with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

CLINICAL GOVERNANCE POLICY
Learning from Deaths

Printed or downloaded copies of this document are not controlled – In exceptional circumstances where hard copies or downloaded versions are required, these will only be valid on the day printed or downloaded – please always ensure that the most up-to-date version is accessed through the Policy section of GHC Intranet. If any updates or changes to this document are required, please contact the Clinical Policy Group on: clinical.policies@ghc.nhs.uk prior to making any amendments. Documents are password protected to prevent any unauthorised changes.

Policy number	CGP005
Version:	V4
Purpose:	The policy sets out the approach to be followed in publishing data relating to patient deaths, deriving and publishing learning and reporting the information publicly through Board meetings.
Consultation:	Dr Alice Groves Community Hospitals and Urgent Care / Clinical Policy Consultation Distribution List
Ratified by:	Clinical Policy Group
Date ratified:	16 April 2026
Date of issue:	29 April 2026
Review date:	01 April 2028 Policy will be reviewed every 2 years or earlier in the following circumstances: This document will be reviewed as determined by changes in: • Legislation • National guidance • Local Trust and system needs
Author / Reviewer:	Reviewed by: Jill Jones, Head of Patient Safety and Learning
Audience:	Registered Practitioners in Mental Health, LD Community Settings and all Inpatient areas
Dissemination:	The policy will be published on the GHC intranet, and its update will be listed on the Clinical Policy update bulletin
Impact assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust

Version history

Version	Date issued	Reason for change
V1	June 2017	New Policy

V1.1	Sept 2019	Transferred to new template
V2	17/05/2021	Harmonised policy replacing CLP104 V1.1 Learning from Deaths Policy - Mental Health and CLP104 V1.1 Learning from Deaths Policy – Physical Health
V2.1	17/12/2021	Appendix C amended to include Charlton Lane Hospital
V2.2	20/01/2023	Correction to review date which was incorrect on V2/V2.1
V3	11/07/2024	Updated by Gordon Benson to reflect changes of terminology, a description of the process for sharing learning and extending the scope of the Medical Examiner Service to cover death within all GHC inpatient units from 9.9.24 in line with legislation
V3.1	28/11/2024	SOP for ME Process link added
V4	29/04/2026	Updated by Jill Jones, Ruth Kyne and Emma Morrall to reflect changes to the Mortality Review processes.

Summary
In accordance with national guidance and legislation, the trust currently reports all incidents and near misses, irrespective of the outcome, which affect one or more persons, related to service users, colleagues, students, contractors, or visitors to trust premises; or involve equipment, buildings, or property. This arrangement is set out in the trust policy on reporting and managing incidents.

Further guidance was published by the National Quality Board in March 2017 setting out mandatory standards for organisations in the collecting of data, review and investigation, and publication of information relating to the deaths of all patients under their care. This information is reported and published on a quarterly basis through the Trust Board.

Table of Contents

Abbreviations

Abbreviation	*Full Description*
CD	Clinical Director
CQC	Care Quality Commission
GHC	Gloucestershire Health Care NHS Foundation Trust
EoL	End of Life
ICG	Improving Care Group
LeDeR	Learning Disabilities Mortality Review Programme
MAZARS	Classification of Patient Deaths
ME	Medical Examiner
MRG	Mortality Review Group
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
PDL	Post Death Learning
PSIRF	Patient Safety Incident Response Framework

1. Introduction

A CQC review in December 2016, 'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England' found that some trusts do not focus on the opportunity to learn and improve from deaths. Subsequently, in March 2017, the National Quality Board published its National Guidance on Learning from Deaths - A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.

This policy relates to the collection, recording, investigating and reporting procedures adopted in respect of the deaths of people who are, or have been within a specified period, patients of GHC. The data generated is likely to provide an overview of the health outcomes for patients who have been seen or treated by providers within the Gloucestershire health and social care systems. The information will be used to inform internal quality and safety reports but is intended also to engage with a wider systemic review of patient deaths across all providers, the scope and function of which is yet to be directed either locally or nationally.

