Board of Directors - Public

SUMMARY REPORT	Meeting Date:	22 November 2023
	Agenda Item:	15

Report Title:	**Mortality Report, Quarter 2 2023/24**	
Author(s):	Vin Lewin, Patient Safety Specialist	
Accountable Director:	Dr Mike Hunter, Executive Medical Director	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee
	Date:	8 November 2023
Key points/ recommendations from those meetings	The Quality Assurance Committee declared that they were assured and formally approved the quarter 2 report for submission to the Board of Directors. Recommendation from Q1 2023/24 The SHSC rates of suicide per 10.000 contacts for 2020, 2021 and 2022 should be included, highlighting data for mental health only patients and mental health and START patients combined, when the report is presented to the Board of Directors in Q2 2023/24.	

Summary of key points in report

A range of learning points in relation to mortality linked investigations were identified during quarter 2 2023/24 including:

- The majority of deaths reported by SHSC staff are in relation to older people living in community settings with a diagnosis of dementia. The most common cause of death is natural causes. In Q2 there were no SHSC deaths reported for people in 24hr care.
- There continues to be a range of learning opportunities in relation to suspected deaths by suicide in the community linked to ongoing improvement actions for communication, documentation and risk assessment or safety planning.
- A number of learning points highlight notable practice on the part of individual clinicians working with patients and their families.
- Learning from Structured Judgement Reviews (SJRs) highlights that there is good monitoring of older adults with dementia who are prescribed anti-psychotic medication. There is also a continued theme of complex comorbid physical health issues and mental health issues that require expert support across a range of professionals.
- The learning from learning disabilities deaths was largely positive and this is particularly highlighted by positive feedback for our teams during and following the closure of Buckwood View.
- All of the learning and action points shared by the ICB in relation to learning disabilities deaths are managed directly by the Community Learning Disability Team.

There continues to be complex IT interface issues that are preventing SHSC from moving to the new Mental Health dashboard and a member of the IT team is working to try and resolve this issue. Whilst it remains a priority to complete this work SHSC remains compliant with current national standards that mandate organisations to provide a mortality dashboard (Appendix 1)

SHSC reviewed 100% of all reported deaths during quarter 2 of 2023/24 and a sample of deaths for people who had died within 6 months of a closed episode of care. SHSC is compliant with the 2017 National Quality Board (NQB) standards for learning from deaths.

Attached Appendix
Appendix 1- Mortality Dashboard

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**		**Assurance**	**X**	**Information**	

It is recommended that the Board of Directors take assurance, from this report, that SHSC reviews all deaths reported via the Ulysses Incident Reporting System and reviews a significant proportion of deaths for people discharged from SHSC but who died within 6 months of their last contact. It is also recommended that the Board of Directors are assured that systems are in place to extract and share learning in relation to the deaths of patient.

Please identify which strategic priorities will be impacted by this report:				
Recover services and improve efficiency	*Yes*	***X***	*No*	
Continuous quality Improvement	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*	***X***	*No*	
Partnerships – Working together to make a bigger impact	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		Person Centred Care and Dignity and Respect
Data Security and Protection Toolkit	*Yes*		*No*	***X***	This is not applicable to mortality processes
Any other specific standard?	*Yes*	***X***			National Guidance on Learning from Deaths (2017)

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety, Engagement and Experience	***Yes***	***X***	***No***		Involving carers and families to ensure their rights and wishes are respected.
Financial (revenue &capital)	***Yes***		***No***	***X***	There are no financial implications in the mortality process. The Better Tomorrow project is funded through the Back to Good improvement funding.
Organisational Development /Workforce	***Yes***		***No***	***X***	No identifiable impact.
Equality, Diversity & Inclusion	***Yes***	***X***	***No***		The mortality processes are inclusive of all ages, genders and cultural and ethnic backgrounds. In the future, we will undertake work to better understand deaths according to protected characteristics.
Legal	***Yes***		***No***	***X***	No identifiable impact.
Sustainability	***Yes***	***X***	***No***		The mortality review process has a low impact on resource usage and offers the opportunity to learn and improve in a sustainable way.

