Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Learning from Deaths/Mortality Report (Quarter 3) – YDH.
SPONSORING EXEC:	Dan Meron, Chief Medical Officer
REPORT BY:	Claire Bailey, Learning from Deaths Lead SFT Laura Walker, Head of Patient Safety and Learning SFT
PRESENTED BY:	Paul Foster, Medical Director YDH
DATE:	7 February 2023

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☒ For Assurance/ Discussion	☐ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	YDH has implemented the required National Guidance on Learning from Deaths recommendations. The Mortality Report includes summary tables for the Trust, which should be presented to the Board on a quarterly basis. This is a requirement of the National Quality Board Guidance on Learning from Deaths March 2017 and the NHS Improvement Implementing the Learning from Deaths framework, key requirements for Trust Boards July 2017. This report reflects the ongoing progress with Medical Examiners identifying cases requiring further investigation through Mortality Reviews or Clinical Investigation and the difficulties experienced when demand exceeds capacity to complete Mortality Reviews.
Recommendation	The Board is asked to discuss the report.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☒ Obj 1 Improve health and wellbeing of population
☒ Obj 2 Provide the best care and support to children and adults
☐ Obj 3 Strengthen care and support in local communities
☒ Obj 4 Reduce inequalities
☒ Obj 5 Respond well to complex needs

☒ Obj 6	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7	Live within our means and use our resources wisely
☒ Obj 8	Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☒ Patient Safety / Quality

Details:
To deliver our culture of learning, research, and continuous improvement to improve safety, outcomes, efficiency, and effectiveness.

To provide safe, effective, high-quality care in the most appropriate setting.

To improve outcomes for people with complex conditions through personalised, co-ordinated care.

Equality
The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics

☒ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics

☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

Public/Staff Involvement History
(Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)

N/A

Previous Consideration
(Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]

The YDH Learning from Deaths report is developed in consideration with the Mortality Review Group and noted at the Clinical Outcomes Committee.

Reference to CQC domains (Please select any which are relevant to this paper)				
☒ Safe	☐ Effective	☐ Caring	☐ Responsive	☐ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

MORTALITY REPORT- LEARNING FROM DEATHS

QUARTER 3 2022/2023

1. INTRODUCTION

1.1. In December 2016 the CQC report Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England, identified that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. In March 2017 the National Quality Board published national guidance on learning from deaths to initiate a standardised approach to learning which includes a number of recommendations to be included into Trust's governance frameworks.

1.2. These recommendations included having a Director responsible for the learning from deaths agenda, a Non-Executive Director to take oversight of progress and implementing a systematic approach to identifying the deaths requiring review, with a robust methodology for case record reviews. Ongoing developments included specific guidance for NHS Trusts in working with families, published in July 2018 and the introduction of Medical Examiners who commenced their role in the Trust on 1st July 2020. The intention is to make sure that all deaths not investigated through the coronial process are subject to a degree of independent scrutiny, with increased transparency for the bereaved and an opportunity for them to raise concerns.

1.3. A review of the first year of NHS Trusts implementing the Learning from Deaths National Guidance was published by the CQC in March 2019. This document highlights the progress that has been made with implementation of the Learning from Deaths Programme as observed during the CQC well-led inspections. The report acknowledges the early progress and the need for cultural change in the NHS, especially in respect of engagement with families. The Trust Learning from Deaths Policy has been amended to reflect these developments and the outcomes reported within future quarterly reports.

1.4. The report highlighted several challenges for Trusts in the future. These include:

- Monitoring and evolving the role of the Medical Examiner, providing continuous safety improvement, and responding to complaints and concerns.
- Developing systems to allow learning from deaths that have occurred outside of a hospital and for those under 18 years of age, with effective information sharing across NHS providers.

- Improving support for staff as agreed across national bodies, including NHS Improvement and the Healthcare Safety Investigation Branch to enable them to carry out robust reviews and investigations of deaths and serious incidents.

1.5. The Quarterly Learning from Deaths report confirms the Trust's position in relation to these challenges as well as documenting our progress with the evolving systems used to identify and learn from a patient's death. All in hospital deaths can provide information about the individual patient's care and management and this report details the learning that can be identified from many investigative sources.

