

## Board of Directors (in Public)

### Item 2.2

**Subject:** Learning from Deaths Quarterly Report – Q2 2024/25  
**Date of Meeting:** 26<sup>th</sup> November 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 ( <i>please tick one</i> ) <i>To be used when the content of the report provides evidence of assurance</i>					
<input checked="" type="checkbox"/>	<b>Acceptable assurance</b> Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input type="checkbox"/>	<b>Partial assurance</b> Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	<b>Low assurance</b> 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 9<sup>th</sup> September 2024.

### **3. Report for Q2 2024/25**

There have been 48 deaths in the trust between July and September 2024. For comparison the total number of deaths in the trust for Q2 2023/24 was 49. Forty-four 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 Q2 24/25 no death has been classified as avoidable (RCP 1- 3)

Three deaths (6.3%) were classed possibly avoidable but not very likely (RCP4); four deaths (9.1%) were classed as slight evidence of avoidability (RCP5); thirty seven deaths (84.1%) were classed as definitely not avoidable (RCP6).

#### **4. Learning from Deaths Q2 (2024-25)**

A report on the deaths at LHCH in Q2 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 Q2 – 2024-25

LHCH Mortalities 2024/25 Quarter1&2 – All Deaths					
	Screened no Review	Screened Review Complete	Screening	Under Review	Total Deaths
Quarter1	43	9	0	0	<b>52</b>
Quarter2	35	9	2	2	<b>48</b>
Quarter3					
Quarter4					
<b>Total</b>	<b>78</b>	<b>18</b>	<b>2</b>	<b>2</b>	<b>100</b>

LHCH Mortalities 2024/25 Quarter 1&2 – Reviewed Deaths					
	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	46	3	2	1	<b>52</b>
Quarter2	37	4	3	0	<b>44</b>
Quarter3					
Quarter4					
<b>Total</b>	<b>83</b>	<b>7</b>	<b>5</b>	<b>1</b>	<b>96</b>

Main Cause of Death - Cardiac Surgery	n
Other	4
CVA	3
High risk Procedure	3
Pre-procedural moribund state	2
Respiratory failure	2
Post-procedural bleeding / Tamponade	2
Hypoxic brain injury	1
Technical procedural issue inc Myocardial protection	1
Mesenteric ischaemia	1
Heart failure – RV / LV	1
<b>Total</b>	<b>20</b>

Main Cause of Death - Thoracic Surgery	n
Respiratory failure	3
Sepsis	2
Other	2
Pre-existing Pathology	2
<b>Total</b>	<b>9</b>

Main Cause of Death - Medical Division	n
Heart failure – RV / LV	15
Pre-procedural moribund state	13
Other	12
Myocardial Infarction	10
Hypoxic brain injury	5
Pre-existing Pathology	5
Unheralded arrhythmia	3
Sepsis	2
Post-procedural bleeding / Tamponade	1
General deterioration in the v elderly	1
<b>Total</b>	<b>67</b>

Month	% Reviewed ≤30 Allocation for Review	% Reviewed OR Screened no time frame	Deaths	Reviewed	Reviewed ≤30 allocation
Apr-24	80%	100%	15	15	12
May-24	94%	100%	17	17	16
Jun-24	85%	100%	20	20	17
Jul-24	76%	88%	17	15	13
Aug-24	88%	94%	17	16	15
Sep-24	86%	93%	14	13	12
<b>YTD</b>	<b>85%</b>	<b>96%</b>	<b>100</b>	<b>96</b>	<b>85</b>

### Summary of data

- There have been 48 deaths in the trust in Q2 of 2024-25, which is very similar to the number of deaths in the same quarter for 2023-24.
- Of those 48 deaths, 44 have undergone either a full review or a screen to determine avoidability and underlying cause of death. The outcomes of 4 reviews are still awaited.
- Of the 44 completed reviews, none have determined that there was a high likelihood of avoidability (RCP 1 to 3)
- Of the 44 deaths reviewed, 39 have undergone only a screen and 5 have undergone a full structured judgement review.
- As of the October MRG meeting one full review and seven screens from Q2 have been discussed. Outstanding screens and reviews will be discussed in the forthcoming MRG meetings.
- Cumulative data for the main cause of death is presented for both Q1 and Q2. A significant number of deaths fall under the “other” category. Further work will need to be done to determine if further categories for cause of death need to be created to allow more accuracy in recording of this data.