While this data will include information concerning cases that have been reviewed through the serious incident process; that process will continue to run alongside the learning from deaths process, and this policy will not affect the scope or purpose of the existing Trust's Incident Reporting Policy (CGP001).

The Trust supports an active approach to reviewing patient deaths and places an emphasis on lessons learned, both internally, and within the wider NHS and social care systems in which it operates. The aim is to improve the quality of the care they provide to patients and their families and identify where the trust could do more.

GHC is mindful of its obligations to people with mental health problems and learning disabilities and recognises the considerable epidemiological information indicating that such people often find disadvantage within the wider health and social care community, leading to their premature deaths, for a variety of reasons.

2. Purpose

The policy sets out the approach to be followed in publishing data relating to patient deaths,

deriving and publishing learning, and reporting the information publicly through Board meetings.

3. Scope

This policy applies to all Registered Practitioners in Mental Health, LD Community Settings and all Inpatient areas. There are no limitations on its circulation within the trust and the wider NHS community, and it can be made available to service users, their families and the public on request.

The Trust does, however, recognise that not all deaths of patients in contact with its services will be subject to review. The following categories of patient will be **considered** in scope for a mortality review process (including application of the Patient Safety Incident Response Framework (PSIRF) where appropriate):

- All inpatient deaths in community hospitals.
- All inpatient deaths in mental health inpatient units or who have been discharged from in-patient care within the last month. If an individual has died in a mental health inpatient unit unexpectantly, suddenly, violently or unnaturally, then these incidents should be reported on the Datix Incident Reporting Form.
- All deaths of those with learning disabilities under our care.
- All patients with a primary diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death.
- All patients with a secondary diagnosis of psychosis who die prematurely.
- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.
- All perinatal/maternal deaths (perinatal mental health service for GHC).
- All deaths of patients receiving care from a service where an 'alarm' has been raised with the Trust through whatever means (for example via an elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator). This will include situations where another organisation has reviewed a death and suggests that our trust reviews its care processes.
- Deaths where learning will inform the provider's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically.
- All deaths of children under 18 years of age will be reviewed under the Statutory Child Death Process set out by Working Together to Safeguarding Children (March 2026). GHC safeguarding team hold the role of Child Death Lead Nurse. Please see GHC *Child Death Review Process Guideline (CLG075).* The MRO closely liaises with the Safeguarding Team.
- All deaths of adults where a safeguarding adults concern has been raised and it is felt that the safeguarding issue contributed to the death will be reviewed by the GSAB Safeguarding Adults Review Sub Group and a Safeguarding adults review may be instigated. Where an adult who has been a victim of domestic abuse dies, a domestic abuse related death review may be instigated, if it is believed that the domestic abuse was a factor in their death.

4. Definitions

Case Record Review	The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened.

Case Selection Meeting	Monthly meetings held with Medical Leads to select cases to be discussed at the MRG Meetings.
Death due to a problem in care	A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in health care and therefore to have been potentially avoidable.
Datix	The computer system used by the Trust to record and manage incidents.
Investigation	The act of all process of investigating; a systemic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.
Learning Disabilities Mortality Review (LeDeR) Program	A programme commissioned by the health care quality improvement partnership for NHS England to receive notification of all deaths of people with learning disabilities, and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age.
MAZARS	Classification of Patient Deaths
National Child Mortality Program	A national review of child mortality review processes conducted by NHS England both in the hospital and community. A key aim is to make the process easier for families to navigate at a very difficult time in their life.
NCEPOD	National Confidential Enquiry into Patient Outcome and Death, maintains and improves standards of care for adults and children by reviewing the management of children, undertaking confidential surveys and research.
National Child Mortality Database	A national database central to the national child mortality programme.
PSIRF	An event or circumstance which could have resulted, or did result in unnecessary damage, loss or harm such as physical or mental injury to a patient, colleagues, visitors or members of the public which does not meet threshold associated with serious incidents requiring investigation.
Post Death Learning (PDL)	Description of the learning once a death is reported using the Datix electronic data submission form.
Staff	For the purposes of this policy, the term “staff” refers to the roles, groups, and individuals identified within the Scope section of this document. This may include employees, bank and agency workers, contracted workers and learners and students on placement. Where learners are included in scope, this may cover Nursing (Adult, Mental Health and Learning Disability) Students, Paramedic Science Students, Allied Health Professional Students, Student Nursing Associates, T Level learners, work experience participants, and individuals returning to practice.
SystmOne	The electronic patient records system used within Trust physical health services

