring tools were identified alongside the need to update senior clinicians and GPs of changing circumstances.
- To minimise the risk of recurrence, the Patient Safety System was made more robust. The staff handover process was reviewed and revised. Team leaders and Hub managers were tasked with sharing the learning regarding documentation and assessment completion. In addition, learning was shared at a Wirral-wide Team Leaders forum, Divisional Governance groups and within the Safety Soundbite publication.

**Recommendations**

28. The Board of Directors is asked to be assured that quality governance systems are in place to ensure continuous monitoring and learning from deaths in accordance with Trust policy.

29. The Board of Directors is asked to be assured the Trust is actively involved in supporting the system-wide development of processes reporting and learning from deaths.

**Dr Nick Cross**
**Executive Medical Director**

15 November 2019

**Appendix 1**

**Learning From Deaths Q2 19/20 Report**

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 2 19/20.

A more detailed report has been ratified and approved by the Quality and Safety Committee as per the Learning from Deaths Policy.

There were 16 deaths reported within scope during this period and all have been reviewed in accordance with Trust policy. Duty of Candour was met in all cases.

16 deaths were not deemed attributable to the care provided by the Trust.

The following learning points were recorded:

- The need to adhere to the Comfort Calling Policy as an important part of safety netting processes during the Out of Hours period. A focussed communication was produced to address the issues raised.
- Communication pathways with external stakeholders (police) were reviewed, revised to add clarity and communicated to teams.
- Following one death, a review of processes surrounding fire risk assessment was undertaken and an action plan devised to share learning and raise awareness of the importance of risk assessments in high risk people. Home fire risk assessment forms and tools added to the clinical system. Fire safety guidance pack devised in partnership with Merseyside Fire and Rescue completed.

There were no deaths which were subject to a LeDeR review.

There were 5 child deaths, all of which were appropriately reported and scrutinised. 4 of these cases followed the SUDIC process and did not reveal any learning specific for the Trust.

We continue to promote shared learning across the health and social care economy.

Dr Nick Cross
Executive Medical Director
Wirral Community Health and Care NHS Foundation Trust

28 October 2019

Wirral Community Health and Care NHS Foundation Trust

# Mortality Report: Learning from Deaths Framework
# Quarter 3: 01 October 2019 - 31 December 2019

| | | | |
|---|---|---|---|
| **Meeting** | Board of Directors | | |
| **Date** | 05/02/2020 | **Agenda item** | **16** |
| **Lead Director** | Nick Cross, Medical Director | | |
| **Author(s)** | Nick Cross, Medical Director | | |

**Action required** (please tick the appropriate box)

| | | |
|---|---|---|
| **To Approve** ☑ | **To Discuss** ☐ | **To Assure** ☑ |

**Purpose**

The purpose of this paper is to provide assurance to the members of the Quality and Safety Committee in relation to the implementation of the Learning from Deaths framework. It is also seeking approval for the statutory report to be presented to Public Board along with its subsequent publication on the Trust website.

**Executive Summary**

This quarterly report provides evidence that learning from deaths is firmly embedded as a priority across the Trust, ensuring full adherence to the NQB Learning from deaths framework. It provides anonymised details of the numbers of unexpected deaths which have occurred within the Trust throughout Q3 19/20, along with a summary of thematic learning identified during investigation into these cases. Attached as an appendix is a report summarising this information for purposes of publication on the Trust website. The report format and content has evolved to reflect the involvement of bereaved families.

**Risks and opportunities:**

Not applicable

**Quality/inclusion considerations:**

Quality Impact Assessment completed and attached No
Equality Impact Assessment completed and attached No
A QIA and EIA is not applicable in this particular case

**Financial/resource implications:**

Not applicable

**Trust Strategic Objectives**

*Please select the top three Trust Strategic Objectives that this report relates to, from the drop down boxes below.*

| | | |
|---|---|---|
| Our Populations - outstanding, safe care every time | Our Populations – provide more person-centred care | Our Populations - improving services through integration and better coordination |

**Committee action**

Board is asked to be assured that 1: processes are in place to meet our statutory obligations surrounding Learning From Deaths 2: that processes are in place to engagement with families and meet our Duty of Candour obligations and 3: to approve the report in Appendix 1 which can be presented in Public Board and subsequently published on the Trusts website

