

Board of Directors (in Public)

Item 4.3

Subject: Learning from Deaths Quarterly Report – Q1 2024/25
Date of Meeting: 24th September 2024
Prepared by: Neil Coulson, Chair – Mortality Review Group
Manoj Kuduvalli – Medical Director
Presented by: Manoj Kuduvalli – Medical Director
Purpose of Report: For Noting

BAF Reference	Impact on BAF
BAF 1	The report provides assurance regarding learning from deaths, and possible avoidable patient harm.

Level of assurance (please tick one)					
To be used when the content of the report provides evidence of assurance					
<input checked="" type="checkbox"/>	Acceptable assurance Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input type="checkbox"/>	Partial assurance Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	Low assurance Evidence indicates poor effectiveness of controls

1. Executive Summary

Guidance on learning from deaths was published by the National Quality Board in March 2017 and was presented to the Board of Directors in May 2017. Quarterly reports have been presented to the Board of Directors since.

Deaths are categorised as to the likelihood of being avoidable or not (on balance of probability >/< 50:50) and the data collected centrally each quarter.

The mortality dashboard year to date has been presented at the Board of Directors in Public and this report includes organisational learning from deaths.

This report also includes any available updates from previous reports.

2. Background

The learning from deaths guidance has a strong emphasis on organisational learning from all deaths rather than from just preventable or avoidable deaths. The definitions of

preventable/ avoidable deaths have been revised. The threshold of defining preventable/ avoidable death is now on the basis of more likely than not encompassing the categories of definitely avoidable, strong evidence of avoidability and probably avoidable (greater than 50:50). Deaths are classified using the RCP (Royal College of Physicians) methodology unless they occur in individuals with an identified learning disability. In those individuals LeDeR (Learning Disability Mortality Review) methodology is used, and a full review carried out without prior screening.

When cases have been reviewed by the MRG (Mortality Review Group) the action logs are sent to the divisions to review in divisional governance. The action log will include when the case is also to be reviewed during the relevant audit day. Joint Cardiology, Surgery and Anaesthesia audit days are held every two months where all relevant reviews are presented and learning discussed and shared. Respiratory Medicine have their own audit days where similar discussions occur.

The Divisions also track action plans arising from learning points. This data will be triangulated with Dr Foster (Telstra Health) data, InPhase, complaints, coroner's cases and audits. This will facilitate system identification of common themes and cross reference to RCAs, divisional minutes and MRG outcomes. Every month at Operational Board the Divisions present a session on organisational learning (not necessarily related to deaths).

All deaths have an initial review by the Deputy Director of Nursing to assess any issues raised by families and carers. The responsible Consultant or an ITU Consultant will invariably have spoken to families at the time of death. Further discussions with families unable to meet immediately after the time of death are offered the opportunity at a time convenient to the family. Any concerns raised by the families after a period of reflection are responded to and where appropriate investigated. If the death is considered avoidable or classed as an incident full duty of candour is exercised and any resultant RCA discussed with families.

Engagement with families has been enhanced by the establishment of the medical examiners who oversee the death certification process and the medical examiner officer who discusses concerns with families. The Medical Examiners and Medical Examiner Officer discuss issues raised by families at the time of death certification. The ME service has become a statutory requirement as of 9th September 2024.

3. Report for Q1 2024/25

There have been 52 deaths in the trust between April and June 2024. For comparison the total number of deaths in the trust for Q1 2023/24 was 41. Fifty of these deaths have been through the complete mortality review process. There have been no deaths in patients with an identified learning disability.

In interpreting the accompanying spreadsheet and Appendix 1, it should be borne in mind that there may be an adjustment of the previous quarter's assessment of avoidability. This is because some of the returned full reviews will subsequently have been recalibrated by the mortality review group at their monthly meeting. Some cases rated by reviewer as less than 50:50 may have been deemed avoidable by the MRG and vice-versa.

In Q1 24/25 one death has been classified RCP 3 (probably avoidable > 50:50).

Two deaths (3.8%) were classed probably avoidable but not very likely (RCP4); three deaths (5.7%) were classed as slight evidence of avoidability (RCP5); forty-four deaths (84.6%) were classed as definitely not avoidable (RCP6).

4. Learning from Deaths Q1 (2024-25)

A report on the deaths at LHCH in Q1 of 2024-25, including a summary of the MRG review process, the main causes of deaths, and a summary of organizational learning is presented in appendix 1.