Mortality Quarterly Report Q2

Section 1: Analysis and supporting detail

Background

1.1 The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people.

1.2 Reports and case studies have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities.

1.3 The findings of the Care Quality Commission (CQC) report "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England", found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed.

National Quality Board (NQB)

1.4 The NQB guidance outlines that all providers should have a policy in place setting out how they respond to the deaths of patients who die under their management and care, including how we will:

- Determine which patients are considered to be under our care and included for case record review if they die (also stating which patients are specifically excluded)
- Report the death within our organisation and to other organisations who may have an interest (including the deceased person's GP)
- Respond to the death of an individual with a learning disability or mental health needs
- Review the care provided to patients who we do not consider to have been under our care at the time of death but where another organisation suggests we should review the care SHSC provided to the patient in the past
- Review the care provided to patients whose death may have been expected, for example those receiving end of life care
- Record the outcome of our decision whether or not to review or investigate the death, informed by the views of bereaved families and carers
- Engage meaningfully and compassionately with bereaved families and carers

Better Tomorrow

1.5 Understanding mortality in mental health settings can be complex and extracting learning may mean that exploration of co-morbidities is necessary. SHSC has a robust mortality review system in place but recognises that this is often extremely process focused. A priority for the mortality review group has been to continue to engage with the national Better Tomorrow project in order to develop better learning from deaths. The Better Tomorrow project came to an end in quarter 4 of 2023. However, SHSC remains an active member of the national mortality and learning from deaths group which is a legacy of the Better Tomorrow project.

Section 2: Risks

2.0 The primary risk is that incomplete learning from deaths is associated with the provision of suboptimal care.

Section 3: Assurance

Benchmarking

3.1 Since the Covid-19 outbreak, the regional benchmarking processes, available via the Northern Alliance for mortality review, have been unavailable. Benchmarking has been developed as a part of the Better Tomorrow project.

3.2 Learning from Deaths was subject to clinical audit during 2022/23

Triangulation

3.3 The outcomes from the learning from deaths processes can be triangulated against the learning extracted from Serious Incident investigations into the deaths of service users.

Engagement

3.4 The current process for reviewing deaths reported within SHSC includes contact with bereaved relatives and carers to express the Trust condolences and ask for feedback on the quality of the service provided to their family member.

3.5 The Structured Judgement Review process requires that all completed reviews and the learning from those reviews is presented to the individual teams that provided care to the deceased patient.

Section 4: Implications

Strategic Priorities and Board Assurance Framework

4.1 Strategic Aims: Provide outstanding care; Create a great place to work

BAF.0024: There is a risk of failing to meet fundamental standards of care with the regulatory body resulting in avoidable harm and negative impact on service user outcomes and experience, staff wellbeing, reputation, future sustainability of particular services which could result in regulatory action. This risk could be associated with the failure to detect closed cultures within clinical teams.

- CQC Regulation 18: Notification of other incidents
- CQC's Review of Learning from Deaths
- LeDeR Project
- NHS Sheffield ICB's Quality Schedule
- NHS England's Serious Incident Framework
- SHSC's Incident Management Policy and Procedures
- SHSC's Duty of Candour/Being Open Policy
- SHSC's Learning from Deaths Policy
- National Quality Board Guidance on Learning from Deaths

Equalities, diversity and inclusion

4.2 The report has been reviewed for any impact on equality, in relation to groups protected by the Equality Act 2010.

Culture and People

4.3 The implication for the workforce is positive as it empowers staff to take ownership of learning from deaths and deliver improved patient care, and links with the development of a safety led culture.

Integration and system thinking

4.4 Mortality review and the development of the processes for learning from deaths is likely to lead to the development of standardized and systematic approaches that can be used in mental health services across systems.

