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NHS Foundation Trust

Mortality Review extract from Quality Report September 2018

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Safe – Key Measures
Mortality Review Process at BWC

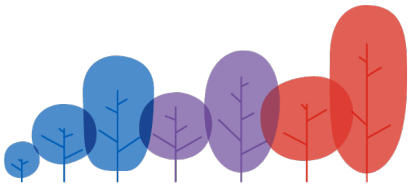
Birmingham Women's and Children's NHS Foundation Trust

Identify cases for review, using criteria listed below → Undertake mortality review using relevant structured tool → Involve parents, family or carers in the process → Link with the Serious Incident process, if applicable → Report outcome of review to Mortality Review Group → Monitor internal and external trends → Identify and share learning across the Trust

BWC is committed to learning from deaths, and reducing our mortality rates as much as possible. Due to the unique and specialist nature of our organisation, benchmarking BWC mortality rates nationally, and with other similar providers, is difficult. The main value is in monitoring the overall trends, as individual rates cannot be adjusted accurately enough to be meaningful. Therefore, BWC has an extensive inclusion criteria for cases that will be subject to a detailed mortality review, to ensure we are learning lessons and identifying areas for improvement.

BWC will review all deaths meeting the following criteria:

- 100% child deaths
- All perinatal deaths >22 weeks, >500g, excluding termination of pregnancy (unless it is a live birth)
- 100% maternal deaths
- All unexpected adult deaths and expected adult deaths in where concerns are raised
- 100% deaths of patients with a learning disability
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.



Safe – Key Measures
Monthly Mortality at BWC

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Number of deaths in August 2018

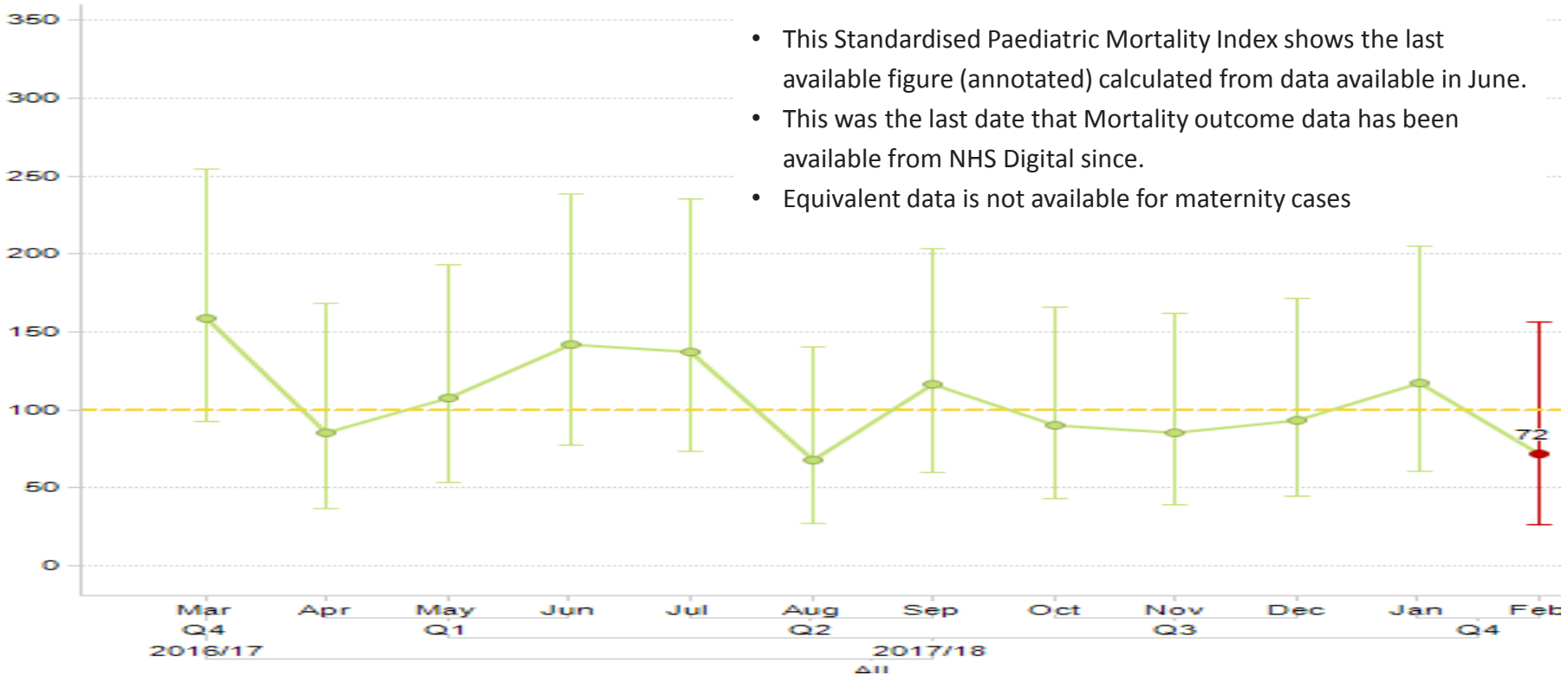
BWH: 9 deaths: *5 still births, and 4 neonatal deaths*