1.6. The way we review a patient's death can take many forms with learning identified through several processes including but not exclusively those detailed below;

- External analysis of Mortality outcomes data through the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI)
- Scrutiny through the Medical Examiner service.
- Formal Structured Judgement Mortality Reviews.
- Coronial activity.
- Serious Incident Reviews.
- Complaints and Bereavement concerns.
- Learning Disability Reviews (LeDeR)
- Perinatal Mortality Reviews.
- Child Death Review processes.
- Review of COVID-19 related deaths.

1.7. Those cases reviewed through the above processes during Quarter 3 have allowed both local and Trust-wide learning to be identified and shared. Within this report we firstly highlight any specific learning and actions followed by more detail about each investigative process and identification of general themes as well as defining the number of reviews undertaken through each process.

1.8. Appendix 1 provides a summary of the reviews undertaken with comparative data from the previous year. These figures are updated at each subsequent Quarterly review period.

2. UPDATE ON THE MORTALITY REVIEW PROCESS

2.1. Since September 2022 the LfD team at SFT have been providing cover for the mortality review and coronial process at YDH. There are significant differences between the existing processes at both organisations. After a period of settling in, we have now met with key stakeholders from both organisations and have begun to plan how we can align these processes, ensuring that we draw on the strengths of each. The inquest process is now aligned and colleagues across both sites are being offered the same support.

2.2. Planning for the roll out of the Medical Examiner service across the whole of Somerset, is underway to include all deaths in the community, is and being led by Helen Gilliland, (Implementation Lead – Somerset Medical Examiner Service). This is still waiting implementation. Some of these developments have coincided with the LfD team working across both SFT and YDH ahead of the upcoming merger, resulting in an opportunity to review and standardise the referral process from the ME service to the LfD team. A digital referral form has been created for use by the ME service. We have now had sight of this and are due to give feedback.

2.3. Our clinical teams and services continue to face unprecedented demands and remain under significant pressure. During this reporting period, the monthly Mortality Review Group has been stood down due to consistently high levels of clinical acuity. This has resulted in further delays to the timely completion of mortality reviews. On the 16th December 2022, an extraordinary meeting was held with the LfD team and medical leadership team at YDH to agree an action plan in response to this. It was agreed that a priority list of required SJR's would be shared with the Associate Medical Directors for Urgent and Elective Care with a deadline for completion of 10th January.

3. LEARNING IDENTIFIED THROUGH THE MORTALITY REVIEW PROCESS

3.1. Previous reports have highlighted thematic concerns around the completion of Treatment Escalation Plans (TEP's), as well as the measures that were initiated to address these through organisational learning and the provision of additional training. There is some funding to teach doctors (at all levels) by equipping them with the tools to have challenging conversations about DNAR/TEP decisions and the importance of filling the forms in properly, with a face-to-face sim and feedback plus a video demonstrating good communications skills and phrases that can be used. There is also a narrated part of the video explaining the importance of filling each section on the TEP form. The progress of these improvement initiatives can be seen in the mortality reviews completed during this quarter.

3.2. Some reviews have highlighted excellence in this area. A patient, with known inoperable cancer, was admitted following a collapse at home. They were found to have raised inflammatory markers, and attempts were made to actively treat their infection. Sadly, their prognosis was poor, and they did not

recover from this infection. It was noted that the TEP was discussed and agreed with the patient and their family in the early stages of this admission. As a result, their End-of-Life care was well managed.

3.3. Other reviews have indicated that there is ongoing learning needed around this theme. A patient had been admitted due to dehydration associated with gastroenteritis. Approximately 1 week after admission, the patient sadly deteriorated, and a small bowel obstruction was noted on CT scan. A surgical review was requested. Concerns were raised as there were delays to this taking place. Whilst it was felt that an earlier surgical review wouldn't have made a difference to the outcome, the patient was known to have been very frail and there had been no discussion about TEP or ceiling of care until after this review had taken place. The review noted that earlier palliation may have resulted in an improved experience of End-of-Life care for the patient and their family.

ED mortality review summary

3.4. Despite considerable ongoing pressures in the department, Dr Joe Rowton, ED mortality lead in YDH, reviews all deaths in ED each month assessing the quality of care, the avoidability of the death and identifying any learning points. These summaries are shared with the ED seniors on a monthly basis and presented at the departmental clinical governance meeting. Deaths considered to be avoidable are subject to further scrutiny.