5. Duties

General roles, responsibilities and accountability

GHC are to ensure that:

- People who use our services are safe from avoidable harm and are supported to maintain their independence and to be actively involved in, and make informed decisions about, their

care and treatment.
- All staff have access to current, evidence-based policy documents.
- Appropriate training and updates are provided to support staff in their roles.
- Staff have access to equipment that meets safety standards and maintenance requirements.

All Employees (including Bank, Agency and Locum staff)

- Take initial corrective actions (where safe) to prevent re-occurrence of any accident/incident leading to the death of a patient.
- Report all inpatient deaths and all deaths of patients on community mental health team and learning disability team caseloads, including those believed to arise from "natural causes", in a timely manner using the designated procedure via the appropriate module on Datix. Natural cause or expected deaths of patients on physical health community team caseloads (adults or children) do not need to be reported on Datix.
- Ensure incident forms (in the event that Datix is unavailable) are given to the line manager as soon as possible after the incident is discovered (within 72 hours).
- Follow the procedure set out in the Policy on Reporting and Managing Incidents (CGP001) in respect of any suspected serious incidents.
- Ensure that learning from deaths is embedded within their practice.
- Practise within their level of competency and the scope of their professional body (where applicable).
- Take appropriate steps to familiarise themselves with and comply with relevant GHC policies and procedural documents applicable to their role.
- Identify areas where training or skills updates may be required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005), see section on MCA Compliance below.

Managers and Heads of Service

- Review incident received in line with relevant policies and procedures which may include PSIRF Policy and Incident Reporting and Management Policy.
- Escalate the incident immediately if there are serious or significant concerns in line with PSIRF.
- Take appropriate steps to make staff aware of, and able to access relevant policy documents.
- Support staff to access training and development appropriate to their roles.
- Ensure staff are offered the opportunity to participate in the appraisal process, including review of competencies.

The Executive Team

- Have joint board level responsibility for the development of this document and may delegate the authority to a subordinate.
- Provide the Quality Committee with quarterly reports of all data relating to learning from deaths prior to their submission to a public board meeting.
- The Chief Executive has overall responsibility to ensure the trust has a robust coordinated response to publishing data and learning from deaths. The Chief Executive is supported in this role by all Executive Directors.
- The Medical Director and Director of Nursing, Therapies and Quality have responsibility for

ensuring that the PSIRF policy is followed and that appropriate processes are in place to review, where necessary investigate, and publish data relating to learning from deaths across the organisation.

The Board

- Take responsibility for receiving and reviewing information in respect of the deaths of patients through its public board meetings.
- Take responsibility for overseeing the measures in place and ensuring that these are understood and monitored at a board level.
- Nominate a non-executive director to take responsibility for oversight of the learning from deaths/mortality review process.
- Have an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress.
- Pay particular attention to the care of patients with a learning disability or mental health needs.
- Acknowledge that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved.
- Work with commissioners to review and improve their respective local approaches following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigation to inform quality improvement and contracts etc.