**Report history**

| Submitted to | Date | Brief summary of outcome |
|---|---|---|
| Mortality Review Group | 09/01/2020 | Report for QSC approved |
| Quality and Safety Committee | 22/01/2020 | Report provided assurance and was approved |

Wirral Community Health and Care NHS Foundation Trust

# Mortality Report: Learning from Deaths
# Quarter 3: 01 October 2019 - 31 December 2019

## Purpose

1. The purpose of this paper is to provide assurance to the members of the Board in relation to the implementation of the Learning from Deaths framework.

## Executive Summary

2. Wirral Community Health and Care NHS Foundation Trust (WCHC) Board recognises that effective implementation of the Learning from deaths framework (National Quality Board, March 2017), is an integral component of the Trusts' learning culture, driving continuous quality improvement to support the delivery of high quality sustainable services to patients and service users.

3. In December 2016, the Care Quality Commission (CQC) published its report: Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. The recommendations of this report were accepted by the Secretary of State and incorporated into a Learning from Deaths framework by the National Quality Board (NQB) in March 2017.

4. The Learning from Deaths framework aims to address the key findings of the CQC report, ensuring a consistent approach to learning from deaths across the NHS, assuring a transparent culture of learning by delivering a commitment to continuous quality improvement, particularly in relation to the care of vulnerable people.

5. The key findings of the CQC report were as follows:

   - Families and carers are not treated consistently well when someone they care about dies.
   - There is variation and inconsistency in the way that trusts become aware of deaths in their care.
   - Trusts are inconsistent in the approach they use to determine when to investigate deaths.
   - The quality of investigations into deaths is variable and generally poor.
   - There are no consistent frameworks that require boards to keep deaths in their care under review and share learning from these.

6. This quarterly report provides evidence that learning from deaths is firmly embedded as a priority across the Trust, ensuring full adherence to the NQB Learning from deaths framework.

7. WCHC compliance with the NQB framework has been self-assessed by an internal review of the Board Leadership requirements as outlined in the National Guidance on Learning from Deaths (NQB, March 2017). The RAG rating for this process has been included in the inaugural Learning from Deaths report.

## WCHC Learning from deaths governance framework

8. All reported deaths are discussed at the weekly Clinical Risk Management Group (CRMG). Further investigations are commissioned on the basis of the events surrounding the death and on the results of the Mortality Screening Tool. The principles around Duty of Candour are also overseen within this group.

9. Pending investigations are monitored against progress and timelines and expediated where necessary. Any reports (ie Root Cause Analysis - RCA) and associated action plans are quality assured at CRMG. This includes cases which are under investigation by the coroner.

10. Lessons learnt and learning themes from Learning from Deaths cases are reviewed at the Trust's quarterly Mortality Review Group which is chaired by the Executive Medical Director who is responsible for the Learning from Deaths agenda.

11. Minutes from the Mortality Review Group are submitted to the Standards Assurance Framework for Excellence (SAFE) Steering Group, which in turn reports directly to the Quality and Safety Committee and finally to the Board.

12. A report is produced which summarises the details of the deaths which have occurred within the preceding quarter, along with details of any thematic learning. This is ratified by the Quality and Safety Committee prior to being presented to Public Board, again on a quarterly basis.

13. In accordance with the Learning from Deaths framework, the Trust ratified and published a Learning from Deaths Policy during September 2017.

14. The policy provides a framework for how the Trust will evaluate those deaths that from part of our mortality review process, the criteria for review and quarterly and annual reporting mechanisms.

15. The Trust's Datix incident reporting system has been aligned to the Learning from Deaths Policy to ensure prompt communication to the Executive Medical Director, Director and Deputy Director of Nursing for all reported unexpected deaths. This includes integrating the Mortality Screening Tool within Datix.

16. The Incident Management Policy - GP08 has been updated during January 2018 and cross references the newly implemented Learning from Deaths Policy, ensuring a consistent approach to implementation. The revised policy contains arrangements for staff to follow in the event of an unexpected death of an adult and in the event of an unexpected death of a child.

