South West Yorkshire Partnership Teaching NHS Foundation Trust

Learning from Healthcare Deaths Report

Cumulative data covering the period 1/4/2025 – 31/3/2026

Prepared by Patient safety support team

Trust Board – 30 June 2026

1. Introduction

Scrutiny of healthcare deaths remains a national priority. The Trust has had a Learning from Healthcare Deaths policy in place since 2017, aligned to National Quality Board guidance, which sets out how deaths are identified, reported, reviewed, and how learning is derived to improve care. The Trust has published its Learning from Deaths data since October 2017 in line with national requirements.

While many people receive high-quality care from the NHS in the weeks, months, and years leading up to their death, there remain important opportunities to learn where care may not have met expected standards, including where system factors contribute to outcomes. National evidence continues to highlight significant health inequalities in mortality. People living with severe mental illness experience a life expectancy gap of 15–20 years compared to the general population, with a substantial proportion of deaths linked to preventable physical health conditions (Royal College of Psychiatrists, 2024; King's College London, 2026). Similarly, people with a learning disability die, on average, around 19–20 years earlier than the general population, with a significantly higher proportion of deaths considered avoidable (NHS England/LeDeR, 2025).

More broadly, national mortality data continues to demonstrate significant variation and inequality in outcomes, reinforcing the importance of robust review processes and system learning (ONS, 2025).

In response, the Trust adopts a broad and inclusive approach to reviewing deaths, ensuring that opportunities for learning are maximised, particularly in relation to health inequalities, physical health, and the quality of care provided across systems.

The Trust continues to work collaboratively with partners across the North of England to develop and strengthen its approach. All reportable deaths are reviewed in line with Trust policy, with a strong emphasis on engagement with families and carers, recognising the valuable insights they provide in understanding care and identifying learning. A representative from the Patient Safety Support Team attends quarterly regional mortality meetings to support the sharing of learning and best practice across organisations.

This Learning from Deaths report is presented alongside the Patient Safety Oversight Report and forms part of the Trust's wider arrangements for patient safety oversight and assurance to the Quality and Safety Committee and Trust Board.

2. Scope

The Trust has systems in place to identify and capture the known deaths of its service users on its electronic clinical information system. The Learning from Deaths policy sets out how deaths are responded to, which deaths are reportable, how they are reviewed, and how the Trust engages with bereaved families and carers.

For core reporting purposes, the Trust is deemed the main provider of care if, at the time of death, the patient met one or more of the following criteria:

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 adopted by the Trust, consistent with National Quality Board guidance.

All in-scope deaths are considered using one of the following levels of review:

Death Certification

- Review of the cause of death as certified by the attending doctor.
- In some cases, the Trust may only be notified that the death was certified or referred to the Coroner, without detailed information regarding the cause.

Case Record Review

Proportionate review of the clinical record to identify learning, including:

- Manager's Service-Learning Review (formerly 48-hour review)
- Structured Judgement Review (SJR) where a more in-depth assessment of care is required

Learning Response

Where further understanding is required, a PSIRF learning response may be commissioned. These approaches aim to identify system factors and opportunities for improvement and may include:

- After Action Review (AAR)
- Patient Safety Incident Investigation (PSII)
- Learning from Lives and Deaths Reviews (LeDeR) (for people with learning disabilities and/or autism)
- Other external reviews, such as safeguarding reviews

Reported deaths predominantly relate to service users who have died whilst receiving care in the community, or within six months prior to their death. All reported deaths are reviewed to determine whether they meet the criteria for inclusion within a mortality review, in line with the scope and criteria outlined earlier in this report. The Trust has strong record for triggering appropriate learning responses to address any patient safety concerns such as commissioning of thematic review, external reviews and reviews of care pathway.

3. Annual Cumulative Dashboard[1] Report 2025/26 covering the period 01/04/2025 – 31/03/2026

A summary of deaths reported during 2025/26 is presented in table 1. A total of 2,125 deaths were identified on the Trust's clinical systems where there had been contact within 180 days prior to death, which is broadly consistent with the previous year (2,150).

Of these, 390 deaths were reported on Datix and reviewed, of which 277 met the Trust's criteria for being in scope for further review. The remaining 113 deaths were not within scope, in line with the defined reporting criteria.