5. Conclusions

The Trust complies with national guidance and populates the mortality dashboard. There is a rigorous review process for all deaths within the Trust. Learning from these deaths is shared widely through Divisional Boards, clinical audit meetings and also by uploading relevant presentations to a mortality SharePoint page which can be accessed at any time.

7. Recommendations

The Board of Directors is requested to note the report.

Appendix 1 –Learning from Death Q1 – 2024-25

LHCH Mortalities 2024/25 Quarter1 – All Deaths					
	Screened no Review	Screened Review Complete	Screening	Under Review	Total Deaths
Quarter1	43	7	2	0	52

LHCH Mortalities 2024/25 Quarter 1 – Avoidability rating					
	Definitely not Avoidable	Slight evidence for Avoidability	Possibly Avoidable, but not very likely, less than 50-50 but close call	Probably Avoidable, more than 50-50 but close call	Total
Quarter1	44	3	2	1	50

Cause of death by division

Main Cause of Death - Cardiac Surgery	n
High risk Procedure	3
CVA	2
Pre-procedural moribund state	2
Post-procedural bleeding / Tamponade	1
Technical procedural issue inc Myocardial protection	1
Heart failure – RV / LV	1
Other	1
Total	11

Main Cause of Death - Medical Division	n
Pre-procedural moribund state	10
Heart failure – RV / LV	9
Other	8
Myocardial Infarction	3
Unheralded arrhythmia	2
Sepsis	2
General deterioration in the v elderly	1
Post-procedural bleeding / Tamponade	1
Total	36

Main Cause of Death - Thoracic Surgery	n
Pre-existing Pathology	1
Sepsis	1
Respiratory failure	1
Total	3

Compliance with agreed timelines for screens and full reviews

Month	% Reviewed <=30 Allocation for Review	% Reviewed OR Screened no time frame	Deaths	Reviewed	Reviewed <=30 allocation
Apr-23	80%	100%	15	15	12
May-23	94%	94%	17	16	16
Jun-23	85%	95%	20	19	17
YTD	87%	94%	52	50	45

Summary of data

- There have been 52 deaths in the trust in Q1 of 2024-2025, which is an increase on last year's 41 deaths in the same quarter
- Mortalities per division are as follows- medicine 36, cardiac surgery 11, thoracic surgery 5.
- In terms of avoidability of the 52 deaths- 44 were judged as definitely not avoidable, 3 as slight evidence of avoidability, 2 as possibly avoidable, and 1 as probably avoidable. Two screens are still outstanding for this quarter so their avoidability rating is awaited.
- The 1 probably avoidable death was under the surgical division but underwent a cardiological procedure during their stay. This death is currently undergoing a PSII to identify potential learning.
- Of the 52 deaths, 43 underwent a screen alone and 7 have undergone a full structured judgement review. 2 screens remain outstanding.
- As of the August MRG, 7 deaths from Q1 have been discussed at the meeting. More deaths from this quarter may be discussed at future MRG meetings, as ongoing screens and reviews are completed.
- The most common main causes of death vary between divisions-
 - Cardiac surgery- the main causes of death were deemed as high-risk procedure and CVA.
 - Thoracic surgery- Pre-existing pathology, sepsis and respiratory failure. 2 screens are awaited to determine cause of death
 - Medicine- the main causes of death were pre-procedural moribund state and heart failure. This presumably reflects patients presenting acutely to cath lab for Primary PCI, who are often in cardiogenic shock at the time of arrival.
- Completion of screens and reviews within the recognised timeframes remains challenging. Further work needs to address how we improve compliance to ensure timeliness of reviews and therefore identify learning at an earlier stage.

Key themes, learning and actions taken

Medicine

- A patient was admitted to LHCH following an out of hospital cardiac arrest secondary to a dilated cardiomyopathy. Prior to discharge an ICD was inserted. The patient then presented to their local hospital a week post discharge with signs of severe sepsis. Staph was grown in blood cultures and the source was felt to be the newly inserted ICD. The patient was urgently transferred to LHCH for device removal, which confirmed clear infection in the surgical site. The patient developed severe sepsis and multi-organ failure and unfortunately died a week later.

A thorough rapid review was undertaken to identify any learning or potential lapses in care that led to the early device infection. This review did not identify any lapses in care- standard surgical site preparation was performed, appropriate antibiotic

prophylaxis was administered, and the surgical environment was found to have been appropriately decontaminated. No other device infections were found to have occurred at around the same time as when this device was implanted.