Financial

4.5 N/A

Sustainable development and climate change adaptation

4.6 The SHSC Green Plan sets out our commitment to:

- Target the emissions we control directly (our carbon footprint) to be net zero by 2030 and for the emissions we can influence to be net zero by 2045.
- To provide sustainable services through ensuring value for money, reducing wastage and increasing productivity from our resources
- Continuously developing our approach to improving the mental, physical and social wellbeing of the communities we serve through innovation, partnership and sharing
- We will promote a culture of collaboration, supporting our people and suppliers to work together to make a difference
- We will innovate and transform to provide high quality care and support as early as possible in order to improve physical, mental and social wellbeing

Compliance - Legal/Regulatory

4.7 As previously described above.

Section 5: List of Appendices

Appendix 1: Mortality Dashboard

Summary Report

This report provides the Board of Directors with an overview of SHSC's mortality processes and any learning from mortality discussed in the Mortality Review Group (MRG) during quarter 2 2023/24.
During quarter 2 SHSC was fully compliant with 2017 National Quality Board (NQB) standards for learning from deaths.
100% of deaths reported through SHSC's incident management system (Ulysses), together with a sample of deaths recorded through national death reporting processes, were reviewed at the weekly MRG.
Within quarter 2 2023/24, the Mortality Review Group reviewed a combined total of 96 deaths individually.
Following an initial review all deaths are subject to in-depth follow up until the following criteria are satisfied:

- cause of death?
- who certified the death?
- whether family/carers or staff had any questions/concerns in connection with the
- death?
- the setting the person was in in at the time of death, e.g., inpatient, residential or home?
- whether the person had a diagnosis of psychosis or eating disorder during their last episode of care?
- whether the person was on a prescribed antipsychotic at the time of their death?

The table below shows the number and type of deaths reviewed by MRG during the period.

Reporting Period	**Source**	**Number**
Quarter 2 2023/24	NHS Spine (national death reporting processes)	16
	Incident report	77
	Learning Disability Deaths	3
Total		**96**

Analysis of Death Incidents Reported
Deaths reported as incidents during quarter 2, are classified as below:

Death Classification	**No. of Deaths Q2**
Expected Death (Information Only)	26
Expected Death (Reportable to HM Coroner)	0
Suspected Suicide – Community	3
Unexpected Death - SHSC Community	29
Unexpected Death - SHSC Inpatient/Residential	0
Unexpected Death (Suspected Natural Causes)	19
Suspected Homicide	0
TOTAL	**77**

LD Death Classification	**No. of Deaths Q2**
Expected Death (Information Only)	1
Expected Death (Reportable to HM Coroner)	0
Suspected Suicide – Community	0
Unexpected Death - SHSC Community	2
Unexpected Death - SHSC Inpatient/Residential	0

Unexpected Death (Suspected Natural Causes)	0
Suspected Homicide – Substance Misuse	0
TOTAL	**3**