3.5. Between March and November 2022, there were 34 deaths in ED. 33 of these were judged unavoidable: 3 "anticipated deaths due to disease progression", 13 "deaths following cardiac or respiratory arrest which occurred before the patient's arrival in hospital", 16 "unexpected deaths despite known preventative measures taken in an adequate and timely fashion", and one "unexpected death" subject to ongoing significant event analysis.

3.6. Following review of a death during April of a patient presenting with massive GI haemorrhage and an out of hospital cardiac arrest, it was noted that the rapid infuser was not used for the multiple blood transfusions required. This was not felt to have affected the outcome for this patient but lead to immediate sharing of information amongst the team of the importance of using the rapid infuser as part of the management of massive haemorrhage, institution of training sessions for ED staff on how to set up and use the rapid infuser, and it has already been incorporated into monthly ED simulation training.

3.7. Further learning was shared amongst the team following unavoidable deaths in September and October around the importance of early decision making in terms of DNAR/TEP in elderly patients presenting with significant illness.

3.8. Also, in July, a death of a patient in the ambulance on the way to hospital (and confirmed by the ED doctor in the ambulance on arrival) was not documented on Trakcare. The importance of this documentation was shared with the wider ED team.

3.9. Following a recent meeting the SFT and YDH LfD team and medical leadership teams, these mortality reviews will be done using the structured judgement review (SJR) methodology going forwards as a further step towards streamlining mortality review processes across the new merged organisation.

4. INVESTIGATIVE PROCESSES UNDERTAKEN WITHIN THE QUARTER

4.1. The following sections of this report describe the investigative processes which have been used to identify the above learning. Where there has been activity within the reporting quarter this is included along with details of any more general themes identified. The Trust's Learning from Deaths Manager has responsibility for collating learning from all inpatient deaths whichever review method is used. Outcomes are reported through the Incident Investigation and Learning Group, Local Governance Meetings, the Mortality Review Group and the Clinical Outcomes Committee as well as being summarised within this quarterly report.

Standardised Mortality

4.2. Standard mortality ratios (SMRs) are the ratio between observed deaths and the estimated number of deaths. The Trust uses two measures of standardised mortality: summary hospital-level mortality index (SHMI) and hospital standardised mortality ratio (HSMR). SHMI and HSMR predict the estimated number of deaths differently by using different risk factors and methodologies.

Summary Hospital-Level Mortality Indicator (SHMI)

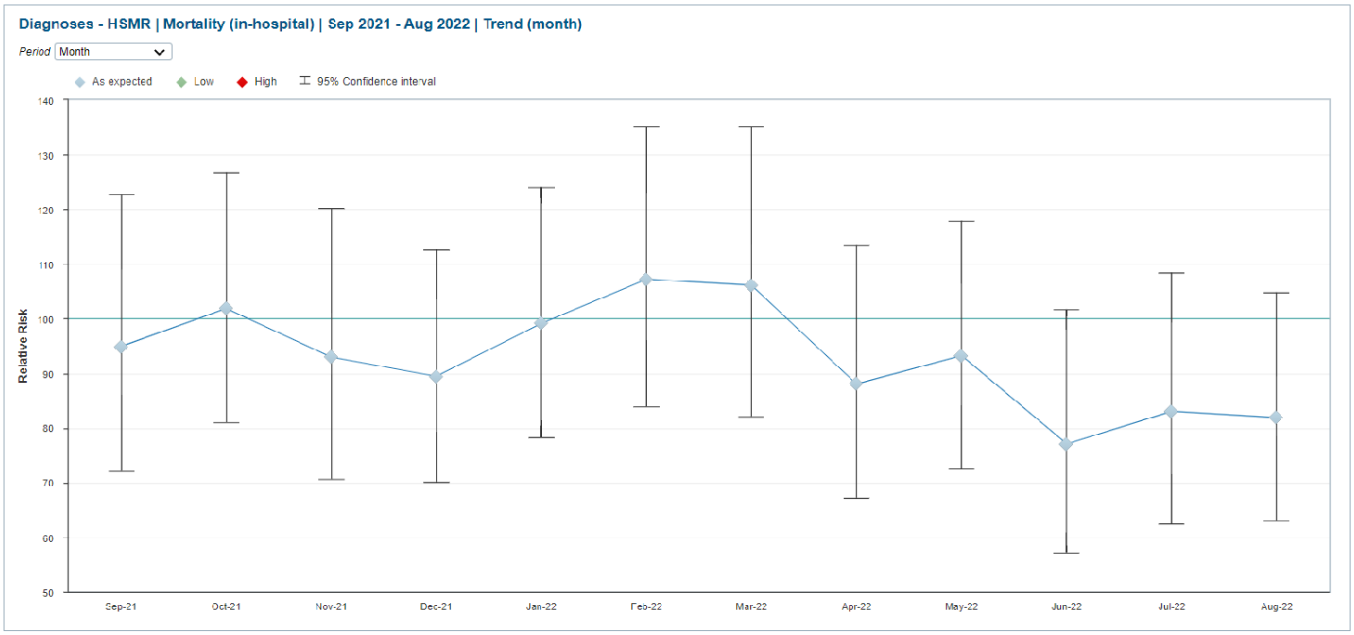
4.3. The number of deaths in hospital is captured through the Summary Hospital-Level Mortality Indicator (SHMI). This reports mortality at Trust level using a standard and transparent methodology, which is published quarterly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Our latest reported SHMI covering 12 months July 2021 to June 2022 is 95.26 which is within the expected range, with no diagnostic groups showing as an outlier.