Medical leads for Learning from Deaths

- Two medics have been identified as having a role for reviewing the data in relation to learning from deaths. One provides senior medical expertise into the Mental Health and Learning Disability Mortality Review Group Meetings; one provides senior medical expertise in the Community Hospital Mortality Review Group Meetings.
- Attend the relevant case selection meetings and mortality review meetings at which data on patients who fall within the scope of this policy will be **considered**, categorised and reviewed.
- Together with the Head of Patient Safety and Learning and Mortality Review Officer, prepare a report to be submitted quarterly to the Trust Quality Committee prior to consideration at a public board meeting.

Head of Patient Safety and Learning

- Produce the learning from deaths report, in conjunction with the medical leads for learning from deaths, and submitting this to the Quality Assurance Group, Quality Committee and Board as appropriate.
- Collate data relating to patient deaths from Datix, Electronic Patient Record and any other appropriate sources.
- Responsible, with the Clinical Director leads for learning from deaths, for commissioning and

reviewing any investigations considered to be appropriate.
- Chair the Mental Health and Learning Disability Mortality Review Group and the Physical Health Mortality Review Group.
- This post will be supported directly by the Mortality Review Officer.

Medical Examiner

- Support and challenge the certifying doctors to ensure the best quality and most accurate medical certificate of cause of death (MCCD) and associated mortality data.
- Provide proportionate scrutiny of all non-coronial deaths.
- Enabling the bereaved to raise any concerns through the ME system in a safe and transparent way.
- Supporting the appropriate direction of deaths to the coroner allowing the ME to act as a specialist resource.
- ME input is provided through Gloucestershire Hospitals NHS Foundation Trust; supported by a Standard Operating Procedure shown in Appendix 2.

Mortality Review Officer

- To actively manage the organisation and administration of the Trust's Mortality Review Group processes across Physical Health, Mental Health and Learning Disability Services.
- Work closely with Service Leads to facilitate the timely nature of mortality reviews and ensure all necessary information is available at review meetings.
- Keep an action log and follow up these actions with the appropriate person/service.
- Liaise with internal and external agencies including Safeguarding, PCET, GP Surgeries, Medical Examiner Offices, Coroners Services and LeDeR to acquire and share information regarding patient death.
- Support the Head of Patient Safety and Learning with the provision of data/information for publication in the Trust's Quarterly and Annual Reports.

Students, Trainees and the Learner Workforce

- Practise within their level of competency and in line with programme outcomes, curriculum requirements and professional standards.
- Take appropriate steps to familiarise themselves with and comply with relevant GHC policies and procedural documents applicable to their role.
- Seek guidance from Practice Educators / Assessors / Supervisors to ensure policy requirements are met.
- Participate in required learner reviews or tripartite meetings.

6. Identifying Patient Deaths for Review

All GHC colleagues will be required to notify, using the Datix process, the deaths of any Trust patients. Deaths recorded on Datix will be reviewed by the Trust's Mortality Review Officer and/or the Patient Safety Team.

The Mortality Review Officer will gather relevant information on the deaths that fall within the scope and share this with the two medical leads to identify cases that meet the criteria for review. Case selection meetings are held monthly with the medical leads to identify these cases.

Where cases are not selected for review at the MRG meetings, the MRO will close these on Datix. Should there be any concerns regarding any death these can be escalated to the Patient Safety Team for consideration in line with PSIRF. Monthly MRG Group meetings will be chaired by the Head of Patient Safety and Learning. If any further concerns are identified at the MRG Meeting these can be escalated to the Patient Safety Team for further consideration.

A range of tools, classifications and mechanisms will be used to support this process including:

- A modified version of the structured judgement review methodology defined by the Royal College of Physicians.
- Royal College of Psychiatrists Care Review Tool for mortality reviews.
- National Confidential Enquiry into Patient Outcome and Death, grading system for use by care reviewers.
- Classification of patient deaths as developed by Mazars following their report into Southern Health NHS Foundation Trust (2015).
- Feedback from Medical Examiner.