The following learning was identified and will be implemented by the medical division-

1. Review the ICD/CIED leaflets to ensure signs of sepsis are clear and lead to immediate medical review.
 2. Provide a monthly report of CIED infections from LHCH device procedures.
 3. Educate referring hospitals re the urgency of explant/extraction for staph sepsis.
 4. Raise awareness of policy for replacement of peripheral access, if inserted within the community
- A patient presented with a late presentation MI. His angiogram demonstrated surgical disease and he was referred for a CABG. He developed further chest pain the following day associated with tachycardia, hypotension and possible new ECG changes. He was taken back to the cath lab for repeat angio and IABP insertion. He was referred for an emergency CABG but subsequently arrested following induction of anaesthesia in theatre. In retrospect this was unlikely to be a new ischaemic episode, therefore emergency CABG was probably not warranted. This was likely a mechanical complication of the myocardial infarction, in the form of acute MR from papillary muscle rupture. This may have changed the acute management of the patient; however, it was deemed that this death was not avoidable even if the management had been different due to the rapidity of the clinical deterioration.

This case has been discussed at Cardiology audit day and a future talk is planned at the combined audit day on mechanical complications following myocardial infarction.

Thoracic surgery

- 2 patients died in Q1 following a lobectomy for lung cancer. Both patients were similar in that they had previously undergone treatment for head and neck cancer and were fed by PEG tubes due to problems with dysphagia. In the post-operative phase both patients vomited and aspirated, which led to acute pneumonitis and subsequent respiratory failure which led to their death. There has subsequently been a patient in Q2 who has died post lobectomy, who also had previous treatment for head and neck cancer, but in this case did not aspirate.

Potential learning identified included early notification of these patients to the speech and language team prior to surgery, and alterations to post-operative feeding regimens to allow for the reduced gastric motility that can occur post-surgery.

The three mortalities will be presented at audit day as a case series for discussion. A working group is also being created with speech and language and dietetics to improve the care of patients at risk of aspiration.

Cardiac surgery

- A patient had undergone a mitral and aortic valve replacement in the past for endocarditis. He was known to have paravalvular leaks of his prosthetic valves and was being monitored for this. He presented to his DGH with heart failure and was transferred to LHCH for potential percutaneous closure of the leaks. He suffered a femoral vascular complication as a result of this procedure and subsequently died from bleeding into a retroperitoneal haematoma.

The MRG identified learning and potential avoidability within this death. A PSII is being undertaken to identify learning around the management of the patient's coagulation status around the time of the procedure, and the diagnosis and

management of the vascular complication. Any learning will be shared trust wide when the PSII has been completed.

- A patient underwent an urgent CABG and aortic valve replacement. This was technically challenging and there were intra-operative difficulties that required insertion of an intra-aortic balloon pump (IABP) to wean from bypass. Due to vascular disease and patient body habitus this was technically challenging and required multiple attempts at accessing both femoral arteries while the patient was fully heparinised on bypass. This led to development of vascular injuries and bleeding, which did not lead to her death, but contributed significantly to morbidity.

A similar situation had been discussed at a recent audit day of a difficult IABP insertion while on bypass. Agreement has been reached that IABP needle insertion in fully heparinised patients will be performed under ultrasound guidance by the most experienced ultrasound operator, which may be the anaesthetist managing the case.

Failure to escalate

A common theme that has been identified in some mortalities, not just in Q1 but throughout the past year, is the failure to escalate deteriorating patients on Critical Care to either the managing Consultant or the Consultant on call. Also, at times escalation has happened, but inappropriate advice has been given. An escalation pathway has been developed to guide resident medical staff on a clear process of escalation in terms of who to escalate to and when this should happen. This has been agreed at the cardiac and anaesthetic business meetings and will be rolled out in the coming weeks.

The aim will be to ensure the timely escalation of deteriorating patients so that reversible causes can be identified and addressed.

Ongoing work and developments

- Compliance with completion of screens and full reviews within the agreed timeframes needs improving to ensure learning is identified as soon as possible. An escalation process will be discussed with the Medical Director to address this issue.
- The allocation and completion of nursing reviews is not consistent. All deaths that undergo a full review should have a nursing review completed, however at present this does not happen. An electronic format of the nursing review document is being developed on InPhase which will make the process more streamlined and will link the medical and nursing review together in one place. Further work will be done on this.
- A review is being undertaken in mortalities in patients under the age of 60 to identify any themes or learning. This will be presented at the next Mortality Improvement Group.