Hospital Standardised Mortality Ratio (HSMR)

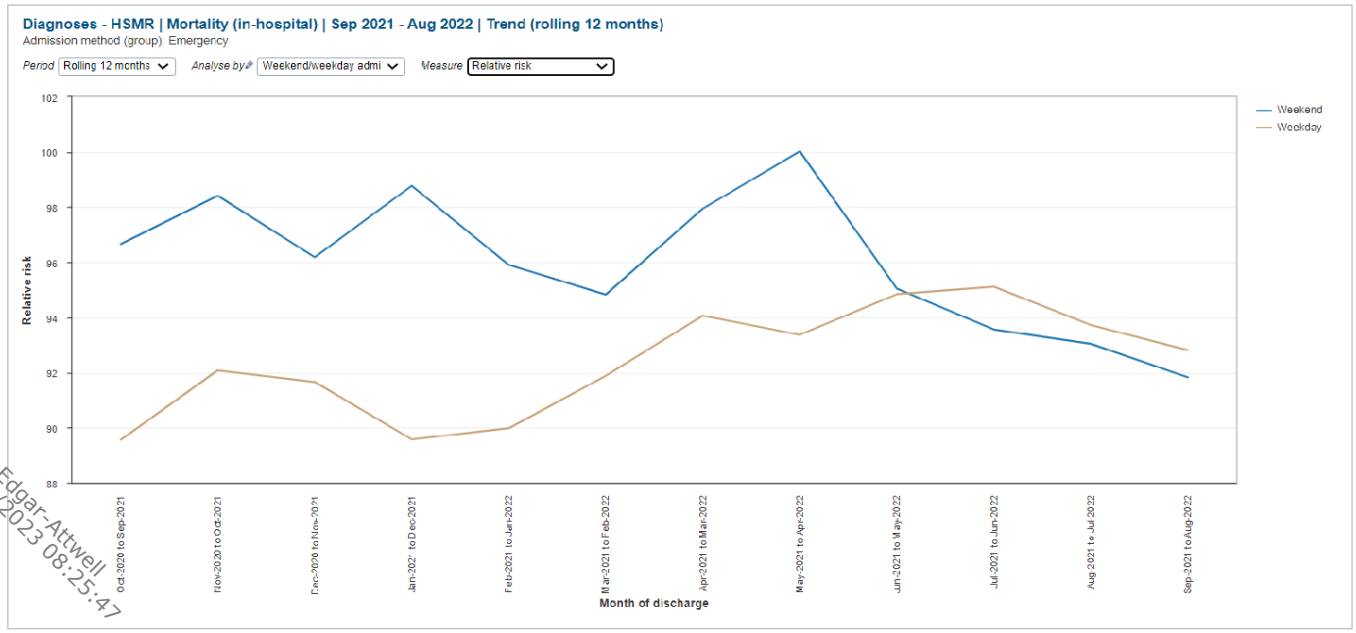
4.4. The Trust uses Dr Foster to support analytical review of outcomes data. There have been changes to the way that Dr Foster receives the national HES (Hospital Episode Statistics) data and this now comes directly from NHS Digital, improving filters and enhancing methodology to improve the accuracy of comorbidity and palliative code indicators and the predictive ability of the risk model.

