Learning Disabilities Mortality Review (LeDeR) Programme

# Briefing Paper 5: Working with other investigation and review processes

This Briefing Paper broadly outlines the remit of other review or investigation processes and provides guidance to the LeDeR reviewer as to the process to follow when a death is subject to more than one process.

A key part of the Learning Disabilities Mortality Review (LeDeR) programme is to support local areas to review the deaths of people with learning disabilities. The purpose of the LeDeR reviews is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation. It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them.

In order to do this in a timely manner and to avoid duplication, reviewers need to be clear where and how the LeDeR process links with other review or investigation processes.

Other investigations or reviews may include, for example: Serious Case Reviews, Safeguarding Adult Reviews, Safeguarding Adults Enquiries (Section 42 Care Act) Domestic Homicide Reviews, Serious Incident Reviews, Coroners' investigations and Child Death Reviews.

**Key principles**

In all cases, the key principles of communication, cooperation and independence should be adhered to.

Communication

Where another review or investigation is indicated or underway, the reviewer should, in the first instance, discuss this with the Local Area Contact. It is important that clear lines of communication between the LeDeR reviewer or Local Area Contact and the lead/key contact of the other investigation or review process are established. On a case by case basis, the extent of each investigation or review, and a plan for the collection of core data for each review process, will need to be developed.

Cooperation

Cooperation is vital between relevant parties where there is more than one review taking place; each review team is likely to benefit from the experience and expertise of each other.

Independence

Although the different review processes should conduct their work in a cooperative manner, each review will have its own remit and focus of attention, and the independence of each party is of importance. Those involved in the LeDeR process should not be involved in the direct care of those patients involved and if possible not work directly with those involved in the delivery of the person's care. When acting as a reviewer they should act with impartiality – challenging the 'status quo' to identify system weaknesses and opportunities for learning while making decisions based on objective criteria. The Local Area Contact should inform the LeDeR Steering Group covering their area about each LeDeR review that significantly

impacts on or is affected by another investigation or review, sharing the agreed plan for data collection and providing the Steering Group with reports on progress and completion of the review.

The needs of the family and carers should receive careful consideration so as to avoid duplication of questioning and unnecessary upset.

**Specific review or investigation processes**

**Structured Judgement Review (SJR)**

The national guidance on Learning from Deaths requires acute, mental health and community NHS Trusts and Foundation Trusts to use an evidence-based methodology (such as the Structured Judgement Review (SJR) methodology) for reviewing the quality of care provided to patients who die. The national Learning from Deaths Implementation Guidance specifies that Trusts should conduct an initial case note review of all deaths of people with learning disabilities using SJR and should also adopt the LeDeR method for reviewing the deaths of people with learning disabilities.

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

National guidance on Learning from Deaths Implementation Guidance
https://improvement.nhs.uk/documents/1747/170921__Implementing_LfD_-_information_for_boards_JH_amend_3.pdf

All deaths of people with learning disabilities in acute hospitals should therefore receive a SJR into their last episode of care. The LeDeR review should discuss the findings of the SJR with the Trust reviewer so that they can feed into the broader LeDeR review. When the LeDeR review is completed, the Trust should be sent a redacted copy of the completed review.

**Child death review process**

It is a statutory requirement to review all deaths of children. '*Working Together to Safeguard Children*' (2018) sets out the high-level principles for child death review. The processes that should be followed by all those involved when responding to, investigating, and reviewing all child deaths are set out in the *Child Death Review Statutory Guidance* issued in 2017.

For more information see https://consult.education.gov.uk/child-protection-safeguarding-and-family-law/working-together-to-safeguard-children-revisions-t/supporting_documents/Child_death_review_stat_guidance.pdf

Deaths of children aged 4-17 (inclusive) will therefore be reviewed by the child death review process. It would not be necessary, nor appropriate, to review the death again but the local reviewer and/or Local Area Contact for the LeDeR programme will need to liaise with the Child Death Review Co-ordinator for their area to ensure the collection of core data for the LeDeR programme and to offer expertise about learning disabilities as appropriate.

**Serious Case Reviews**

A serious case review takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons than can help prevent similar incidents from happening in the future. Local Safeguarding Children Boards follow statutory guidance for conducting a serious case review. For more information see '*Working together to safeguard children*' (2018).

The Child Death Review Co-ordinator is likely to be aware if a Serious Case Review is being conducted. As with deaths of all children, it would not be necessary, nor appropriate, to review the case again but the local reviewer and/or Local Area Contact for the LeDeR programme will need to liaise with the Child Death Review Co-ordinator to ensure the collection of core data for the LeDeR programme and to offer expertise about learning disabilities as appropriate.