All deaths of patients with a learning disability or diagnosis of autism are reported to and reviewed through the local LeDeR process. Outputs and learning from LeDeR are reported back into the Mental Health and Learning Disability Mortality Review Group. The MRO closely liaises with the LeDeR team.

7. Mortality Review Groups

The Trust currently has two separate Mortality Review Groups to ensure that appropriate focus is directed into the review process, these are as follows:

- Physical Health Mortality Review Group
- Mental Health and Learning Disability Mortality Review Group
- Have a systemic approach to identifying those deaths requiring review, through a monthly case selection meeting.
- To have a consistent approach to care reviews through staff completing and presenting the modified **Structured Mortality Review Report** thus providing a consistent high-quality review with an emphasis on learning.
- The information gathered in the mortality review group will be used to inform the learning from deaths quarterly reports.
- To identify any risks/themes/trends identified to be escalated.
- To identify health outcomes and premature deaths.
- To identify an NCEPOD score or a MAZAR's categorisation.
- Ensure that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care and reported in annual quality accounts.
- Any learning from concerns or complaints can be shared where appropriate.
- Share relevant learning across the organisation and with other services where the insight gained could be useful.
- Offer timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death.
- Agenda in the meeting supports colleagues to reflect and offers the opportunity for reflection and support.

Learning

- Learning from mortality reviews is captured through structured case discussions, enabling clinical teams to reflect on the care provided, identify areas for improvement, and document key learning points. These insights are used to develop SMART action plans in collaboration with clinical teams. Each action is assigned an accountable owner and a clear timescale for completion.
- The Learning Assurance Team monitors the progress of these actions, seeking assurance of both completion and meaningful embedding into practice. Action plans and their progress is regularly reported through monthly directorate updates and governance channels.
- To support wider learning, a 'Learning on a Page' summary may be created where appropriate for reviews. These summaries are disseminated through governance structures and displayed on the Trust's Patient Safety and Quality of Care noticeboards to promote organisational learning.

Processes for each of these groups is seen in Appendix 1a and 1b

8. Involving Families

The Trust will endeavour to:

- Should a death be investigated as a PSI then Family Liaison Practitioners will be invited to make contact with the family.

9. Publication of Findings

The Trust Board will receive a quarterly (or as prescribed nationally) dashboard report to a public meeting, including:

- Number of deaths
- Number of deaths subject to case record review
- Number of deaths investigated under the Patient Safety Incident Response Framework (and declared as serious incidents)
- Number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- Themes and issues identified from review and investigation (including examples of good practice)
- Identification of learning points.

The Trust will publish an annual overview of this information in its Quality Report, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.

10. Process for Monitoring Compliance

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
The Trust Board is responsible for ensuring that compliance against the standards defined by the National Quality Board within the National Guidance is upheld.	Quarterly	By receiving a quarterly report from the Medical Director.

11. Incident and Near Miss Reporting and Regulation 20 Duty Of Candour Requirements

To support monitoring and learning from harm, staff should utilise the Trust's incident reporting system, Datix. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

12. Training

All staff at the Trust receive Patient Safety Syllabus eLearning. Additional training is provided through Datix sessions run by the Datix Team.

13. Resources

National guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf.

Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

Learning from deaths dashboard NHS England » Learning from deaths in the NHS

Resources from the national patient safety team; NHS England » Patient safety

The Improvement Hub NHS England » Improvement resources

Developing people – improving care: A Framework for leadership and improvement Developing People – Improving Care

Royal College of Physicians mortality review materials National Mortality Case Record Review (NMCRR) programme resources | RCP

NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)

Hogan et al Research on mortality review http://www.bmj.com/content/351/bmj.h3239 Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis | The BMJ

PSIRF NHS England » Patient Safety Incident Response Framework

Duty of candour Regulation 20: Duty of candour - Care Quality Commission

National Confidential Enquiry into Patient Outcome and Death Grading system (ncepod.org.uk)

The NHS Patient Safety Strategy NHS England » The NHS Patient Safety Strategy

14. References

Implementing the Learning from Deaths framework: key requirements for trust boards (NHS Improvement, July 2017)

National Guidance on Learning from Deaths (National Quality Board, March 2017)

Mazars LLP. Independent review of deaths of people with a learning disability or mental health problem in contact with Southern health NHS Foundation Trust April 2011 to March 2015 (2015).

