South West Yorkshire Partnership Teaching NHS Foundation Trust

Learning from Healthcare Deaths Report 2024/25 to the end of March 2025

(Please note this report is extracted from the Patient Safety Oversight Report 2024/25)

Background context

Introduction

Scrutiny of healthcare deaths remains high on the Government's agenda. In line with the National Quality Board report published in 2017, the Trust has had Learning from Healthcare Deaths policy which sets out how we identify, report, investigate and learn from a patient's death. The Trust has been reporting and publishing our data on our website since October 2017.

Most people will be in receipt of care from the NHS at the time of their death and experience excellent care from the NHS for the weeks, months and years leading up to their death. However, for some people, their experience is different, and they receive poor quality care for several reasons including system failure. 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. Therefore, it is important that organisations widen the scope of deaths which are reviewed to maximise learning. The Confidential Inquiry into premature deaths of people with learning disabilities showed a very similar picture in terms of early deaths.

The Trust worked collaboratively with other providers in the North of England to develop our approach. The Trust will review/investigate reportable deaths in line with the policy. We aim to work with families/carers of patients who have died as they offer an invaluable source of insight to learn lessons and improve services. The Trust has a representative from the Patient Safety Support Team who attends the Regional Mortality Meeting which are held quarterly. This meeting facilitates the dissemination of good practice around learning from deaths with sharing of processes that other trusts have in place to review deaths and improve care.

Of note, a quarterly learning from healthcare deaths report was previously an appendix to the Incident Management reports. As part of the transition to the Patient Safety Oversight Report, this report was not included as an appendix for Quarters 1 and 2. Going forward, the quarterly Learning from Healthcare Deaths paper will be an appendix to the quarterly Patient Safety Oversight Report that is submitted to Committee and Trust Board.

Scope

The Trust has systems that identify and capture the known deaths of its service users on its electronic clinical information system and on its Datix system where the death requires reporting. The Trust's Learning from Deaths policy sets out how deaths should be responded to, which deaths are reportable, how we should engage families and how reportable deaths will be reviewed.

For core reporting principles, the Trust is deemed the main provider of care, if at the time of death, the patient was subject to:

1. An episode of inpatient care within our service.
2. An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
3. A Community Treatment Order.
4. A conditional discharge.
5. An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
6. Guardianship
7. Deprivation of Liberties legislation (DOLS)
8. Patient discharged from SWYPFT inpatient bed in the 30 days prior to death.

Each reported death that meets the scope criteria is reviewed in line with the three levels of scrutiny the Trust has adopted in line with the National Quality Board guidance:

In scope deaths should be reviewed using one of the 3 levels of scrutiny:		
1	Death Certification	Details of the cause of death as certified by the attending doctor. In some cases, we may only be aware that death was certified (or reported to the coroner), without any information about the specific cause of death.
2	Case record review	Includes: (1) Managers 48-hour review (2) Structured Judgement Review (3) Case note review
3	Investigation	From 1/12/2023, the Trust commenced working under the Patient Safety Incident Response Framework and our review processes include: • After Action Review • Specialist Learning Review • Patient Safety Incident Investigation (PSII) • Learning from Life and Death Reviews (LeDeR) (learning disability and autism deaths) • Safeguarding review

Deaths reported are mainly deaths of those who have died in the community. All reported deaths are reviewed to understand if the death meets the critieria for being in scope for mortality review using the 3 levels as described earlier.

