ADVANCES IN PERIOPERATIVE CARE

NARRATIVE ARTICLE

Learning from deaths

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Abstract

This narrative article explores why healthcare systems repeatedly fail to learn from preventable deaths. We present Mrs L, who died less than 6 weeks after routine hip replacement surgery. She had attended preoperative assessment with hypertension and renal impairment, which worsened before surgery. Postoperatively, she became hypotensive and hypoxic overnight, but the senior staff were not informed. She developed multiple organ infarctions, required two further operations and died 3 days later. The Parliamentary and Health Service Ombudsman identified multiple missed opportunities to intervene. This case reflects a persistent problem. Studies show that 5.2% of hospital deaths are preventable, with surgical patients at higher risk. Despite decades of inquiries and reports, the same issues recur: poor clinical monitoring, diagnostic errors and inadequate fluid management. In practice, high-profile investigations rarely translate into frontline learning. The 2017 National Quality Board guidance now requires National Health Service (NHS) Trusts to publicly report on deaths and learning, but real change often comes from bereaved families rather than healthcare systems. Connor Sparrowhawk's death and the subsequent family campaign exposed widespread failures in death investigation processes. What works? When families like Joshua Titcombe's and Elaine Bromiley's drive change, systems actually improve. Their personal stories create experiential learning that statistics cannot achieve. As healthcare professionals, we need both systematic processes for reviewing deaths and personal narratives that make lessons stick.

Keywords: avoidable harm, death, inquiry, NCEPOD, ombudsman

Case history

Fewer than 6 weeks after a routine hip replacement, Mrs L died. On retrospectively reviewing her case the Parliamentary and Health Service Ombudsman noted multiple opportunities when clinicians could have intervened to improve her care. Prior to her hip operation, Mrs L attended the preoperative assessment clinic, where she was found to be hypertensive with renal impairment. One week later, but before the operation, her renal function had deteriorated. Postoperatively, Mrs L was hypotensive and hypoxic overnight; this information was not communicated to senior

clinical staff. The next day intravenous fluids were given for hypotension and a blood transfusion was required. The following day Mrs L was admitted to the Critical Care Unit, she was unresponsive and increasingly anaemic. Serial computed tomography imaging demonstrated multiple organ infarctions and later a haematoma adjacent to Mrs L's hip. She required two further operations under general anaesthesia, including relocation of a dislocated hip. Three days later she died, post-mortem examination demonstrated ischaemic colitis [1].

Question to be answered

What are the reasons for not learning from deaths in hospital and what can be done to improve this?

Discussion background

When a patient dies due to complications of care, clinicians and the healthcare system as a whole should set out to ensure that no future deaths will occur as a result of the same or similar problems with care. In essence, healthcare systems should learn from deaths and, if they do not, then they need to ask why this is the case and what can be done to substantially improve the avoidance of similar errors and deaths.

Mrs L's case is not unique and may be similar to many cases across the UK over several decades, in which opportunities to ensure patient safety have been missed and care has been judged inadequate [2, 3]. Potentially preventable deaths have occurred and continue to occur in all sectors of healthcare, including primary care, acute hospital settings and mental health institutions. Hogan et al. [4] found that, in English acute hospitals, 5.2% of deaths were considered preventable and that these deaths occurred more commonly among surgical patients. Problems frequently found to be associated with preventable deaths involved poor clinical monitoring, diagnostic errors and inadequate drug or fluid management. These problems persist despite previous initiatives or reports attempting to address them both nationally and internationally [5–7].

National inquiries (and enquiries)

Reviewing patient deaths has been the purpose of the longstanding National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD). NCEPOD is independent of government bodies and professional associations. There have been multiple reports produced since the original Confidential Enquiry into Perioperative Deaths in 1987, several conclusions from the original report are still relevant nearly 40 years later: [2]

- important differences in clinical practice between regions; [8]
- difficulties and deficiencies with data and data governance; [9]
- difficulties in transferring patients for specialist treatment to other hospitals.

Within individual healthcare providers there have been several high-profile inquiries and investigations looking at the preventability of deaths such as children's heart surgery at the Bristol Royal Infirmary, the Francis Report and the Morecambe Bay Investigation [10–12]. We must ask whether frontline clinicians have actually read and learnt from these reports as well as whether systems change and improve as a result of these reports, and if not, why not?

In July 2013, Connor Sparrowhawk, an 18-year-old man with autism and epilepsy, died unsupervised in a bath at Slade House, a National Health Service (NHS) specialist assessment and treatment centre run by Southern Health [13]. An independent investigation, requested by his family, demonstrated that his death was preventable. Subsequently they campaigned for a wider investigation into deaths at Southern Health in an attempt to uncover deficiencies and improve healthcare for future patients. This work was commissioned by NHS England and undertaken in 2015 as an independent review [14, 15]. The report found that Southern Health had failed to investigate hundreds of unexpected deaths and concluded that the Trust had no effective overall way of reporting, investigating and learning from deaths. Following this report the then Secretary of State for Health wrote to the Care Quality Commission (CQC), expressing the need for a wider review into the investigation of deaths in NHS Trusts.