GHC Documents:

- *Incident Reporting and Management Policy and Procedure (CGP001)*
- *Raising Concerns Protocols*
- *Child Death Review Process Guideline (CLG075)*

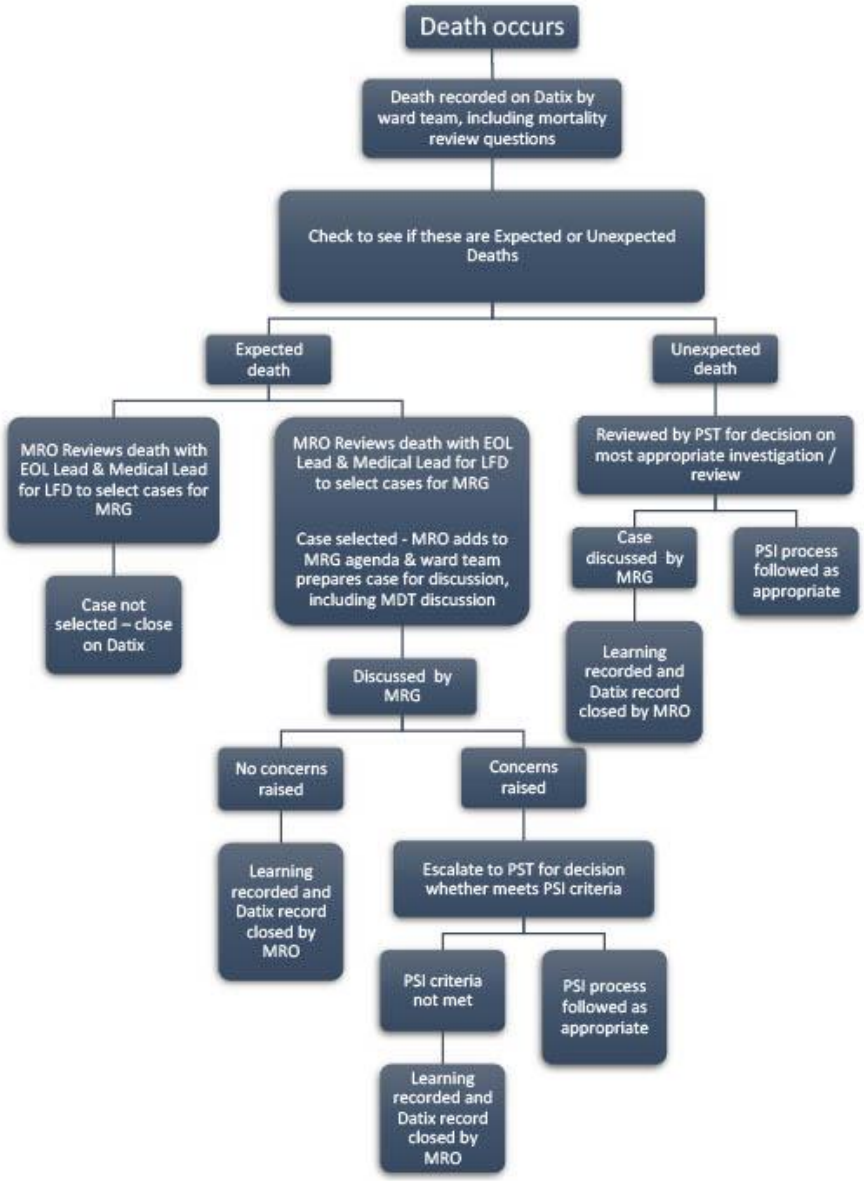
Reference Royal College of physicians. Using the structured judgement review method. A clinical governance guide to mortality case record reviews (2016).