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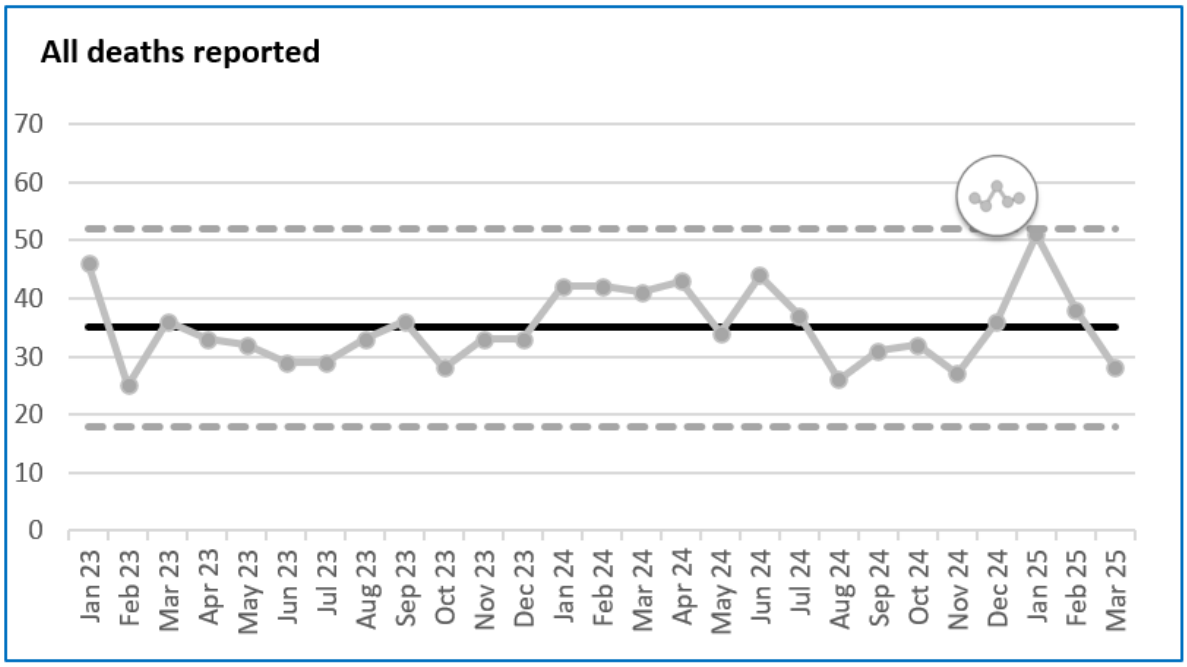
Annual Cumulative Dashboard[1] Report 2024/2025 covering the period 01/04/2024 – 31/03/2025

Figure 1 Summary of 2024/2025 Annual Death reporting by financial quarter to 31/03/2025

Reporting criteria		2023/ 2024 total	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	2024/ 2025 Total
1	Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death[2]	2127	530	501	612	507	2150
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	409	121	94	95	117	427
3	Total Number of deaths which were in scope	285	78	71	60	73	282
4	Total Number of deaths reported on Datix that were not in the Trust's scope	124	43	23	35	44	145

Figure 2 Statistical Process Control Report of all deaths reported 01/01/2023 – 31/03/2025 by date reported



[1] Dashboard format and content as agreed by Northern Alliance group.
[2] Data extracted from Business Intelligence Dashboards. Data is refreshed each quarter so figures may differ from previous reports. Data changes where records may have been amended or added within live systems

Figure 2 shows a Statistical Process Control chart of all reported deaths (by reported date) between 01/01/2023 - 30/03/2025. There is natural variation in the data relating to those who have died who were known to us. In January 2025 there has been an increase in the number of deaths reported, however there are no areas of special cause variation that require further exploration at this time.

Figure 3 Breakdown of the total number of in scope deaths reviewed in 2024/2025 by Care Group by financial quarter

Financial quarter - date reported	Barnsley Physical Health & Wellbeing Care Group	Adults and Older People Mental Health Care Group (Community)	Adults and Older People Mental Health Care Group (Inpatient)	Learning Disability and ASD/ADHD Care Group	Forensic Services Care Group	Children Young People and Families Care Group	Total
2024/2025 Q1	2	60	4	11	0	1	78
2024/2025 Q2	0	48	3	17	0	3	71
2024/2025 Q3	1	37	5	14	1	2	60
2024/2025 Q4	0	52	5	15	0	1	73
Total	**3**	**197**	**17**	**57**	**1**	**7**	**282**

Figure 4 Summary of total number of all in scope deaths in 2024/2025 to the end of Quarter 4 by the respective level of mortality review process

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review			Level 3: Learning Response					
	Certification of death	Manager's 48-hour review (1st stage case note review)	Structured Judgment Review (SJR)	Case Note Review	After Action Review	Specialist Learning Review	Patent Safety Incident Investigation (PSII)	Learning Disability Death process (LeDeR)	Other reviews	Total
2024/2025 Q1	11	45	5	0	1	2	1	13	0	78
2024/2025 Q2	12	31	3	2	0	2	1	20	0	71
2024/2025 Q3	13	29	1	1	0	0	0	16	0	60
2024/2025 Q4	23	30	1	2	1	0	0	16	0	73
Total	**59**	**135**	**10**	**5**	**2**	**4**	**2**	**65**	**0**	**282**

Figure 4 above shows the total number of all in scope deaths in 2024/2025 to date. The majority of mortality reviews are undertaken through case record review (a Manager's 48 hour rapid review, Structured Judgement Review and case note review) or the Learning Disability Death (LeDeR) process. In line with the national reporting of deaths, we are required to separate our reporting of in scope deaths into learning disability deaths and all other deaths. Figures 5 and 6 below provide this breakdown.