4.5. Dr Foster outcomes data includes reporting of the Hospital Standardised Mortality Ratio (HSMR), which reviews a set number of indicators to inform understanding of quality and improvements in clinical care. The Trust HSMR for the latest reporting period 12 months from September 2021 to August

2022 is 92.9 which is statistically lower than expected. The rolling HSMR trend shows a level picture over the last 4 data points. The rolling HSMR 3-year trend shows that the HSMR has changed from a position of “within expected” to “lower than expected” for the last data period, having been within the expected range for the 6 periods prior. This is a different pattern compared to regional peers where the HSMR is continuing on an upward trajectory.



4.6. The Trust’s weekday HSMR is currently 92.8 with the weekend figure at 91.8 both are within the expected ranges. The Weekday rate had seen an increasing trend to the July 21 to June 22 data point but now shows a decreasing trend over the last 2 periods (July and August 22). The weekend rate trend continues to decline.



4.7. The COVID pandemic has resulted in a change in patient activity which has reduced the denominator data and the variation in the number of observed deaths in some diagnoses groups. This trend is monitored within the monthly data report. Currently if all Covid-19 activity is removed from the HSMR the figure reduces to 90.5, which is statistically lower than expected, weekday HSMR decreases to 90.4 which is statistically lower than expected, and weekend HSMR reduces to 89.5 which is statistically within the expected range.

Mortality Alerts

4.8. CUSUM is short for cumulative sum and an alert occurs when the number of deaths, readmissions, or activity within the Trust in a cohort of patients with the same coded condition, (taking account of their comorbidities) is higher than anticipated. There was 1 new CUSUM Mortality Alert reported by Dr Foster in Quarter 3. The alert was in relation to the diagnosis group “other perinatal conditions”, where there were 2 observed deaths, both had a P95 still birth coding. There will be a request for these cases to be looked at within their speciality due to the low number.

4.9. CUSUM Mortality alerts are reviewed firstly by identifying the number of patients in the cohort to ascertain if monitoring or review is appropriate. Where there are small numbers, the data may be subject to change. If a review is commissioned, the accuracy of the codes allocated to their case is interrogated. If this does not show any issues an assessment of care and management from the patient records is completed. This allows us to ascertain why the alert has occurred and to identify any actions that should be taken to address any issues with the management of this group of patients. This process may result in the coding for the patient spell being amended if their main documented condition or cause of death has changed since their admission. Reviews are carried out through the Mortality Review Group or by the clinical teams involved, with the outcome fed back through the Clinical Outcomes Committee.

The Medical Examiner service

4.10. The introduction of the Medical Examiner Role in 2020 has helped to formalise our Mortality Review Processes. The current challenges and development include:

- There is an expectation for all patients who die in the hospital to have an initial notes review by the Medical Examiner. This scrutiny enables identification of any issues for referral to Learning from Deaths for further review. However, there have been challenges with achieving scrutiny of all deaths. Additional Medical Examiner sessions have been recruited and these changes are beginning to be reflected in the number of case reviews undertaken.

- A discussion also occurs with the doctor responsible for completing the Medical Certificate of Cause of Death (MCCD). This prompts learning

for the individual doctor and can serve to reduce the possibility of the documented cause of death being rejected by the Registrar's Office.

- There will also be a conversation between the Medical Examiner Officer or Medical Examiner and the patient's Next of Kin to explore any care concerns that they may have. This allows the team to identify any potential issues and to address these at an early stage.

- Where a cause of death has not been identified or this fits within the coronial rules an initial Coroner's referral is made to determine if further investigation will be required.

- Active collaboration with the Medical Examiner service at Somerset Foundation Trust to provide a seamless cross-country process is ongoing. The appointment of a dedicated lead with the responsibility for the rollout of integrated systems to include scrutiny of all community deaths and in the future evolving the role of the Medical Examiner to include scrutiny of all neo-natal and child deaths.

Formal Structured Judgement Mortality Reviews - the three stage process

4.11. In addition to the above overview reporting mechanisms it is important to provide a formal system to review the care and management of any patient who dies within the Trust. The Trust's Learning from Deaths Manager holds responsibility for ensuring robust systems are used to identify and share learning from any death within the hospital.

4.12. The Structured Judgement Review Tool (SJR) from the Royal College of Physicians has been adapted to facilitate its use throughout the hospital. Formal mortality reviews are undertaken with data analysis used to inform improvements in care and provide reports to the Board.