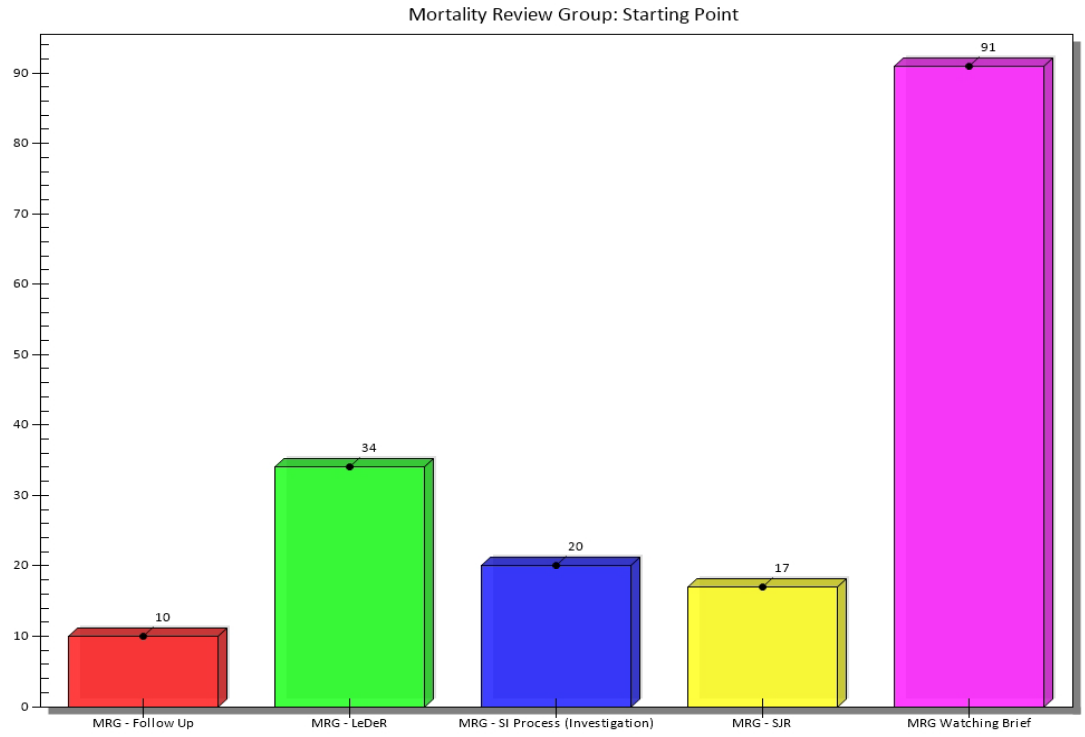
Out of the 80 (including of LD) deaths that were incident reported in Q2, 45 were deemed to have been due to natural causes requiring no inquest (this determination may have been following initial Coronial enquiries). 9 unexpected deaths are still awaiting further investigation/inquest through HM Coroner.
There were 3 suspected suicides in the community. All incidents were subject 48hr reporting, however 2 of the incidents went on to further serious incident investigation. In the incident that did not go on to further investigation the 48hr report identified that the individual had not had contact with mental health services since 2021.

Examples of the natural cause deaths recorded during quarter 2 include:

- Bronchopneumonia, Enterobacter Cloacae Sepsis, Gallbladder carcinoma, Ischemic Heart Disease, Type 2 Diabetes Mellitus, Pulmonary Fibrosis, Hypotension Syndrome, Sepsis, Multiple Sclerosis, Metastatic Cancer, Alzheimer's Dementia, Non-Hodgkin's Lymphoma and Acute Myocardial Infarction.

Where deaths were referred to HM Coroner, follow up has been/is being undertaken to ensure that any additional learning for SHSC is identified. SHSC has a formal coronial link, authorised by the senior coroner, in order to facilitate timely reviews of deaths referred to the coroner's office for inquest.

As can be seen in the table below there are currently 172 deaths in total that are being processed through the internal or external systems - 34 are being managed externally through the ICB learning disabilities (LeDeR) process and 91 are subject to an external investigation such as coroner's inquest.
Overview of current number of mortality cases being processed as of: 30 September 2023



Current and Future Learning from Death Outcomes

All incidents reported as having a catastrophic impact were in relation to death and 31% of these were either suspected or known to be due to natural causes.
During Q2 there was a 38% decrease in the number of deaths reported when compared to Q1. This reduction is due to the cessation of reporting by the substance misuse teams, which are no longer within SHSC.

All deaths from suspected suicide (3%) were subject to individual due diligence and where required a 48hr report was completed.

It should be noted that this report considers deaths but not those arising from serious incidents (except for capturing the statistical side within the figures). Detailed learning outcomes following serious incident investigations are reported within the monthly 'learning lessons' bulletin and presented to the Quality Assurance Committee in the quarterly learning and Safety report. Below is a brief summary of the identified learning taken from investigations completed in Q1 and potential learning identified in Q2.

Learning and notable practice from completed investigations in Q1:

Notable Practice

In regard to notable practices that have been identified during an investigation, investigators found the following:

- "Throughout the care under SHSC, all professionals involved had the dedication to do the right thing for patient J. In particular nurse 2 showed dedication supporting him and doing the right thing throughout his care. This was highlighted through wife D's gratitude expressed to the service after his death."
- "Service User S's care coordinator and more recent peer recovery worker took a holistic approach towards the care they offered, acknowledging, and validating the potential impact of physical health, including menopausal symptoms and encouraging Service User S to contact the GP."
- "The Liaison Psychiatry team has started to introduce continuing professional development (CPD) session on crisis assessment documentation and formulation. This is going to be on a rolling rota and not just for new starters."
- "The consultant has been a consistent presence and may have been able to begin to build a relationship and was learning how to communicate with Service User A. This represents good practice within autism spectrum disorder (ASD)."
- "It is noted that the service worked flexible in offering appointments that allowed the patients significant other to attend and give support."