BCH: 9 deaths: *8 inpatient;1 out of hospital arrest.*

FTB: 0 reported deaths *of service users.*

All of the BWH and BCH cases will undergo the standard mortality review.

The Mortality Review Committee met in August and graded 1 BCH case as outcome 3 (yellow category; The care provided was less than adequate; and different management would not reasonably be expected to have altered the outcome.) This case was not subject to RCA. The committee noted a delayed response to the deterioration in PEWS.



- This Standardised Paediatric Mortality Index shows the last available figure (annotated) calculated from data available in June.
- This was the last date that Mortality outcome data has been available from NHS Digital since.
- Equivalent data is not available for maternity cases

Mortality and external benchmarking information

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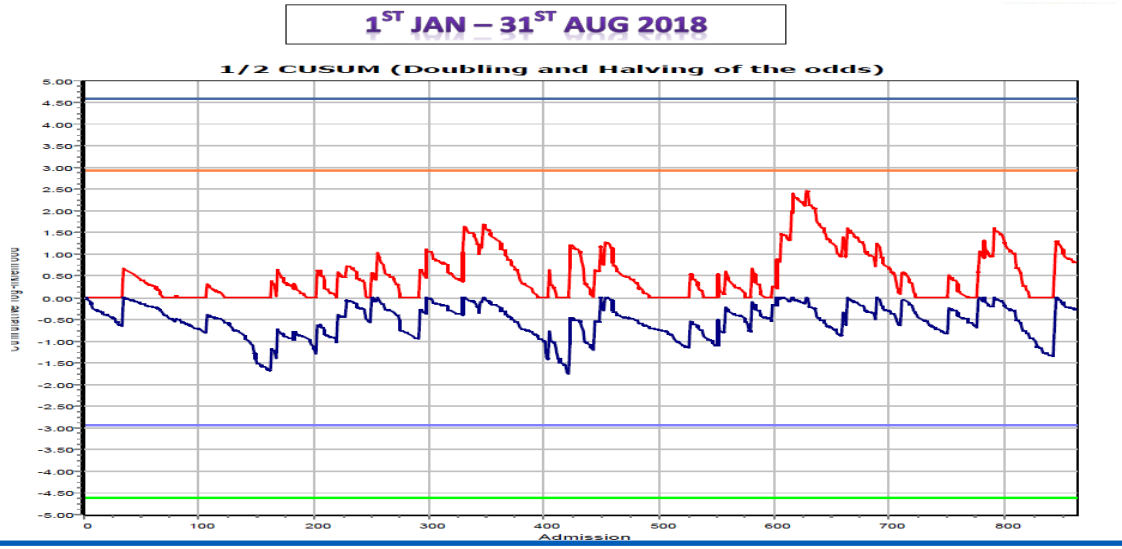
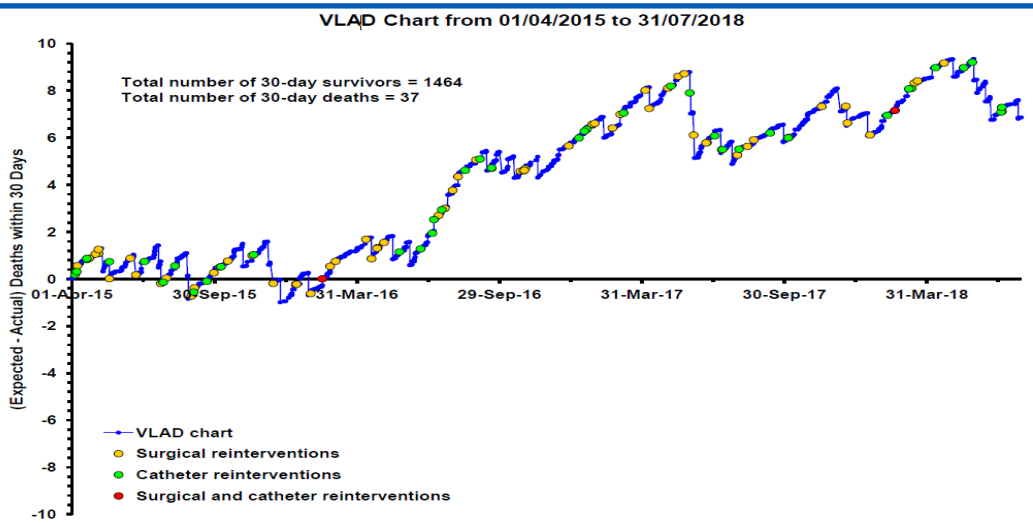


This chart represents the clinical outcome for patients cared for on the PICU. The chart does not highlight any cause for concern.



