

## Board of Directors (in Public)

### Item 2.1

Subject: Organisational Learning from Deaths – Q1 2025/26  
 Date of Meeting: 23<sup>rd</sup> September 2025  
 Prepared by: Liam Mullen, 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.

<b>Level of Assurance (please tick)</b> To be used to provide the Board / Committee with a guide on the extent of assurance and evidence of assurance provided within the report		<input checked="" type="checkbox"/>
<b>Level of Assurance</b>	<b>Description</b>	
<b>High</b>	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.	<input type="checkbox"/>
<b>Substantial</b>	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.	<input checked="" type="checkbox"/>
<b>Moderate</b>	There is an adequate system of internal control, however, in some areas weakness in design and/or inconsistent application of controls puts the achievement and some aspects of the system objectives at risk.	<input type="checkbox"/>
<b>Limited</b>	There is a compromised system of internal control as weaknesses in the design and / or inconsistent application of controls puts the achievement of the system objectives at risk.	<input type="checkbox"/>
<b>No</b>	There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives.	<input type="checkbox"/>

## **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.

#### **4. Quarter 1 deaths 2025-26**

There were a total of 43 deaths in Quarter 1 of 2025-26. Of these 41 deaths have completed the review process. There was 1 avoidable death (RCP 3 >50:50 avoidable).

1 death has been classed as probably avoidable but not very likely (RCP4); 1 death was classed as slight evidence of avoidability (RCP5); 38 deaths were classed as definitely not avoidable (RCP6).

#### **5. Organisational Learning from Deaths (2025-26)**

A report on the deaths at LHCH in 2025-26, including a summary of the MRG review process, the main causes of deaths, and a summary of organizational learning is presented in appendix 1.

#### **6. 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 – Organisational Learning from Death – 2025-26

LHCH Mortalities 2025/26 – All Deaths					
	Screened no Review	Screened Review Complete	Screening	Under Review	Total Deaths
Q1	38	3		2	43
Q2					
Q3					
Q4					
Total	38	3		2	43

LHCH Mortalities 2025/26 – Reviewed deaths							
	Definitely not avoidable (RCP 6)	Slight evidence for avoidability (RCP 5)	Possibly avoidable, but not very likely, less than 50-50 (RCP 4)	Probably avoidable, more than 50-50 (RCP 3)	Strong evidence for avoidability (RCP 2)	Definitely avoidable	Total Deaths
Q1	38	1	1	1			41
Q2							
Q3							
Q4							
Total							

Main Cause of Death – Cardiac /Aortic Surgery	n
Post-operative multi-organ failure	3
High risk Procedure	3
Pre-existing pathology	1
Cardiogenic shock due to myocardial infarction	1
Total	8

Main Cause of Death - Thoracic Surgery	n
Malignancy or related complications of	2
Sepsis	1
Total	3

Main Cause of Death - Medical Division	n
Myocardial Infarction	8
Cardiogenic shock due to myocardial infarction	5
Mechanical complication of myocardial infarction (e.g VSD, papillary muscle rupture or free wall rupture)	3
Heart failure	2
Hypoxic brain injury (generalised)	2
Complication of percutaneous procedure (inc MI, coronary perforation)	1
Pericardial effusion during procedure	1
Major haemorrhage (not at operative site)	1
Post-operative Tamponade	1
Unheralded arrhythmia	1
Post-operative multi-organ failure	1
Sepsis	1
Heart Failure	1
Heart failure – RV / LV	1
PM awaited	1
<b>Total</b>	<b>30</b>

Month	% Reviewed <=30 Allocation for Review	% Reviewed OR Screened no time frame	Deaths
Apr-25	76%	100%	17
May-25	73%	87%	15
Jun-25	91%	100%	11
<b>YTD</b>	<b>79%</b>	<b>95%</b>	<b>43</b>

### **Summary of mortality data**

- There were fewer deaths in this quarter compared to Q1 in 2024/25 (43 compared with 52).
- There were no specific themes identified, with the causes of death seemingly as would be expected given the nature of our services at LHCH. Of note, given a recent change to the diagnosis list available on inPhase, some caution would be required assessing the frequency of certain causes of death compared to historic figures. These changes however will allow better understanding and oversight/audit going forward.
- There was only 1 death deemed as being probably avoidable > 50:50 (RCP 3) and 2 other deaths with any level of deemed avoidability (but <50/50).
- Compliance with target time for completion of screens and full reviews remains an issue. This may be in part explained by increasingly higher workloads for many of our clinicians. A more robust process is now in place for escalating to clinical leads and divisional medical directors to try and improve compliance with these targets. Despite this, we are still facing challenges and have plans to implement new changes such as the creation of more visible deadlines. The mortality group intends to then produce service line specific audit data on these metrics and escalate if necessary.

### **Changes to the MRG and learning from deaths process.**

- The MRG sits monthly and has been under new chairmanship since February 2025.
- Attendance at the MRG has now been expanded to give greater representation from other specialities including therapies, trainees from medicine and surgery and members of the risk and safety team.
- Key learning is identified at the MRG meeting and is shared for discussion at audit day. Any deaths with cross speciality learning (cardiology/surgery/anaesthesia) are discussed at the combined audit days with cardiology, to ensure that the learning is disseminated across all the teams.
- A bespoke mortality module has been developed on the new In Phase system. This is a significant improvement compared to the old PDF based system. It allows all deaths to be tracked by stage and for actions to be generated which can then be allocated to a specific person to take forwards. This therefore closes the loop on key outcomes generated by the MRG.
- A new mortality SharePoint page has been developed, on to which case presentations and learning can be uploaded. This can be accessed by staff at any time, so learning is not just limited to those that were present at audit day.

### **Key themes, learning and actions taken.**

- With reference to the death adjudged probably avoidable, there were multiple learning points that came out of the MRG process. This was extensively discussed in the cardiology PCI team meeting and at audit day. These included: recognition of case risk and complexity, appropriate consenting, and some technical PCI factors learning. There was also some learning around proper incident reporting. This has led to the implementation of an additional fail-safe mechanism within the PCI team, to ensure adequate incident reporting of major incidents such as unexpected deaths in the catheter lab. There is further discussion ongoing within the PCI team service line about the management/ownership of deferred ACS cases and subsequent listing.

Other learning points/actions from the period have included:

- Recognition of sepsis on surgical wards and appropriate escalation to senior medical staff. In addition work is ongoing regarding EPR changes to ensure standard dose of antibiotic delivery in sepsis management.
- There have been several incidences of issue with intra-aortic balloon pump placement, that have occurred outside of the cath lab setting (ITU/crit care areas). Whilst recognising the challenges of this without fluoroscopy it was agreed that further education was required including the use of TOE. This has been disseminated within surgical and anaesthetic teams.
- A case of coronary occlusion following redo AVR has yielded some learning and discussion in surgical meetings around recognition of high risk features pre-op.
- An instance of cardiac arrest in a post op patient with no monitoring/connected pacing leads was not felt to be avoidable, however