Learning from investigations

Regarding themes, lessons learned and actions, investigations found the following:

- Theme 1

Follow the suspected death by suicide of a community patient, the investigation identified a need for improved communication. The following actions were undertaken:

  - The admin processes within the team are being reviewed to ensure that discharge letters are not lost and are sent out in a timely manner.
  - All clinical staff are being made aware of the risks associated with medications and will be able to review the side effects with patients. Leaflets will be readily available and offered to patients to support with decision-making around medication, particularly those patients with any memory lapses or concerns.
  - The team will review their processes around sending letters to patients to ensure patients are not receiving different letters regarding different elements of their care from the same service.

- Theme 2

Following the suspected death by suicide of a liaison psychiatry patient, it is relevant that national guidelines have been introduced in September 2023 "Suicide Prevention in England: 5 year cross sector strategy". With this a key action is to provide additional alternatives to A&E, these include specialist mental health ambulances and an increase in infrastructure for A&E and crisis cafes. The plan also identifies that 'effective crisis support is

needed' with an increase in investment in these areas. The investigation also identified that in some cases staff may be expected work into the Liaison Psychiatry team and may not always be clear on the expectations of formulating crisis assessments. To mitigate this the team are ensuring that there is a clear escalation process for staff new to the team in order to offer support and to facilitate quality assurance of assessments.

- Theme 3

Following the suspected death by suicide of a patient, the Recovery Service is reviewing Safety Planning work within the teams and agreeing guidelines and templates. The allocation system is now being documented as part of a Standard Operating Procedure (SOP) in order to ensure rapid identification of those people that are not seen within time scales.

In Q2 of the 3 Serious incidents related to mortality, where potential learning was identified:

- 3 were suspected suicides in the community, and learning from the resulting investigations will be detailed in future mortality reports to QAC and Board.

Learning from LeDeR Deaths

LeDeR reviews are managed via the Integrated Commissioning Board (ICB) and any identified learning for SHSC is initially reviewed via the weekly mortality review group before being actioned and reported on by the Community Learning Disability Mortality Lead. LeDeR referrals are also made for any patients with a formal diagnosis of autism.
During Q2 there were 3 learning points and 6 positive practice point identified for SHSC from the 10 LeDeR reviews that were completed and returned by the ICB. All 10 LeDeR reviews were shared with the Community Learning Disability Team in order to promote wider learning.

LeDeR Review Learning points and positive practice:

Learning points:

- Professionals should always use the preferred spelling of a person's name, and this should be used throughout health and social notes.
- Copies of the speech and language therapy guidelines and best interest decisions should be shared with day services in order to promote continuity of care.
- "It was unfortunate that circumstances led to ****** having to move house when she was so frail. Although everything was done to plan and minimise disruption to ****** it may have expediated her death"

Positive Practice

- The Community Learning Disability Team (CLDT) made good use of the Mental Capacity Act in assisting in decision making and the patient was supported to die peacefully, at home, surrounded by her family and friends.
- The CLDT increased the care package several times in order to ensure the patient could stay in the home environment, factoring in the knowledge that moving someone with a comorbid dementia could be detrimental to their wellbeing.
- Referral for CLD physiotherapy was appropriately signposted to the neuro-enablement team. The patient had good communication and a mild Learning Disability with an underlying neurological condition and was best served by mainstream services.
- "Care received at Buck Wood View was highly regarded by the family. Notes, care plans and risk assessments were person centred and thorough and there was evidence of mental capacity assessments, best interest decision making and referrals to the community learning disability team. Family were informed in a timely manner of the proposed closure and had time to view other establishments and make a decision of where ****** should move to in her best interests. All plans and assessments had been reviewed and updated in preparation for the move to the new accommodation."