Learning Disability deaths

The death of any patient with a diagnosis of Learning Disability and/or Autism is reported to LeDeR[3]. It should be noted that the figures may not tally with the numbers by care group (in figure 3 above). This is because we identify Learning Disability and Autism not just through the reporting team, but by a field on Datix to determine if any patient who died had a learning disability or autism irrespective of where they were cared for.

Figure 5 below shows the number of learning disability/autism deaths and their status of being reported to the Learning Disability Review Programme (LeDeR).

Figure 5 Summary of total number of in scope deaths in 2024/2025 by the Review process (including people with Learning Disability and/or Autism deaths)

	Reported to Learning Disability Death process (LeDeR)	Reported on LEDER by another organisation	Not reportable to LEDER as under 18 years of age	Total
2024/2025 Q1	12	1	0	13
2024/2025 Q2	19	1	1	21
2024/2025 Q3	16	0	0	16
2024/2025 Q4	16	0	0	16
Total	**63**	**2**	**1**	**66**

Of the sixteen Learning Disability/Autism deaths which were reported to LeDeR, all had the Manager's 48-hour review completed.

LeDeR learning identified

Feedback is received routinely from LeDeR focussed reviews from across the region. The key highlights received to date were overall positive:

- Positive practice received from family.
- Good evidence of joint working between learning disability and mental health services in the coordination and management of the service user's needs.
- Record keeping of both physical and mental health symptoms for service users referred to eating disorder clinics. This learning has been shared with local service areas for reflection and subsequent action.

When the next annual report from Learning from Life and Death Reviews national team is received, this will be reviewed and a summary and response will be shared separately with Trust Board.

[3] Learning Disability deaths reportable to Learning from Life and Death Reviews (LeDeR)

Other deaths

Figure 6 below shows all deaths where the patient is recorded as not having a learning disability and what level of review was completed. All deaths reported have the Manager's 48 hour review completed to ensure the care and treatment leading up to a death was considered, although if there is another review process followed or the death was certified, this will be what is reported on.

Figure 6 Summary of total number of in scope deaths in 2024/2025 by the Review process (excluding Learning Disability deaths)

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review			Level 3: Learning Response			
	Certification of death	Manager's 48-hour review (1st stage case note review)	Structured Judgment Review (SJR)	Case Note Review	After Action Review	Specialist Learning Review	Patient Safety Incident Investigation (PSII)	Total
2024/2025 Q1	11	45	5	0	1	2	1	65
2024/2025 Q2	12	30	3	2	0	2	1	50
2024/2025 Q3	13	29	1	1	0	0	0	44
2024/2025 Q4	23	30	1	2	1	0	0	57
Total	**59**	**134**	**10**	**5**	**2**	**4**	**2**	**216**

Inpatient deaths

Figure 7 below shows that over the year 2024/25 to date there have been 19 inpatient deaths. All inpatient deaths are considered for the most appropriate level of review, and reported to LeDeR where necessary.

Figure 7 Trust wide Inpatient deaths in 2024/2025 by date reported

Care Group	Service	Ward	Financial quarter - date reported				Total
			2024/2025 Q1	2024/2025 Q2	2024/2025 Q3	2024/2025 Q4	
Adults and Older People Mental Health Care Group (Inpatient)	Acute Inpatient (adult)	Ashdale	0	1	0	0	1
		Elmdale	0	0	1	0	1
		Stanley	2	0	0	0	2
		Ward 18	0	1	0	1	2
	Older People Inpatient	Beechdale	0	1	1	1	3
		Crofton	0	0	1	0	1
		Poplars	1	0	0	1	2
		Ward 19	0	0	2	2	4
		Willow	1	0	0	0	1
Forensic Services Care Group	Low secure Learning disability	Newhaven	0	0	1	0	1
Barnsley Physical Health and Wellbeing Care Group	General community inpatient wards	Stroke unit, Barnsley	0	0	1	0	1
Total			**4**	**3**	**7**	**5**	**19**

Of these deaths, the below table provides detail on whether the deaths were expected or unexpected/natural or un-natural, by inpatient ward.