**Safeguarding Adult Reviews**

The Care Act 2014 introduces statutory Safeguarding Adults Reviews, mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology. A Safeguarding Adults Review (SAR) must be carried out when someone with care and support needs dies as a result of neglect or abuse and there is reasonable cause for concern about how professionals worked together to safeguard the adult. The focus of the review is to identify any lessons to be learnt and apply those lessons to future cases. Safeguarding Adults Boards are required to publish an annual report which includes the findings of any Safeguarding Adults Reviews conducted during that year and what it has done to implement the findings.

If the death of a person with learning disabilities is subject to a Safeguarding Adult Review, the local reviewer and/or Local Area Contact for the LeDeR programme will need to liaise with the Chair of the Safeguarding Adult Board to ensure the collection of core data for the LeDeR programme and to offer expertise about learning disabilities as appropriate.

**Serious Incident Reviews**

The revised Serious Incident Framework (2015) builds on previous guidance that introduced a systematic process for responding to serious incidents in NHS-funded care. Serious Incidents in health care are defined as '*adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified*.' There are three levels of Serious Incident reviews:

a) concise investigations -suited to less complex incidents which can be managed by individuals or a small group of individuals at a local level

b) comprehensive investigations - suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators

c) independent investigations

The level of investigation should be proportionate to the individual incident and is agreed at an initial review (sometimes called a 72-hour review). Concise and comprehensive investigations should be completed within 60 days and independent investigations should be completed within 6 months of being commissioned.

For more information about the Serious Incident Framework see:

https://improvement.nhs.uk/resources/serious-incident-framework/

If the death of a person with learning disabilities is subject to a Serious Incident Review, there is usually no problem in continuing with the LeDeR review which is generally broader in perspective. This should be discussed with the healthcare service provider's safeguarding lead.

**Police Investigations**

The police will be involved in investigating a death if there is a suspicion that a crime has occurred. Generally, deaths should be reported to the police if:

- It is possible that assault or violence caused or contributed to the death.
- It is possible that intentional or accidental poisoning (but not food poisoning) could have contributed to the death.
- Neglect may have caused or contributed to the death.
- A road traffic collision may have caused or contributed to the death.
- The deceased's own actions may have caused or contributed to the death (e.g. by drug use, self-harm or self-neglect).
- the deceased's employment have caused or contributed to the death.
- The death occurred in police custody, or shortly after police contact, or if it is thought that police action or inaction may have caused or contributed to the death.

Criminal investigation by the police takes priority over other enquiries, and the LeDeR review will need to be put on hold, as it may potentially prejudice a criminal investigation and subsequent proceedings (if any). Where this is the case, the LeDeR reviewer or the Local Area Contact and the police should agree a date for the LeDeR review to recommence.

**Domestic Homicide Reviews**

Domestic Homicide Reviews were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004) and came into force in April 2011. Domestic Homicide Reviews are locally conducted, multi-agency reviews of the circumstances in which the death of a person aged 16 or over, has or appears to have resulted from violence, abuse or neglect by:

- A person whom he/she was related or had been in an intimate personal relationship, or
- A member of the same household.

Local Community Safety Partnerships are informed of a suspected domestic homicide by the relevant police force and it is their responsibility to set up a Domestic Homicide Review. The purpose of the review is to identify what lessons are to be learned from the domestic homicide, particularly the way in which local professionals and organisations work individually and together to safeguard victims; and how the lessons will be acted on.

For more information see the Crown prosecution Service information at:
https://www.gov.uk/government/collections/domestic-homicide-review

Where domestic homicide is suspected in a person with learning disabilities, the LeDeR reviewer should contact the Chairperson of the local Community Safety Partnership Board to agree a plan for the collection of core data for the LeDeR programme and to offer expertise about learning disabilities as appropriate.

**Deaths referred to the Coroner**

A coroner is an independent judicial office holder, appointed by a local council. Coroners usually have a legal background but will also be familiar with medical terminology.

Coroners investigate deaths that have been reported to them if it appears that

- The death was violent or unnatural.
- The cause of death is unknown.
- The person died in prison, police custody, or another type of state detention, including having a Deprivation of Liberty order.

The role of the coroner is to determine who the deceased person was and how, when and where they came by their death. When the death is suspected to have been either sudden with unknown cause, violent, or unnatural, the coroner decides whether to hold a post-mortem examination and, if necessary, an inquest.

A post-mortem examination of the body will usually establish the cause of death, but if it is unable to do so, or the death is found to be unnatural, the coroner has to hold an inquest. An inquest is a public court hearing held by the coroner in order to establish who died and how, when and where the death occurred.

For more information about the role of the coroner see the Ministry of Justice Guide to Coroner Services at: https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide

Where a death has been referred to the Coroner for investigation, the LeDeR reviewer or the Local Area Contact should contact the local Coroner's Officer and agree a plan for the LeDeR review. In the majority of cases, the LeDeR review process can go ahead, and would be informed by the results of the post-mortem examination. Separate investigations into a death usually take place *before* an inquest so that the coroner can draw on the information for the inquest, but this would need to be agreed with the relevant coroners officer.