Table 1 Summary of 2025/26 Annual Death reporting by financial quarter to 31/03/2026

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	517	546	567	495	2125
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	427	102	89	112	87	390
3	Total Number of deaths which were in scope	282	74	67	77	59	277
4	Total Number of deaths reported on Datix that were not in the Trust's scope	145	28	22	35	28	113

Figure 1 presents two Statistical Process Control (SPC) charts for the period 1 January 2024 to 31 March 2026, showing:

- All deaths reported (by reported date)
- Deaths identified as being in scope for further review

The chart of all reported deaths demonstrates normal (expected) variation over time. Although there was an increase in reported deaths in January 2025, this did not meet the threshold for special cause variation and therefore did not require further investigation. A proportion of these deaths were not in scope for mortality review, in line with the criteria outlined earlier.

The chart of deaths in scope for review also shows stable variation within expected limits, providing assurance that there are no emerging trends or signals of concern requiring escalation.

[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 1 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

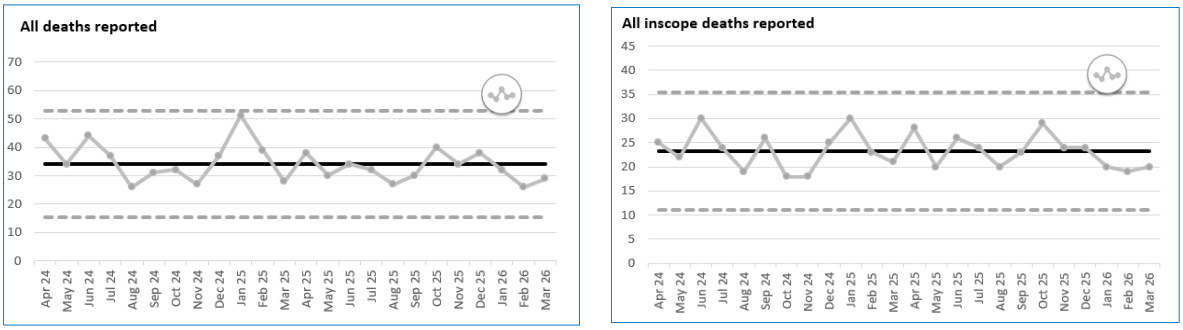

Table 2 shows the distribution of 277 deaths in scope for review during 2025/26 across Care Groups. The majority of in-scope deaths (217; 78%) relate to Mental Health Community services, reflecting the nature of the Trust's service provision, where most patients receive care in community settings. Smaller numbers are seen across Mental Health Inpatient services (20), Learning Disability services (31), and other Care Groups, with very low numbers reported in Forensic Services, Children and Young People's Services, and Cheswold Park Hospital.

The data demonstrates consistent reporting across quarters, with no significant variation between Care Groups, providing assurance that deaths are being identified and reported in line with Trust policy.

Table 2 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	0	4	49	0	0	6	0	59
Total	**5**	**20**	**217**	**1**	**1**	**31**	**2**	**277**

Table 3 outlines how these deaths were reviewed. All 277 deaths should have received a first-stage case note review (Service-Learning Review), which provides the information required to support decision-making on whether further review or investigation is needed. Where a death is certified and no further concerns or indicators for additional review are identified, it is recorded as

'certification'. Where a death requires further learning, it is recorded under the relevant review or learning response type.
The data has been refreshed for the full year 2025/26 to reflect the most up-to-date position, including any changes following confirmation of cause of death or progression of review processes.

Table 3 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	service learning 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	37	16	6	1	0	13	1	74
2025/26 Q2	32	22	3	1	0	9	0	67
2025/26 Q3	31	27	6	0	2	8	3	77
2025/26 Q4	24	27	0	0	0	8	0	59
Total	**124**	**92**	**15**	**2**	**2**	**38**	**4**	**277**

3.1 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. Tables 4 and 5 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 table 2 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.

Table 4 shows there were 40 deaths of people with a diagnosis of learning disabilty and/or autism. These breakdown as below:

- 31 patients were under the care of learning disability teams (or within the previous 6 months) (learning disabilty and/or autism)
- Seven patients were under the care of other Trust mental health services:

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

  - Five patients under Core Team care (learning disability or autism diagnosis)
  - One patients under Enhanced Team care (learning disability diagnosis)
  - One early intervention
- 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.