- "There was excellent collaborative and joint working between Integrated Care Team Physiotherapy and Community Learning Disability Team Physiotherapy to meet ******* needs in terms of equipment and management plan."
- "Positive work was commenced with ****** by the psychology assistant who used many reasonable adjustments including appointment times that suited ****** and family, using easy read information to help ****** understand her condition and spending time getting to know ****** which was acknowledged by the family."

Learning from Structured Judgement Reviews (SJR)

SJRs are intended to identify any areas of learning and good practice from the care and treatment provided to patients before their death.

The learning drawn from each SJR is shared with the teams involved with the patient at the time of their death and the final approved SJR is uploaded on to the Trust-wide learning hub.

During Q2 the learning themes extracted for the 5 completed SJRs included:

Communication

- The liaison psychiatry team were unable to fully support the discharge of a patient back into the community as they were not informed of the discharge by STH. However, the team were able to very quickly mobilise the Older Adult Community team in order to offer further support in the patient's home.

Use of Anti-psychotic medication in older adults with dementia

- 2 SJR's were completed as it was identified that anti-psychotic medication had been prescribed despite there being a diagnosis of dementia. In both cases the older adult psychiatrist reviewed the use of the medication and gave clear advice to the patients GP. In one case the medication was discontinued immediately and in the other the medication was carefully monitored via regular review. In both cases it was evident that the psychiatrist had explained the pros and cons of the medication to the family involved.

Capacity

- The SJR noted that for one service user, with long standing mental health issues, engagement with unknown professionals was limited. The recovery worker acted as a conduit for communication between the GP, mental health professionals and the social work team. During a period of absence of the recovery worker key staff maintained contact via telephone calls as the patient would not allow anyone into her property. There was evidence of structured communication across the team in order to maintain the patient's optimum well-being.

Clozapine monitoring

- The Patients family were supported by the team to ensure that the patient engaged with attendance at the clozapine clinic and that potential side effects were well understood and monitored. The team spent time trying to understand and work to meet the specific cultural needs of the patient particularly in regard to their ongoing experience of hallucinations and voices.

Family support

- The patient's wife and daughter were assessed as experiencing increased carer stress due to the ongoing nature of the patients deteriorating condition. The team supported the family in making the difficult decision to move their loved one into 24hr nursing home care. Following this the team spent a period of time supporting nursing home staff to manage the patient's complex presentation.

Analysis of National Spine-System Recorded Deaths

From the sample of 16 cases reviewed from the spine (for people who were not under our care at the time of their death but died within 6 months of contact with SHSC services) during quarter 2 (2023/24), deaths were recorded primarily as:

- Old age frailty, cognitive impairment and older age-related conditions, drug and alcohol related conditions and pre-existing medical conditions.

The ages of those who died ranged from 53 to 93 (with the majority being over 70). Cases reviewed from the spine are people living in the community, either in their own homes or residential/supported living settings.

Some deaths occur in general (acute) hospital settings, many of these individuals are seen by SHSC's Liaison Psychiatry Service for advice/assessment. These are logged as SHSC deaths for the purposes of internal recording, even though there has been minimal input. 4 of the deaths reviewed in Q2 were in relation to older adults with a diagnosis of dementia. These deaths had not been internally reported by the service involved, the memory service, as they were patients that were considered to be on the 'dementia register' and were open on the electronic records system, despite them having no active contact with services.

SHSC rates of suicide per 10,000 patients under care for 2020, 2021 and 2022

During 2022, the National Confidential Inquiry provided SHSC with data indicating that during the three-year period 2017-19 our rate of death by suicide per 10,000 patients under our care was 8.65 / 10,000 – a figure that was amongst the ten NHS trusts with higher suicide rates for the period. The national data significantly lags in its reporting to NHS trusts because of the process of processing, assuring and comparing information across organisations. This means that SHSC will not receive national data concerning 2022 until the latter part of 2025. Due to this, we have undertaken to calculate our own local data to provide a more up to date picture of rates per 10,000 patients under our care.

There is a working hypothesis that SHSC's higher rates may reflect the inclusion of deaths by suicide amongst people under the care of substance misuse services, which was the case in SHSC until August 2023.