17. The Trust continues to work with our system partners to devise systems whereby Learning from Deaths can take place in a consistent way across all major health and social care providers.

18. The Learning from Deaths report is based on the template devised by the National Quality Board. This report will be published on the Trust's website in keeping with our statutory obligations.

**Bereaved Families**

19. Families will be treated as equal partners following a bereavement and will always receive a clear, honest, compassionate and sensitive response in a supportive environment and receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.

20. Families are informed of their right to raise concerns about the quality of care provided to their loved one and their views help to inform decisions about whether a review or investigation is needed.

21. Families will receive timely, responsive contact and support in all aspects of an investigation process, in line with duty of candour and with a single point of contact and liaison. They are treated as partners in an investigation to the extent, and at whichever stages, that they wish to be involved. Their experiences of the death of their loved one, offers a unique and valid source of information and evidence that better informs our investigations; bereaved families and carers who have experienced the investigation process help us to embed the learning to continually improve patient safety.

**Q3 2019/20 WCHC Reported deaths (Datix incident reporting)**

22. During Q3 there were a total of 20 reported deaths within scope.

23. During Q3 no deaths met the criteria for StEIS reporting.

24. Family and carer concerns were sought in keeping with the Duty of Candour policy.

| **Structured Judgement Reviews:** | | |
|---|---|---|
| Total Number of Deaths in scope | 20 | |
| October (8)<br>W32300 – ICCT(Wallasey), learning noted<br>W32603 – Rapid Response team, learning noted<br>W32736 – ICCT, no learning for the Trust<br>W32820 – Child death, SUDiC/CDOP processes, system-wide learning noted<br>W32936 – ICCT(Birkenhead), no learning for the Trust<br>W32888 – ICCT (West Wirral), learning noted<br>W32889 – ICCT (West Wirral), system-wide learning noted<br>W32903 – STAR, no learning for the Trust<br><br>November (4)<br>W33369 – T2A bed base, system-wide learning noted<br>W33214 – T2A bed base, no learning for the Trust<br>W33358 – Cardiac arrest, system-wide learning noted<br>W33558 – Rapid Response team, no learning for the Trust, good practice noted<br><br>December (8)<br>W33557 - ICCT (Birkenhead), no learning for the Trust, good practice noted<br>W33670 – ICCT (Birkenhead), review in progress (any learning will be noted in Q4 report)<br>W33759 – Child death, SUDiC & CDOP processes followed, no learning for the Trust<br>W33797 – STAR, review in progress (any learning will be noted in Q4 report)<br>W33811 – ICCT (Birkenhead), mental health trust made aware in case they need to undertake a Learning Disability Review (LeDeR).<br>W33884 – Child death, SUDiC & CDOP processes followed, no learning for the Trust<br>W33963 – T2A bed base, no learning for the Trust,<br>W33965 – ICCT (Birkenhead), review in progress (any learning will be noted in Q4 report) | | |
| Total Number of Deaths considered to have more than 50% chance of being avoidable | 0 | |

| **Recording data on LeDeR reviews: - Please note that these are undertaken by the mental health trust** | | |
|---|---|---|
| Total Number of Deaths in scope | 1 case has been referred to mental health trust | |
| Total Deaths reviewed through LeDeR methodology | outstanding | |
| Total Number of deaths considered to have been potentially avoidable | outstanding | |

| **Recording data on SUDIC reviews:** | | |
|---|---|---|
| Total Number of Child Deaths | 3 | |
| Total Deaths reviewed through SUDIC methodology | 3 | |

**Summary of Thematic Learning**

25. Each unexpected death reported during Q3 has been analysed and investigated as appropriate, to identify any relevant learning points for the Trust and the wider health and social care system.

26. Of the 20 cases reported, after investigation, seven had lessons which the Trust and system partners could learn from. Themes from the learning included:

Communication

27. An outcome of a SUDiC investigation was that communication systems could be strengthened between the Named GP for Safeguarding, Health Visitors and Child Health. This did not, however, contribute to the death of the person. As a result, the 0-19 service will lead on this piece of work to improve system-wide processes.

