South West Yorkshire Partnership Teaching NHS Foundation Trust

Learning from Healthcare Deaths Report 2025/26

Cumulative data covering the period 1/4/2025 – 30/9/2025

(Please note this report is extracted from the Patient Safety Oversight Report Quarter 2 2025/26)

Background context

Introduction

Scrutiny of healthcare deaths remains high on the Government's agenda. The Trust has had a Learning from Healthcare Deaths policy in place since 2017 in line with the National Quality Board guidance. It sets out how we identify, report, review 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 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. A representative from the Patient Safety Support Team attends the quarterly Regional Mortality Meetings; this aims to facilitate the dissemination of good practice around learning from deaths between organisations.

This quarterly Learning from Healthcare Deaths paper will be an appendix to the quarterly Patient Safety Oversight Report that is submitted to Quality and Safety 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. The Trust's Learning from Deaths policy sets out how deaths should be responded to, which deaths are reportable and how they will be reviewed, and how we will engage with bereaved families.

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. Patient discharged from SWYPFT inpatient bed in the 30 days prior to death.

3. An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
4. A Community Treatment Order.
5. A conditional discharge.
6. An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
7. Guardianship
8. Deprivation of Liberties legislation (DOLS)

It should be noted that there will be some overlap in reporting with other providers due to complexities in healthcare provision.

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 rapid review (2) Structured Judgement Review
3	Learning response	The Trust Patient Safety Incident Response Framework methods for further review which aim to seek further understanding include: • After Action Review • Patient Safety Incident Investigation (PSII) • Learning from Life and Death Reviews (LeDeR) (learning disability and autism deaths) • Other external reviews, such Safeguarding review

Reported deaths are mainly service users/patients who have died whilst receiving current care in the community, or where this was within the 6 months leading up to their death. All reported deaths are reviewed to understand if the death meets the critieria for being in scope for mortality review using the criteria described earlier.

South West Yorkshire Partnership Teaching NHS Foundation Trust

Annual Cumulative Dashboard[1] Report 2025/26 covering the period 01/04/2025 – 30/09/2025

Figure 1 Summary of 2025/26 Annual Death reporting by financial quarter to 30/09/2025

Reporting criteria		2024/ 2025 total	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	2025/ 2026 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]	2150	507	497			1004
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	427	102	89			191
3	Total Number of deaths which were in scope	282	75	67			142
4	Total Number of deaths reported on Datix that were not in the Trust's scope	145	27	22			49

Figure 2 Statistical Process Control charts for all deaths reported in the 24 month period up to the end of the financial quarter by date reported and all deaths which were in scope for further review

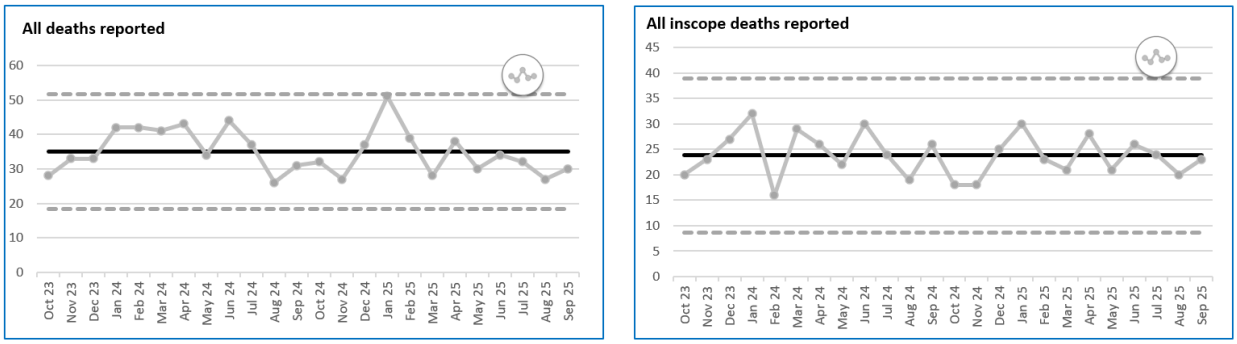

Figure 2 shows two Statistical Process Control charts over the period between 01/10/2023 - 30/09/2025. Firstly this shows all reported deaths (by reported date). There is natural variation in the data relating to those who have died which have been reported as incidents. January 2025 showed an increase in the number of deaths reported, however there are no areas of special cause variation that require further exploration at this time. Many of these deaths were not in scope in line with the critieria described above. The second chart shows those deaths which were in scope, and these were in normal variation.

