South West Yorkshire Partnership Teaching
NHS Foundation Trust

Learning from Healthcare Deaths Report 2025/26

Cumulative data covering the period 1/4/2025 – 31/12/2025

(Please note this report is extracted from the Patient Safety Oversight Report Quarter 3 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.

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Annual Cumulative Dashboard[1] Report 2025/26 covering the period 01/04/2025 – 31/12/2025

Figure 1 Summary of 2025/26 Annual Death reporting by financial quarter to 31/12/2025

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	512	540	491		1543
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	427	102	89	112		303
3	Total Number of deaths which were in scope	282	74	67	77		218
4	Total Number of deaths reported on Datix that were not in the Trust's scope	145	28	22	35		85

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

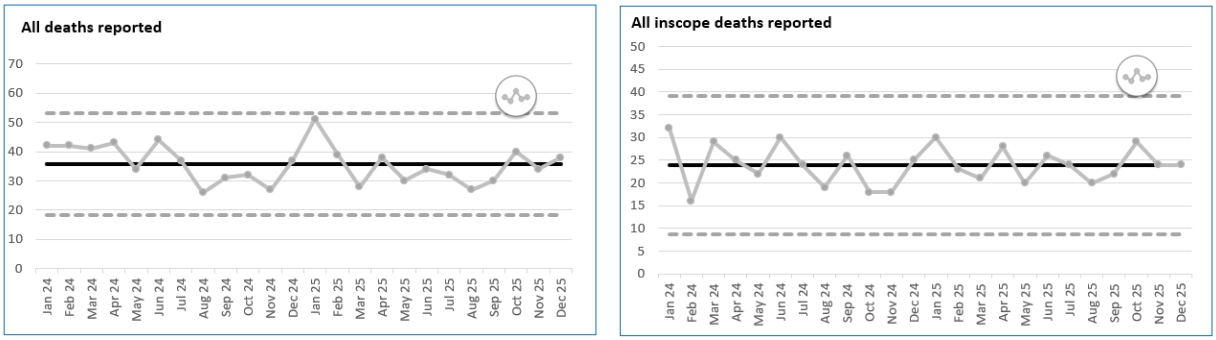

Figure 2 shows two Statistical Process Control charts over the period between 01/01/2024 – 31/12/2025. Firstly this shows all reported deaths (by reported date). There is natural variation in the data relating to those who have died which have been reported as incidents. January 2025 showed an increase in the number of deaths reported, however there are no areas of special cause variation that required further exploration. 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)	Forensic Services Care Group	Cheswold Park Hospital	Learning Disability and ASD/ADHD Care Group	Children Young People and Families Care Group	Total
2025/26 Q1	1	5	57	0	1	10	0	74
2025/26 Q2	2	4	50	0	0	9	2	67
2025/26 Q3	2	7	61	1	0	6	0	77
2025/26 Q4								
Total	**5**	**16**	**168**	**1**	**1**	**25**	**2**	**218**

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	35	19	6	1	0	13	0	74
2025/26 Q2	31	24	3	0	0	9	0	67
2025/26 Q3	24	38	5	0	2	8	0	77
2025/26 Q4								
Total	**90**	**81**	**14**	**1**	**2**	**30**	**0**	**218**

Data included in this report from 1 April 2025 has been refreshed to ensure it reflects current position. This may be where the inclusion/exclusion of a death in the figures has been amended based on further information such as cause of death. The type of review level has been updated to reflect where cause of death are now known.

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. Of the 217 deaths, all should have received a first stage case note review (managers 48 hour rapid review). This review process provides infomration to aid decision making prior to any further learning process being undertaken.

Where a death is certified and not undergoing any other response process, it will be captured as 'certification'. This data has been refreshed for Quarters 1 and 2. Where a death is undergoing a learning process, it will be recorded as that type of review.

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. This 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.

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 and/or autism diagnosis, irrespective of where they were cared for.

Figure 5 shows there were 32 deaths of people with a diagnosis of learning disabilty and/or autism. These breakdown as below:

- 25 patients were under the care of learning disability teams (or within the previous 6 months) (learning disabilty and/or autism)
- Five patients were under the care of other Trust mental health services:
    - Four patients under Core Team care (learning disability or autism diagnosis)
    - One patients under Enhanced Team care (learning disability diagnosis)
- Two patients were under the care of Trust physical health services:
    - One patients under Neighbourhood nursing team care (learning disability diagnosis)
    - One patient under Paediatric therapy team care (learning disability diagnosis)

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 check to ensure a death meets the LeDeR criteria, and if a death is already known to LeDeR by another provider.

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	8	0	2	10
2025/26 Q4				
Total	29	1	2	32

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

As shown in figure 6, two deaths were not reported to LeDeR, as this applies only to those aged 18 and over.

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 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	35	19	6	1	0	0	61
2025/26 Q2	31	24	3	0	0	0	58
2025/26 Q3	24	36	5	0	2		67
2025/26 Q4							
Total	**90**	**79**	**14**	**1**	**1**	**0**	**186**

Inpatient deaths

Figure 7 below shows that over the year 2025/26 to date there have been 20 inpatient deaths. All inpatient deaths are considered for the most appropriate level of review, and reported to LeDeR where necessary. Of the eight deaths in Quarter 3 2025/26, all had the managers 48 hour rapid review completed. Four of the eight deaths had no further learning response because the deaths were certified or expected deaths, or no problems in care were identified in the initial review undertaken. Two deaths are subject to a Patient Safety Incident Investigation.

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	2	0	1		3
		Crofton	1	0	0		1
		Poplars	1	1	2		4
		Ward 19	1	0	1		2
		Willow	0	0	1		1
	Adult Acute Inpatient	Beamshaw	0	1	0		1
		Elmdale	0	1	1		2
		Nostell	0	1	1		2
Forensic Care Group including Cheswold Park Hospital	Low Secure Inpatient	Thornhill Ward	0	0	1		1
		Esk Ward	1	0	0		1
Barnsley Physical Health and Wellbeing	General Community Inpatient	Neuro Rehab Unit	0	2	0		2
Total			**6**	**6**	**8**		**20**

The deaths of inpatients included in figure 7 includes deaths in the community where this occurred within 30 days of discharge from inpatient care. This table has been refreshed back to 1 April 2025 to ensure the data is accurate.

The eight inpatient related deaths in Quarter 3 are broken down as follows:

- Three were confirmed to be expected deaths related to physical health causes
- One death was unexpected but physical cause is suspected (respiratory).
- Four deaths were unexpected; all have been referred to the coroner to determine manner and cause of death.

Death whilst on leave from a ward	1
Death whilst AWOL from a ward	1
Death in acute hospital after transfer from a ward	2

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

Updates

- The review of the Patient Safety Incident Response Framework plan, policy and procedures continues. This has included 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.

- All deaths reported, irrespective of cause or severity, continue to be reviewed by patient safety specialists.
- A separate update on suicide prevention strategy and the apparent suicide report have been provided separately to Quality and Safety Committee.

Next steps

- Time has been scheduled in March to review the structured judgement review processes including allocation to reviewers, training, themes and output is planned for March 2026.

Patient Safety Support Team
12 January 2026