28. It was recognised that resuscitation awareness process could be strengthened. As a result, a resuscitation grab bag will be introduced. Its use and location will be integrated into resuscitation training. Awareness will also be raised through a communication campaign throughout the Trust (including Vlogs, screensavers).

29. An investigation revealed that a communication breakdown between the care home and hospital led to confusion over diet and textures of foods. To reduce to risk of a similar recurrence, the Trust's Speech and Language Team will provide additional education and training to the care home sector. The incident was also raised with the hospital team.

Medicine management

30. In one case, confusion existed within a care home about prescribing and administration of parenteral antibiotics and fluids during the out of hours period which lead to a delay in treatment. This did not contribute to the death of this person. Our medicines management team have responded to this by clarifying the pathways with the care home and ensuring greater awareness of them.

Discharge Processes

31. Two cases involved issues with the discharge process, from the hospital to an intermediate care bed. This involved discharges without accurate or complete clinical information, and also inappropriate discharge destinations. These have been raised through our joint governance systems, to address potential pathway changes with an aim of raising safety and patient experience.

32. It can be seen that there are multiple examples of system-wide learning during this quarter. As a result of the Trusts clinical governance oversight within our Clinical Risk Management Group, a paper is being developed to formally gather this evidence and its effects. This will then form the basis of quality and safety discussions with system-wide stakeholders to reduce the risk of recurrence of these issues, including escalation where appropriate.

**Recommendations**

33. The Board of Directors is asked to be assured that quality governance systems are in place to ensure continuous monitoring and learning from deaths in accordance with Trust policy.

34. The Board of Directors is asked to be assured that quality governance systems are in place to Duty of Candour and the involvement on the family are taken in to account when an unexpected death occurs in accordance with Trust policy.

35. The Board of Directors is asked to be assured the Trust is actively involved in supporting the system-wide development of processes reporting and learning from deaths.

**Dr Nick Cross**
**Executive Medical Director**

15th January 2020

**Appendix 1**

## Learning From Deaths Q3 19/20 Report

The following information reflects the high-level reporting of deaths which occurred within our services over the period of Quarter 3 2019/20.

A more detailed report has been ratified and approved by the Quality and Safety Committee as per the Learning from Deaths Policy.

## Unexpected Deaths

There were 20 deaths reported within scope during this period and all have been reviewed in accordance with Trust policy. Duty of Candour was met in all cases where this was appropriate.

None of the deaths were deemed attributable to the care provided by our Trust.

As a result of thorough investigations into unexpected deaths which occurred whilst in receipt of the Trust's care, learning points were identified where present and acted upon as part of the continual learning processes. These learning points have been collated into themes and are described below**:**

### Communication

- An outcome of an investigation was that communication systems could be strengthened between the Named GP for Safeguarding, Health Visitors and Child Health. As a result, the 0-19 service will lead on a piece of work to improve system-wide processes.

- It was recognised that resuscitation awareness process could be strengthened. As a result, a resuscitation grab bag will be introduced. Its use and location will be integrated into resuscitation training. Awareness will also be raised through a communication campaign throughout the Trust (including Vlogs, screensavers).

- An investigation revealed that a communication breakdown between the care home and hospital led to confusion over diet and textures of foods. As a result, the Trust's Speech and Language Team will provide additional education and training to the care home sector.

### Medicine management

- In one case, confusion existed within a care home about prescribing and administration of parenteral antibiotics and fluids during the out of hours period. This did not contribute to the death of this person. Our medicines management team have responded to this by clarifying the pathways to the establishment and ensuring greater awareness of them.

### Discharge Processes

- Two cases involved issues with the discharge process, from the hospital to an intermediate care bed. This involved discharges without accurate or complete clinical information, and also inappropriate discharge destinations. These have been raised through our joint governance systems, to address potential pathway changes.

## Learning Disabilities

There was one death which may be fall under the scope for a Learning Disability review. This has been referred to the appropriate mental health provider as this is outside of our scope of work.

## Children and Young People

There were 3 child deaths, all of which were appropriately reported and scrutinised. All of these cases followed the SUDIC process. Any learning raised as a result of these investigations is then embedded into future practice, where appropriate.

We continue to promote shared learning across the health and social care economy.