- Completion of screens and reviews within the recommended timeframes is comparable to previous quarters. There is still an area of focus to improve the timeliness of the completion of reviews.

### **Key themes, learning, actions and update on previous actions.**

#### **Cardiology**

- There have been three deaths either following or during a TAVI procedure. Two of these cases were related to annular rupture during the procedure, and a further death from this complication has also recently occurred. Feedback from the TAVI team has confirmed that this is a national issue and may be related to balloon expanding valves in a heavily calcified annulus. The other death occurred during the procedure when the patient went asystolic when the wire crossed the valve. Although no strong avoidability was found in any of these cases, this a series of deaths in a short period of time in patients undergoing a TAVI. The cases are to be discussed at the TAVI M and M meeting later this month and any learning will be shared at the next joint audit meeting and via the MRG.
- A patient had been admitted with myocarditis and heart failure secondary to immunotherapy for her lung cancer. She was treated with high dose steroids and tacrolimus and made some improvement. She subsequently fell while walking on the hospital grounds and developed bruising to the left side of her chest and neck. Over the following days her haemoglobin dropped and then she suffered a cardiac arrest from which she could not be resuscitated. The cause of death was felt to be heart failure from myocarditis, and that the fall was incidental and did not contribute to the death. A rapid review was performed with regards to how this lady fell on the hospital grounds. The MRG felt that certain aspects of her care following the fall needed further review including lack of senior medical review, no imaging to determine if any injuries had been sustained, and continuation of therapeutic anticoagulation despite a falling Hb. This is being further investigated through a PSIRF process and will be brought back to the MRG when complete.

#### **Thoracic surgery**

- A patient underwent sternotomy and thyroidectomy for a papillary thyroid cancer as a joint procedure with an endocrine surgeon. During the procedure the right recurrent laryngeal nerve needed to be sacrificed. She made a slow post-op recovery complicated by a stroke, poor swallow, diarrhoea (hx of Crohn's disease) and hospital acquired pneumonia. On day 11 she acutely deteriorated and suffered a cardiac arrest from which she could not be resuscitated. This may have been associated with a GI bleed although the history of this is not fully clear. Immediate learning identified: -
  - Earlier referral to SALT should have taken place due to sacrifice of the recurrent laryngeal nerve as per the SALT policy.
  - Metoclopramide was prescribed and administered regularly post-op despite her ongoing diarrhoea. The post-op order sets have been amended so that metoclopramide does not default to a regular prescription but just as a PRN medication.

#### **Cardiac surgery**

- A patient underwent a redo sternotomy, RV-PA conduit, TV repair and ascending aorta interposition graft. He was on considerable support post-operatively and deteriorated on day 4 after his surgery. ECMO was instituted due to severe

vasoplegia and acute lung injury. He was subsequently transferred to Wythenshawe but subsequently died. We have no further information from Wythenshawe at this stage but have contacted them to share any learning they may have identified. Learning at LHCH identified the need for more coordinated management in complex ACHD patients on critical care as there were multiple teams involved here making changes to the patient's management. This will be presented at the next audit day with the ACHD surgical team present.

### **Escalation policy**

As highlighted from previous mortalities and in previous reports, concerns have been highlighted about the failure to escalate unwell patients to senior medical staff. An escalation policy has been developed and agreed with key stakeholders including the ANPs and ITU and Cardiac Consultant bodies. This is now in established clinical practise and provides a clear structure for the escalation of unwell patients, particularly out of hours.