Expected or Unexpected death	Total
Unexpected natural death eg cardiac arrest, stroke, Road Traffic Collision	**7**
Beechdale Ward, The Dales, Calderdale	1
Elmdale Ward, The Dales, Calderdale	1
Poplars Unit, Wakefield	1
Ward 19 (OPS), Priestley Unit, Kirklees	4
Expected natural death eg terminal illness	**5**
Beechdale Ward, The Dales, Calderdale	1
Integrated Stroke and Early Support Discharge (ESD) Team, Barnsley	1
Newhaven Forensic Learning Disabilities Unit	1
Poplars Unit, Wakefield	1

Willow Ward - Barnsley	1
Unexpected un-natural death eg suicide, homicide, abuse, neglect	**4**
Beechdale Ward, The Dales, Calderdale	1
Stanley Ward, Wakefield	2
Ward 18, Priestley Unit, Kirklees	1
Expected natural death eg cancer, but sooner than expected	**1**
Crofton Ward (OPS), Wakefield	1
Unexpected natural death eg alcohol dependency or where there are care concerns	1
Ward 18, Priestley Unit, Kirklees	1
Unknown/unclear	**1**
Ashdale Ward, The Dales, Calderdale	1
Total	19

Location of deaths

Figure 8 below shows the locations where patients died (where this was recorded). Acute/general hospital is the highest noted location at 31%.

Figure 8 Location of deaths that were reported during 2024/25

	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	Total
Acute Trust / General Hospital	30	25	26	30	**111**
Patient's home	27	22	16	20	**85**
Care/Residential Home	7	10	8	8	**33**
Public place	5	4	0	8	**17**
Unknown	3	3	3	5	**14**
Hospice	2	4	3	2	**11**
Inpatient facility (SWYPFT)	0	0	3	0	**3**
Family or friends' home	2	1	0	0	**3**
Other country	0	2	0	0	**2**
Other mental health provider (not SWYPFT)	2	0	1	0	**3**
Total	**78**	**71**	**60**	**73**	**282**

Where the location of death is unknown, this is often because we identify a patient has died from a third-party update on the clinical record.

Causes of death

In terms of causes of death, figure 9 below shows the broad cause of death for the 282 patients who died. The highest types of cause of death recorded was from physical causes, which will include expected and unexpected deaths. Where possible, records where end of life/palliative care was noted have been captured separately.

Figure 9 Causes of death for in scope deaths recorded during 2024/25 by care group area

Cause of Death (themed)	Barnsley Physical Health & Wellbeing Care Group	Adults and Older People Mental Health Care Group (Community)	Adults and Older People Mental Health Care Group (Inpatient)	Learning Disability and ASD/ADHD Care Group	Forensic Services Care Group	Children Young People and Families Care Group	Total
Respiratory	0	8	1	4	0	0	**13**
Apparent suicide suspected	0	28	3	0	0	3	**34**
Unknown/unclear	0	21	3	4	0	1	**29**
Unascertainable	0	1	0	0	0	0	**1**
Cancer	0	16	0	4	1	0	**21**
Haemorrhage	0	2	0	1	0	0	**3**
Drowning	0	0	0	1	0	0	**1**
Stroke	0	1	0	1	0	0	**2**
Alzheimer's	0	3	0	0	0	0	**3**
Pneumonia	0	18	2	14	0	0	**34**
Physical cause suspected	1	8	1	3	0	1	**14**
Dementia	0	6	0	4	0	0	**10**
Pulmonary embolism	0	5	0	0	0	0	**5**
Renal failure	0	4	0	2	0	0	**6**
Physical cause suspected - end of life	0	11	1	3	0	0	**15**
Sepsis	1	11	0	4	0	0	**16**
Overdose	0	2	0	0	0	0	**2**
Accidental death	0	1	0	0	0	0	**1**
Frailty of old age	0	6	0	1	0	0	**7**
Suspected carbon monoxide poisoning	0	0	0	1	0	0	**1**
Multi-organ failure	1	1	0	0	0	0	**2**
Sudden death	0	0	0	1	0	0	**1**
Physical cause suspected	0	2	1	0	0	1	**4**
Covid	0	1	2	0	0	0	**3**
Hypoglycaemia	0	1	0	0	0	0	**1**
Necrotic bowel	0	1	0	1	0	0	**2**

Asphyxia	0	1	0	1	0	0	**2**
Cardiac related	0	32	2	7	0	0	**41**
Drug/alcohol related	0	6	1	0	0	1	**8**
Total	**3**	**197**	**17**	**57**	**1**	**7**	**282**

Apparent suicides

The apparent suicides will be reported on further in the Apparent Suicide annual report which will be available separately. The figures will be based on the live data, so may not match figures in this report.