Implementing Structured Judgement Reviews for Improvement - West of England AHSN 2018

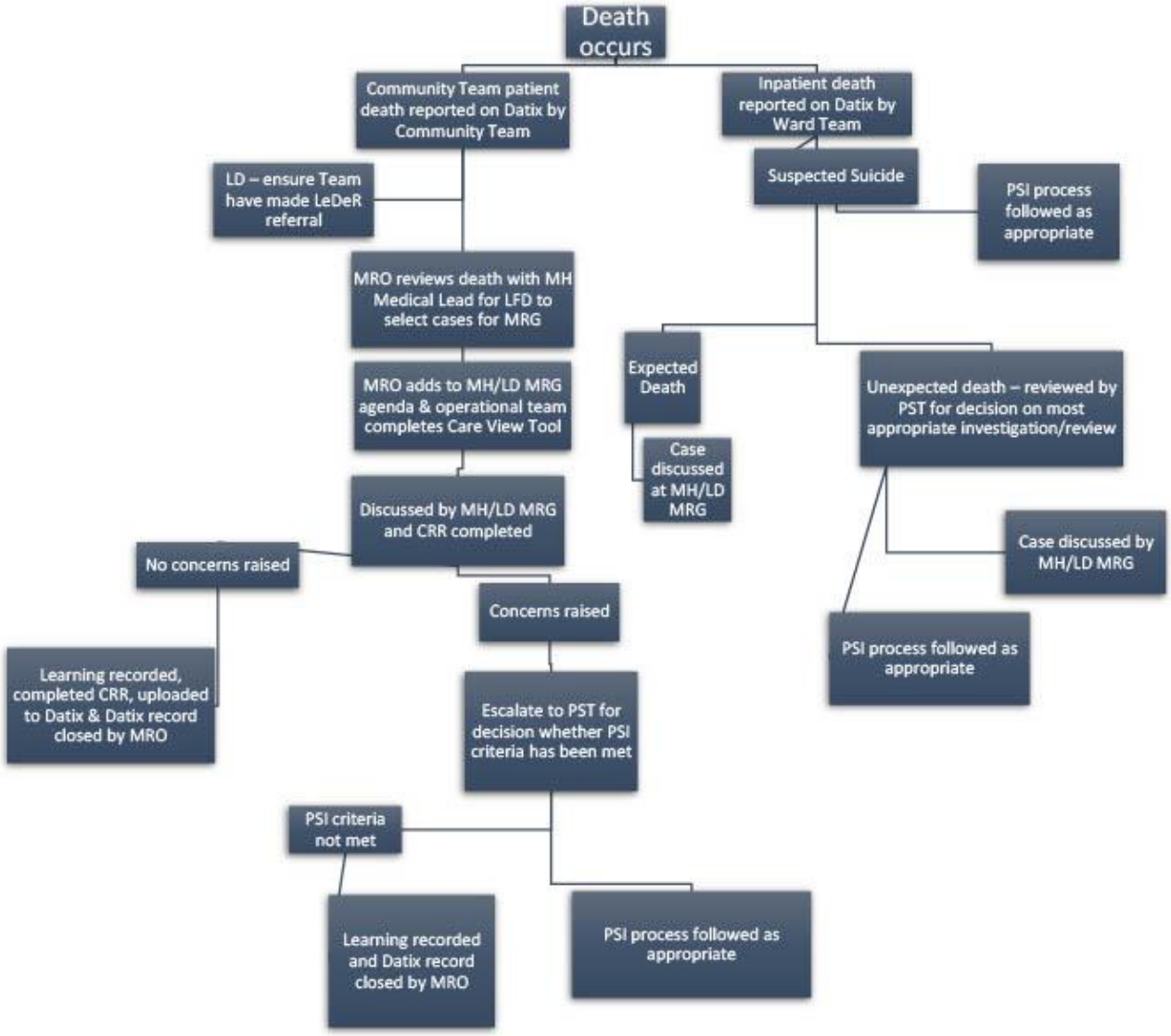
Care Quality Commission, December 2016: Learning, candour and accountability: A review of the way NHS trusts review and investigate