4.13. The Mortality Review Group and the Learning from Deaths Manager oversee reviews of the management and care of all patients who have died within the hospital. A three-stage process is used with those patients requiring a formal review identified through the formal Medical Examiner interventions at the time of completing the death certification.

- Mortality review 1 - An initial assessment completed by the Medical Examiner enables early identification of any case where a potential problem exists. For example, where the cause of death does not follow from the admission diagnosis or where a potential omission in care or poor management is identified. Any such case is referred to the Specialty Team or the Mortality Review group who are responsible for undertaking a detailed mortality review to identify any concerns and to ensure learning for improvement. This system ensures that all patient deaths are subject to an initial review of their management and care, with a small number going forward for a full formal Mortality or Clinical review.

- Mortality Review 2 - Cases identified for this type of review will undergo a full review via speciality Morbidity and Mortality meetings with presentation of any significant findings at local Clinical Governance Sessions. Outcomes from these meetings, in particular any learning and actions taken will be recorded through the Learning from Deaths Manager within the Structured Judgement Review tool. The SJR tool summarises each review with an avoidability score. This is used to determine whether the information identified during the review, shows any evidence that the patient's death could have been avoided if different actions had been taken or the circumstances had been different. Any investigation undertaken outside of this process, for instance Serious Untoward Incident Investigations where death has occurred will now include an avoidability score as part of the investigation summary. This ensures all patient in hospital deaths can be categorised depending on the level of avoidability in each individual case regardless of the investigative process.

  There are some groups of patients who will automatically be subject to a Mortality Review 2, regardless of any findings identified by the Medical Examiner. These are where the number of deaths in the specialty is small, where the patient had a Learning Disability and where there is evidence of a hospital acquired COVID-19 infection which has been cited as the cause or contributed to the death.

- Mortality Review 3 - The third stage of the process involves the referral of any patient whose Mortality review has identified a degree of avoidability greater than 50% to the Mortality Review Group for verification and action. The Medical Examiner may also refer cases direct for this level of review. These cases may also include those where an incident investigation has been undertaken which does not cover the patient's death or where a case has been referred for a formal coroner's inquest.

Quarter 3 Review Outcomes

- Quarter 3 saw 182 of our 242 inpatient deaths (75%) scrutinised by the Medical Examiner. These would be classified as a Mortality Review at level 1 as described above. When compared to Quarter 2, the total number of Mortality Reviews completed at level 1 has increased from 166, however the overall percentage has decreased from 85%.

- 19 deaths were referred for a Mortality Review at level 2. Clinical activity within the Trust has resulted in the need to cancel the Mortality Review Group since August 2022. To ensure that these reviews, as well as the 15 outstanding from Quarter 2, do not fall too far outside of the desired timeframes, we have arranged for these reviews to be completed by colleagues outside of the Mortality Review Group setting. To date, 12 of these reviews have been completed. For those reviews undertaken using the Structured Judgement Tool in Quarter 2, 10 were judged to be unavoidable and the remaining 2 were judged to have

slight evidence of avoidability. Both noted delays to diagnosis and treatment.

Learning Disability Deaths

4.14. All deaths where a patient has been confirmed as having a Learning Disability are reported in line with national requirements and reviewed as part of the Trust's formal process with a subsequent referral externally for a full LeDeR review. Seven patients with a Learning Disability have been identified as needing a review in the quarter. These cases have been referred for a LeDeR review in line with Trust policy.

Perinatal and Child Death reviews

Neonatal and Maternal Deaths

4.15. CNST requires that cases and actions reviewed using the **Perinatal Mortality Review Tool (PMRT)** are reported to Trust Board quarterly. The PMRT facilitates a comprehensive, robust and standardised review of all perinatal deaths from 22+0 gestations (excluding terminations) to 28 days after birth; as well as babies who die after 28 days following neonatal care. Review is undertaken by a multidisciplinary panel of clinicians which has to include a panel member who is external to the unit.

4.16. The web-based tool presents a series of questions about care from pre-conception to bereavement and follow-up care. The factual information is entered in advance of a multidisciplinary panel of internal and external peers (allowing for a 'Fresh eyes' perspective) review of cases. The tool is used to identify required learning with action plans generated, implemented and monitored.