This chart represents the clinical outcome for patients who have undergone cardiac surgery. The chart shows that overall the outcomes are better than expected and this chart does not highlight any cause for concern.

Recent inquests
(with critical conclusions)

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The Trust has had two inquests over recent months where the coroner has expressed concern

Inquest on 20 August 2018 touching upon the death of a two day old baby girl on NNU who collapsed following an accidental overload of TPN. The case had been investigated by the trust as a SIRI.

The Coroner recorded a narrative conclusion: *"Baby died from an inadvertent fluid overload of TPN which was as a result of unsafe staffing levels, a failure to follow the correct procedure and a lack of learning from a previous incident. Death was contributed by neglect."*

A Report to Prevent Future Deaths was issued to the Trust and the Commissioners and the Trust is working to provide a response to this.

Inquest held on 31 August 2018 touching upon the death of a young man, known to FTB services, who was found deceased in Moseley Bog having taken an overdose of anti-depressant medication. The case had been investigated by the trust as a SIRI.

The Coroner concluded that the young man intended to take his life and would have known the potential fatality of the overdoses he had taken. He established that the clinical assessments by RAID and FTB were appropriate and also described the decision to discharge him from the crisis team as a reasonable and appropriate.

The Coroner voiced concerns that the responsibility for accessing continued help and support was placed on the young man at the time of discharge and felt that follow up should have been done by FTB on his behalf given his recent experience of mental health crisis. The Coroner recorded that the cause of death was Suicide – death by Venlafaxine Overdose

A Report to Prevent Future Deaths will be sent to the Trust in regards to the follow up of Crisis patients. FTB have already put measures in place to prevent a recurrence of this circumstance and the report will be responded to in a timely manner once received.

Future inquests
(with potential critical conclusions)

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A further inquest is scheduled during September. We anticipate a critical conclusion to this inquest and possible prevention of future deaths report.

Inquest on 13 September 2018 touching upon the death of a young man, known to FTB services, who died following a fall from a tower block. The case had been investigated by the trust as a SIRI.

The inquest had been classed as a rule 23 (statements are simply read out by the Coroner and witnesses are not required to attend), however, the coroner has now called witnesses. The RCA found gaps in care for this patient on a number of occasions. It cannot be established if the gaps identified contributed to the death of the patient, however, the RCA concluded that more active, timely and consistent follow up may have had a positive impact.

Evidence of completion of most of the recommendations from the RCA will be provided to the coroner prior to the inquest to demonstrate learning and try to avoid or minimise the extent of any report to Prevent Future Deaths.

Notable claims update

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There are two high value claims which are nearing conclusion in future months

Birth Injury sustained during delivery in 2008: The child has an asymmetric spastic form of cerebral palsy. The Trust has admitted that there was a delay in delivery and that the injuries would have been avoided if there had been no delay.
We were notified of this claim in January 2010. Admissions were agreed in 2012 but the claim was stayed until injuries could be fully assessed. The stay was lifted in March 2017 as it was deemed that the baby was of an appropriate age to be properly assessed. A settlement meeting has been arranged for 21 September 2018 in London.
As the claim is quantified at over £15m, the Department of Health are required to authorise the settlement.

Maternal post natal death in 2014: The Claim is brought by the husband of the Deceased patient who delivered her first child at Birmingham Women's Hospital on 20 February 2014 by elective caesarean section. The cause of death was recorded as "sepsis due to the infection with E-coli, occurring 6 days after elective caesarean section surgery (38 weeks) for breech and diabetes mellitus in first pregnancy". It is alleged there were two missed opportunities for earlier intervention and that death could have been avoided.
Expert evidence has been received on this matter and advised that the Community Midwife should have taken the patient's pulse when she saw her at home on 25 February. This is consistent with the findings of the RCA which found there was an inadequate assessment by the Midwife. The Trust changed its guidelines and practice following this case; community midwives now carry temperature probes and are to carry out observations on women who are unwell. Owing to the identified litigation risk, this case will proceed to attempted settlement at Mediation which is due to take place on 3 October.