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To understand whether 'similar deficiencies exist in other NHS Trusts and any improvements that need to be put in place', 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 providers were not giving learning from deaths enough priority and were missing valuable opportunities to identify and make improvements in quality of care [16].

Proposed solutions

In March 2017, the National Quality Board introduced, as part of a national learning from deaths programme, new guidance for NHS providers on how they should learn from the deaths of people in their care [17]. This guidance included an amendment to the 2010 NHS quality account regulations, making it a legal requirement for Trusts to publicly report on an annual basis the absolute number of deaths, the number of reviews and investigations into deaths, the number of deaths more likely than not due to problems in care and the 'learning' that has occurred as a result of a death or deaths. In addition to the changes to quality account requirements, other initiatives have been set up; the Health Safety Investigation Branch was established in 2017 as an independent body to investigate up to 30 safety incidents each year to provide safety recommendations to share across the whole healthcare system.

Arguably it is still early days since the learning from deaths programme has been introduced and it is unclear in the guidance when we should expect to see significant improvements. Many families whose relatives have died while under the care of the NHS continue to have reservations as to whether lessons have and will be learnt, particularly in view of our collective failure to learn at a system level from previously widely publicised lessons and extensive inquiry reports. One thing that is clear is that doing things in the same way is unlikely to improve outcomes. We need to find systems/processes/mechanisms that enable true learning from deaths for the staff who can actually help prevent these errors from occurring: junior doctors, staff nurses, midwives, pharmacists and others who work on the frontline. In addition, healthcare systems, providers and clinicians need to have a better dialogue and partnership with patients, families and the public to facilitate investigations, understanding and learning.

What can we do to meaningfully change the status quo? We have individual, provider, Royal College and regulator responsibilities to ensure that healthcare workers understand the factors affecting patient safety and that we engage with national alerts and reports. There are several routes to educate and engage healthcare professionals, this can be provided nationally, for example, through the national organisation with responsibility for education and training (previously Health Education England), or through the Royal Colleges or individual healthcare providers or could be left to the responsibility of individual healthcare professionals. To date these strategies have been largely unsuccessful. How could we do it differently to ensure a better outcome? What examples are there of successfully communicating information to frontline staff and resulting in a change in practice and better outcomes?

Cases of system changes

Examples of when learning from preventable deaths has resulted in either Trust-level or whole-system culture change within the health service should be scrutinised to understand how and why this happened in these particular cases.

- The eventual transformation of care at University Hospitals of Morecambe Bay NHS Foundation Trust after increased scrutiny and investigation following the tragic death of Joshua Titcombe and other babies at Furness General Hospital. The pressure to carry out these investigations, through regulatory organisations (including the CQC and the Nursing and Midwifery Council), the Parliamentary and Health Service Ombudsman and the Morecambe Bay Investigation, was led by Joshua's father [18].
- The death of Elaine Bromiley in 2005 due to an inability to intubate her during a routine sinus operation. Her husband has widely publicised the importance of human factors in medical errors, founding the Clinical Human Factors Group, promoting best practice around human factors and significantly altering the way medical error is understood and investigated [19, 20].

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It appears that often, real change is not driven by those working within the health service or government, but rather by individuals who have tragically lost loved ones, who capture the attention of the healthcare system through their own drive and determination to make a difference to future patient care. The involvement of patient and family stories should be better used to inform frontline staff through experiential learning [21]. As humans we learn and assess risk most frequently through our own prior experience adding to our own unconscious biases, which affect our future actions. It is less common, but necessary, to learn from the experience of others and be able to understand how this could apply to all hospital teams as opposed to thinking that this could not happen or does not apply to me or the patients I look after. Consideration should also be given to changing processes, to ensure that clinicians are learning from others' experiences, such as making learning from deaths part of mandatory training or even a requirement for revalidation for healthcare professionals. It is likely that both experiential learning and process-driven learning will be required to significantly improve the safety of the healthcare system.

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Declarations and conflicts of interest

Research ethics statement

Not applicable to this article.

Consent for publication statement

Narrative articles are based on clinical vignettes and created to provide a framework for discussion and maximise learning. These are not based on real individual patients and do not describe discrete patient interactions or outcomes. The objective is to summarise an interesting topic in perioperative medicine in response to a specific clinical question posed by the authors.

Conflicts of interest statement

Professor David Walker is Editor in Chief of *Advances in Perioperative Care*. The authors declare no further conflicts of interest with this work.

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