4.17. Reviews undertaken and the findings are detailed in the Trust's Quarterly Maternity Quality Report.

Paediatric Deaths

4.18. The Child Death Overview Panel reviews all child deaths. Notification of a child death to the Local Safeguarding Children Board is made at the time of any agency becoming aware of the death of a child. Where the death occurs within the hospital, responsibility for completing this notification is usually undertaken by the paediatrician managing the case.

Review of COVID-19 related deaths

4.19. The Trust is required to maintain processes to investigate and learn from cases where COVID-19 has been identified as hospital acquired and listed as the cause of death or a contributory factor.

4.20. The South West Regional Healthcare Setting Outbreak Framework from NHS England and NHS Improvement guidance states that where there is any evidence that the COVID-19 infection may have been hospital-acquired and a death has resulted, there is scope for learning. If the infection was acquired due to issues in healthcare provision, such as non-compliance with IPC processes this is potentially a Serious Incident.

4.21. The Mortality processes and Medical Examiner Role link closely with the Post Infection Review (PIR) process which, in agreement with the CCG and following the Outbreak Framework, requires a serious incident review for all cases where a lapse in care has been identified.

4.22. The Trust has developed processes to identify any care and service delivery problems within the group of patients where a COVID-19 infection has contributed to or caused their death. Where a patient has COVID-19 identified as a cause of death documented on their death certificate a review is undertaken to determine if there were any lapses in care. Those cases where a lapse is identified a serious incident review is commissioned. No reports have been completed in the quarter.

Coronial Activity

4.23. The newly substantively appointed Senior Coroner Mrs Samantha Marsh has requested statements from staff in relation to the death of an inpatient or where the patient had a recent admission or procedure that could be relevant to their death. 9 new instructions were received relating to deaths in quarter 3. There have been no inquests with staff required to attend, and no pre-inquest hearings have been conducted during this quarter.

Serious Incident Reviews, Complaints and Bereavement concerns.

4.24. One reported case in Quarter 3 resulted in a Serious Incident Investigation being commissioned concerning a patient who died whilst under our care. This incident was a never event due to incorrect blood products being administered to the patient. The initial review has clarified that the incident did not contribute to the patient's death in any way. An additional two cases from a previous reporting period remain under review. Additional details will not be available until these investigations are complete.

Appendix 1

This table is a summary of the number of deaths in month against the number reviewed using the investigative processes available. Please note there is a delay in accurate reporting of in-quarter reviews due to the time frames of external surveillance data from Dr Foster and the mortality review process . This table will be updated quarterly.

2021-	2022-

	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	April	May	June	Q1 Total	July	Aug	Sept	Q2 Total	Oct	Nov	Dec	Q3 Total
Total deaths in the Trust (including ED deaths)	68	71	62	**201**	87	71	82	**240**	86	88	79	**234**	82	83	64	**229**	62	72	61	**195**	68	71	103	**242**
Number subject to a Level 1 Mortality Review	49	47	25	**121**	38	35	39	**112**	64	63	54	**181**	49	53	41	**143**	53	58	55	**166**	68	58	56	**182**
Number referred for a Level 2/3 Mortality Review	6	4	3	**13**	5	3	10	**18**	9	8	6	**23**	12	8	5	**25**	7	3	6	**16**	9	5	7	**21**
Number of completed Level 2/3 Reviews	5	3	1	**9**	5	3	5	**9**	8	6	4	**18**	9	0	2	**11**	12	2	3	**17**	0	0	2	**2**
Number investigated as a Serious Incident	0	0	0	**0**	0	0	1	**1**	0	1	0	**1**	0	0	0	**0**	1	0	1	**2**	0	0	1	**1**
Learning Disability deaths	0	1	0	**1**	0	0	0	**0**	1	0	0	**1**	2	0	0	**2**	2	0	2	**4**	3	1	3	**7**
Bereavement concerns	0	0	1	**1**	0	1	2	**3**	0	1	0	**1**	1	0	0	**1**	3	0	0	**3**	0	1	1	**2**
Coroner's Inquest investigations	2	2	1	**5**	4	2	4	**9**	1	1	3	**6**	1	4	2	**7**	2	2	6	**10**	4	3	2	**9**
Number thought more likely than not to be due to	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**

problems with care																							

It should be noted that scrutiny of all patient deaths by the Medical Examiner and the resultant change in process means that comparative data is not yet available for all types of investigative review. Where available retrospective data has been added to the above chart.