For the three-year period 2020-22, the rate in SHSC was 7.41 / 10,000 patients under our care including people receiving care from substance misuse services. Excluding people receiving care from substance misuse services, the rate was 6.99 per 10,000 patients. This is a preliminary analysis and we will develop the approach to provide annual reporting on trajectories and comparisons, ahead of the availability of national data.

Public Reporting of Death Statistics

National Quality Board (NQB) Guidance states that Trusts must report their mortality figures to a public Board meeting on a quarterly basis. The current dashboard attached at Appendix 1 was developed by the Northern Alliance for this purpose and contains information from the SHSC's risk management system (Ulysses) as well as information from our patient administration system (Insight). The dashboard was due be replaced with the Mental Health national dashboard version during Q1 2023/24. However there have been a number of significant IT interface issues that are still in the process of being resolved between SHSC and the national team. It is anticipated that the interface issues will be resolved in order for the new dashboard to be used in quarter 3 of 2023/24.

The learning points recorded in the dashboard are actions arising from serious incident investigations, SJRs, or LeDeR reviews, that result in changes in practice. The dashboard will be updated as and when processes are completed, and learning is identified.

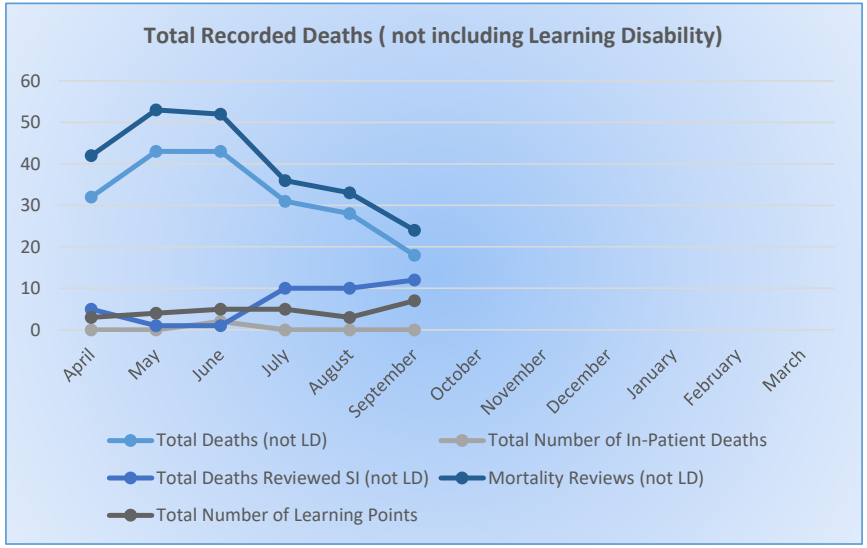
Appendix 1 - Learning from Deaths Dashboard
Data Taken from Trust's Risk Management System (Ulysses) and Patient Information System (Insight)
Reporting Period - Quarter 2(July to September 2022)

NHS Sheffield Health and Social Care NHS Foundation Trust

Summary of total number of deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

Total Number of Incident Reported Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework	Total number of deaths subject to Mortality Review (incident reported and a sample of SPINE deaths)	Total number of actions resulting in change in practice
Q1	Q1	Q1	Q1	Q1
118	**2**	**7**	**147**	**12**
Q2	Q2	Q2	Q2	Q2
77	**0**	**32**	**93**	**15**
Q3	Q3	Q3	Q3	Q3
0	**0**	**5**	**0**	**0**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
195	**2**	**44**	**240**	**27**



Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDeR

Total Number of Learning Disability Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework or Subject to Mortality Review	Total number of deaths reported through LeDeR	Total number of actions resulting in change in practice
Q1	Q1	Q1	Q1	Q1
12	**0**	**12**	**12**	**4**
Q2	Q2	Q2	Q2	Q2
3	**0**	**3**	**3**	**9**
Q3	Q3	Q3	Q3	Q3
0	**0**	**0**	**0**	**0**
Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD
15	**0**	**15**	**15**	**13**