Learning from Structured Judgement Reviews (SJRs)

Positive practice identified

- Arrangements and plans for transfer of care between different teams and joint visits, with the service users being made aware.
- Regular medication reviews and monitoring which involve service users, taking into consideration their views and agreement on changes collaboratively.
- Good treatment for service users with complex disabilities.
- Evidence of service users being listened to and their concerns being followed up accordingly.
- There was evidence of building good rapport with service users, and following several failed contact attempts with a service user (including named emergency contacts) a home visit was undertaken in accordance with DNA protocol.
- Discharge pathway was identified within 48 hours admission to the team following the case management review meeting and identified as Core. This supports the working model of beginning the discharge process at point of admission.
- One overall review of care highlighted evidence of good risk assessment, risk formulation and planning: all reflective of current need and demonstrated good risk recognition which informed safe, sound clinical decisions.

Areas of Improvement identified

- FIRM (formulation informed risk management) risk assessments are not always updated following changes in service user risks. Information is often added to progress notes but is not transferred to the FIRM/risk assessment. This intelligence has been provided to the Care planning and clinical risk assessment group for consideration in ongoing improvement work.

Progress to note from the Mortality Review Group

- The internal Mortality Review Group has met several times during the year. The next meeting is scheduled for 9 July 2025.
- Care groups continue to review SJR outcomes and create actions plans for identified areas of concern.
- SJR training sessions were relaunched in March 2025, which have been positive and supports the pool of trained reviewers within the Trust. Further training continues scheduled in May, July and October 2025.

- The Bereavement Link Supporter role job description has been finalised, and it is hoped the role will be launched to coincide with the 'Dying Matters' week commencing on 5 May 2025.
- Three Postvention Assisting those Bereaved By Suicide (PABBS) training sessions are being rolled out this year. The first session has taken place at the end of March 2025 in Barnsley with two more sessions scheduled in May 2025 at Fieldhead hospital and Folly Hall. Early feedback has been very positive (similar to the sessions held last year).
- A family liaison officer questionnaire has been developed and consulted on with Patient Safety Partners and the Quality Governance team and will be shared for final approval before it can be implemented in practice.
- A task and finish group began in April 2025 to look at the governance process in responding to questions from families. This group will link with care groups, legal services and possibly customer services.
- A generic LeDeR email address has been set up and a staff guide develop to help improve LeDeR reporting and that requests for information received from LeDeR are assessed and information shared appropriately, in line with Trust policy.
- Barnsley Physical Health and Wellbeing Care Group are in regular contact with the Medical Examiner's officers and have been acting on their feedback which has been largely positive. A leaflet has been produced in collaboration with the Lead Medical Examiner for Barnsley Hospital, for community staff within Neighbourhood Nursing teams and Urgent Care Response team in Barnsley to distribute to families/carers following an expected death. This will follow following the verification of death taking place first. The leaflet explains the process in more detail following the advent of the Medical Examiner's role. This is currently in draft format and will be submitted to the Care Group's Clinical Governance Group for their approval, and has been suggested that the leaflet could be used by the Bereavement Link Supporter role.
- The Regional Mortality group (hosted by the Improvement Academy) have continued to meet during 2024/25. The group asks for information to be shared across providers to support identification of common themes from around the region.
- The Northern Alliance Group (mental health and learning disability Trusts) have met during 2024/25. A Microsoft Teams channel has been set up for discussion and sharing information amongst the group. The next meeting is scheduled to take place on the 14 May 2025.

Next Steps

Our work to support learning from deaths continues, and annual review provides an opportunity for reflection, therefore over the coming year the mortality review group will undertake a review and refresh of its purpose to provide an opportunity to refocus how we learn from deaths and identify problems in care. It will consider changes made with the introduction of PSIRF and take opportunities to identify learning themes from learning responses to widen the scope. This will be in relationship with the Patient Safety Improvement Group (PSIG).