[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 3 Breakdown of the total number of deaths in scope for review in 2025/26 by Care Group by financial quarter

Financial quarter - date reported	Barnsley Physical Health & Wellbeing Care Group	Mental Health Care Group (Inpatient)	Mental Health Care Group (Community)	Learning Disability and ASD/ADHD Care Group	Forensic Services Care Group	Cheswold Park Hospital	Children Young People and Families Care Group	Total
2025/26 Q1	1	4	59	10	0	1	0	75
2025/26 Q2	2	4	50	9	0	0	2	67
2025/26 Q3								
2025/26 Q4								
Total	**3**	**8**	**109**	**19**	**0**	**1**	**2**	**142**

Figure 4 Summary of total number of all in scope deaths in 2025/26 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 rapid review (1st stage case note review)	Structured Judgment Review (SJR)	After Action Review	Patent Safety Incident Investigation (PSII)	Learning Disability Death process (LeDeR)	Other reviews	Total
2025/26 Q1	7	48	6	1	0	13	0	75
2025/26 Q2	15	41	2	0	0	9	0	67
2025/26 Q3								
2025/26 Q4								
Total	**22**	**89**	**8**	**1**	**0**	**22**	**0**	**142**

Figure 3 above shows the total number of all in scope deaths in 2025/26 to date by care group. Figure 4 shows how those deaths were reviewed, with the majority of mortality reviews are undertaken through a first stage case record review (a Manager's 48 hour rapid review). This report has a singular review process for each death, although many will have also had other levels of review to aid decision making.

Learning Disability deaths

The death of any patient with a diagnosis of Learning Disability and/or Autism is reported to the Learning from Life and Death Reviews LeDeR[3] process. It should be noted that the figures in the sections below may not tally with the numbers by care group (in figure 3 above). This is because we identify Learning Disability and Autism diagnosis by a field on Datix to determine if any patient who died had a learning disability or autism diagnosis, irrespective of where they were cared for. For example, in figure 5, of the 22 deaths, 19 patients were under the care of learning disability teams, and three were under Core Team care. Of those three patients, 2 were reported to have a learning disability, and one had an autism diagnosis.

The Learning from Life and Death Review (LeDeR) programme was previously known as the Learning Disabilities Mortality Review. The LeDeR work originated from the Confidential Inquiry into the Premature deaths of people with Learning Disabilities (CIPOLD). Information available here. In line with the national reporting of deaths, we are asked to separate our reporting of in scope deaths into learning disability deaths and all other deaths. Figures 5 and 6 below provide this breakdown.

Figure 5 below shows the number of deaths of people with a learning disability and/or autism diagnosis who had contact with the Trust, either current or within the previous six months prior to death. These deaths are reported to the Learning from Life and Death Review Programme (LeDeR). We first check if the death is already known to LeDeR by another provider before reporting.

Figure 5 Summary of total number of in scope deaths in 2025/26 by the Review process (including people with Learning Disability and/or Autism diagnoses)

	Reported to Learning Disability Death process (LeDeR)	Reported on LEDER by another organisation	Not reportable to LEDER as under 18 years of age	Total
2025/26 Q1	12	1	0	13
2025/26 Q2	9	0	0	9
2025/26 Q3				
2025/26 Q4				
Total	21	1	0	22

LeDeR reviews are led by colleagues outside of the Trust services, such as by an Integrated Care Board. This gives them objectivity and the ability to review the whole care provision of the person who has died. As these reviews can take some time to conclude, we as managers complete the Manager's 48-hour rapid review to ensure any internal learning and reflection can take place at a much earlier stage.