Table 4 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	8	0	0	7
Total	**37**	**1**	**2**	**40**

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 ask managers to complete the service learning review to ensure any internal learning and reflection can take place at a much earlier stage.

Across the region of West and South Yorkshire a process is established for the reviewing of all deaths under the LeDeR framework. SY ICB routinely share to Patient Safety Support Team the outcomes of all reviews completed, this has also included the outcome of a thematic analysis completed over the period of time September 2024 up to March 2026.

Learning shared following the thematic analysis identified that out of 32 individual reviews completed the reports highlighted persistent inequities for autistic adults when compared with the wider LeDeR population, in relation to premature mortality, suicide risk, mental health need, and inconsistent autism-informed practice.

The reports cites that the findings reinforce the need for a coordinated, system-wide response focused on autism-informed suicide prevention, improved mental and physical healthcare, consistent implementation of reasonable adjustments, and proactive identification and support for socially isolated autistic adults.

A sustained shift from reactive models of care to anticipatory, personalised and prevention-focused approaches, with clear ownership and accountability across health, social care, and partner organisations

SWYPFT are aware of a difference in the approach across the West ICB where reports completed are not being shared back to the Trust. This has been noted as an action to take forward in to the relaunched SWYPFT internal Mortality meeting, where LeDeR learnings are an identified standing agenda item to help inform and shape actions internally. This will support the ongoing improvement workstreams across physical health, culture of care and suicide prevention strategic aims and objectives.

3.2 Other deaths

Table 5 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 service learning 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 service learning review completed as standard process.

Table 5. 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	service learning review (1st stage case note review)	Case note review	Structured Judgment Review (SJR)	After Action Review	Patent Safety Incident Investigation (PSII)	Specialist learning review	Total
2025/26 Q1	37	16	1	6	1	0	0	61
2025/26 Q2	32	22	0	3	1	0	0	58
2025/26 Q3	29	27	0	6	0	2	3	67
2025/26 Q4	24	27	0	0	0	0	0	61
Total	**122**	**92**	**1**	**15**	**2**	**2**	**3**	**237**

3.3 Inpatient deaths

Table 6 below shows that over the year 2025/26 to date there have been 24 inpatient deaths across Forensic, Cheswold park, Mental Health Acute inpatient units and Neuro-rehabilitation.

As with all deaths, every inpatient death is reviewed to determine the most appropriate level of learning response. Across all four quarters, each death underwent a manager-led service learning review, and the 'Death of a Service User' questionnaires were completed appropriately. All initial learning responses were subsequently reviewed by the Trust's Patient Safety Oversight Group to determine the need for, and level of, any further review.

A detailed review of each of the 24 deaths classified as inpatient deaths under the Learning from Deaths framework has been completed or is ongoing. Of these, four deaths were identified as apparent suicides, one death was attributed to choking, and the remaining nineteen deaths were associated with physical health deterioration. These individuals were either receiving end-of-life care under SWYPFT at the time of death or died in other organisations due to terminal conditions. There were no in-patient learning disability deaths.

One inpatient death occurred as a result of choking. This case was subject to detailed review at care group level, alongside completion of a Structured Judgement Review (SJR). The Trust has previously undertaken a comprehensive programme of improvement work arising from the Learning from Deaths framework, specifically focused on the identification and management of choking risks.The SJR provided assurance that learning from previous incidents had been effectively implemented and embedded across the organisation, with clear evidence of sustained improvements in clinical practice. No gaps in care or service delivery were identified. At the time of the incident, a partner organisation raised concerns regarding Trust equipment and staff competence in its use. However, the review confirmed that staff acted appropriately, in line with Trust policies, procedures, and training, and utilised the equipment available to them effectively. Compliance with Basic Life Support (BLS) and Intermediate Life Support (ILS) training was also confirmed to be at a good standard, further supporting the position that prior organisational learning has been translated into safe and consistent frontline practice.