NHS Patient Safety Strategy (July 2019): Safer culture, safer systems, safer patients

Appendix 1a - Mortality Review Process – Community Hospitals Inpatients



Appendix 1b - Mortality Review Process - Community MH/LD Teams and Mental Health Inpatients



Appendix 2 - Standard Operating Procedure for Medical Examiner Service Input with all Inpatient Deaths

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Standard Operating Procedure
For Medical Examiner Service Input with All Inpatient Deaths

Death of Patient

↓

Ward Staff to contact Next of Kin (NoK)

Advise NoK to expect contact from the ME Service, who will review circumstances of death and need to discuss this with them prior to being able to register the death.

In Mental Health Services for any unexpected death, NoK are notified of the death by the police. Only contact NoK regarding the above once police confirm death notification has been given.

↓

Ward medical staff to contact Medical Examiner's Service on 0300 422 6982 or email details to ghn-tr.meservice@nhs.net and inform the Medical Examiner Officer of:

1. Date, time and place of death
2. The patient's last occupation
3. Proposed **cause(s)** of death for the Medical Certificate for Cause of Death
4. Any indication for referral to the coroner
5. Contact details of NoK/nominated relative
6. Name, GMC number, phone/email of referring Doctor

↓

Typically, 90% of proposed causes of death are accepted by the ME office.
To avoid delay and if cause of death understood, ward medical staff can complete a MCCD at this point, pending approval.

1. **Physical Health Services.** Scan and upload into the deceased patient's records in SystmOne, under "Record Attachments"
2. **Mental Health Services.** Scan and upload into the deceased patient's record in RiO, under "Documents and Editable Letters".

↓

Medical Examiners (available weekdays 9-5) will review the death remotely on the relevant clinical system, and after discussion with NoK will:

1. Approve the cause of death, or
2. Challenge and suggest alternative wording for the cause of death, or
3. Need to speak further to the attending doctor, or
4. Recommend referring the patient to the coroner for further action.

In all cases the ME team will speak to the nominated relative about the case of death and provide an opportunity to ask questions/raise concerns.
The ME Service will provide a confirmatory phone call/email with the outcome to support the above actions. Ward medical staff to complete or rewrite MCCD, as needed. The paper copy of the MCCD can be filed in the patient's notes or shredded.

↓

Medical Examiner service to:

1. ME countersigns the completed MCCD and sends to the Registration Office.
2. The ME will advise NoK they can contact the Registration Office to register the death.

Out of hours an on-call ME is available 17:00-21:00 weekdays and 09:00- 21:00 weekends via GHFT switchboard (0300 422 2222) for **urgent** queries or circumstances only. Otherwise, contact the ME office when it re-opens the next working day. Any queries, contact -

- Kathryn Griffin, Head of Bereavement and Medical Examiner Mortality Review Services, k.griffin@nhs.net
- Dr Alice Groves, Clinical Director Community Hospitals and Urgent Care, Alice.Groves@ghc.nhs.uk
- Dr Peter Dutton, Clinical Director MH & LD Urgent Care & Inpatient, Wotton Lawn Hospital, Peter.Dutton@ghc.nhs.uk
- Dr Katie Kelly, Consultant Psychiatrist, Charlton Lane Hospital, Katie.Kelly@ghc.nhs.uk
- Dr Paul Winterbottom, Consultant Psychiatrist, Berkeley House, Paul.Winterbottom@ghc.nhs.uk