Other deaths

Figure 6 below shows all deaths where the patient is recorded as not having a learning disability or autism diagnosis along with the level of review which was completed. All deaths reported have a Manager's 48-hour rapid 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 included in this report. For example, if a death is

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

reported in the table below as Certified, or has a Structured Judgement Review, it will also have had a Manager's 48-hour Rapid review completed as standard process.

Figure 6 Summary of total number of in scope deaths in 2025/26 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 rapid review (1st stage case note review)	Structured Judgment Review (SJR)	After Action Review	Patent Safety Incident Investigation (PSII)	Other reviews	Total
2025/26 Q1	7	48	6	1	0	0	75
2025/26 Q2	15	41	2	0	0	0	67
2025/26 Q3							
2025/26 Q4							
Total	**22**	**89**	**8**	**1**	**0**	**0**	**120**

Inpatient deaths

Figure 7 below shows that over the year 2025/26 to date there have been 11 inpatient deaths. All inpatient deaths are considered for the most appropriate level of review, and reported to LeDeR where necessary. Of the 11 deaths, all had the managers 48 hour rapid review completed and one will have a Structured Judgement Review. Two of the deaths are recorded as being certified at the time of reporting.

Figure 7 Trust wide Inpatient deaths in 2025/26 by date reported

Care Group	Service	Ward	Financial quarter - date reported				Total
			2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4	
Mental Health Care Group (Inpatient)	Older People Inpatient	Beechdale	1	0			1
		Crofton	1	0			1
		Poplars	1	1			2
		Ward 19	1	0			1
	Adult Acute Inpatient	Beamshaw	0	1			1
		Elmdale	0	1			1
		Nostell	0	1			1
Barnsley Physical Health and Wellbeing	General Community Inpatient	Neuro Rehab Unit	0	2			2
Cheswold Park Hospital	Low secure	Esk Ward	1	0			1
Total			**5**	**6**			**11**

The six inpatient related deaths in Quarter 2 are broken down as follows:

- Three were confirmed to be related to physical health causes (1 respiratory; 1 frailty of old age; 1 deterioration from known physical condition).
- One death is pending further clarification on the cause of death, but physical cause is suspected (respiratory).
- One death was related to an unexpected death on the ward.
- One death was unexpected and related to a service user who died within 14 days of being discharged from the ward.

The ethnicity of the six deceased inpatients/recent inpatients is White - English/Welsh/Scottish/Northern Irish/British group.

Updates

- During Quarter 2, a trial of reviewing mortality activity at the Patient Safety Improvement Group took place. This has been considered and concluded that a sub group is needed to give this subject the dedicated space for discussion, particularly in relation to learning and themes. This has been established and will report into future Patient Safety Improvement Groups from Quarter 3 onwards. One of the first pieces of work will be to review the structured judgement review processes which will include allocation to reviewers, training, themes and output.
- The review of the Patient Safety Incident Response Framework plan, policy and procedures is underway. This includes introducing flowcharts to aid the selection of

the most appropriate PSIRF response which also supports the learning from deaths requirements in helping to determine if a death resulted from a problem in care which led to a death occurring. The review is also considering how we can improve the theming of data to aid analysis, and this will include deaths.

- A separate update on suicide prevention work and an analysis of apparent suicides will be provided separately early in 2026.
- A questionnaire for family members about the experience of working with the Trust's family liaison officer has been finalised. Families will be invited to complete this following their last contact with the family liaison officer.
- Representatives from patient safety support team continue to attend both the Regional Mortality group (hosted by the Improvement Academy) and the Northern Alliance Group (mental health and learning disability Trusts). Both groups aim to support providers with sharing common themes across the region or Mental health settings.

Next steps

- Production of learning from deaths themes/data in Quarter 3 that will be reviewed at the new sub group.
- Ensuring our PSIRF processes include identification of any case where a problem in care lead to a death occurring.

Patient Safety Support Team
10 October 2025