At each stage of the reporting process, opportunities for learning are identified and acted upon. Care group leaders are actively encouraged to implement immediate improvements where this can be achieved at a local level, ensuring teams are empowered to lead on safety and quality. This approach supports timely intervention and reduces reliance on the completion of formal reporting processes before action is taken. It also mitigates the risk of recurrence by avoiding unnecessary delays in implementing changes while reviews are ongoing.

With the exception of apparent suicides, which remain subject to ongoing review, no inpatient deaths due to physical health causes were identified as having been contributed to by the care or treatment provided by the Trust.
A number of areas for learning have been identified to support continuous improvement. These include strengthening processes for inter-organisational transfers of care for patients who are physically unwell; ensuring walking (mobility) assessments are routinely updated; enhancing

staff understanding of individual needs when patients are approaching end of life; and improving consistency in end-of-life pathways and care planning.
Further learning relates to increasing awareness and application of the ReSPECT process, as well as ensuring clarity and completeness of Do Not Attempt Resuscitation (DNAR) documentation.

Table 6 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	1	4
		Crofton	1	0	0	1	2
		Poplars	1	1	2	1	5
		Ward 19	1	0	1	0	2
		Willow	0	0	1	0	1
	Adult Acute Inpatient	Beamshaw	0	1	0	0	1
		Elmdale	0	1	1	1	3
		Nostell	0	1	1	0	2
Forensic Care Group including Cheswold Park Hospital	Low Secure Inpatient	Thornhill Ward	0	0	1	0	1
		Esk Ward	1	0	0	0	1
Barnsley Physical Health and Wellbeing	General Community Inpatient	Neuro Rehab Unit	0	2	0	0	2
Total			**6**	**6**	**8**	**4**	**24**

The inpatient deaths reported in Table 6 include those occurring in the community where death took place within 30 days of discharge from inpatient care. The dataset has been refreshed to include activity from 1 April 2025 to ensure completeness and accuracy of reporting.

3.3.1 Inpatient apparent suicides

During 2025/26, there have been four inpatient apparent suicides: two occurring on the ward, one whilst on agreed leave, and one in the days following discharge. All investigations remain ongoing, including one independently commissioned Patient Safety Incident Investigation (PSII). In addition, the Trust has commissioned an independent review of the women's care pathway, due to conclude in July 2026. The findings from this review, alongside the ongoing investigations, will further inform targeted improvement activity.

The Suicide Prevention Lead is also undertaking a retrospective review of inpatient apparent suicides between April 2023 and March 2025. The aim of this review is to undertake detailed analysis of themes and patterns across these deaths, including for patients who were on the ward, on agreed leave, absent without leave, or within 30 days of discharge. This analysis is intended to strengthen organisational learning, inform service improvement, and support actions to prevent future loss of life.

4. Wider Patient Safety and Learning System Updates

The following section provides an overview of broader patient safety developments and system improvements.

- The review of the Patient Safety Incident Response Framework (PSIRF) plan, policy and procedures is nearing completion. The final version of the PSIRF Plan is scheduled for review by the Quality and Safety Committee in July 2026. Updated procedures and flowcharts will be published on the Trust's patient safety webpages, alongside clarified governance and sign-off arrangements, to ensure that learning is consistently captured, reviewed and shared. The review has also introduced practical flowcharts to support the selection of the most appropriate PSIRF response. These include alignment with Learning from Deaths requirements, supporting decision-making where there is a need to determine whether a death may have resulted from problems in care.
- All reported deaths, irrespective of cause or severity, continue to undergo review by Patient Safety Specialists. Findings are systematically escalated through the Trust's Patient Safety Oversight Group (PSOG) and mortality governance meetings, ensuring robust oversight and organisational learning.
- Separate reports on the Suicide Prevention Strategy and the thematic review of apparent suicides have been presented to the Quality and Safety Committee, providing focused assurance and oversight in these priority areas.

5. Next Steps

The following section outlines the key actions and developments planned to further strengthen the Trust's approach to mortality review, learning, and patient safety.

- A review of the Structured Judgement Review (SJR) template is underway to ensure full alignment with the updated national template requirements.
- The Datix 'Death of a Service User' questionnaire has been enhanced to align with regional reporting requirements, supporting near real-time suicide surveillance and improved system-wide intelligence.
- Work is in progress to strengthen the organisation's understanding of the needs and care pathways for individuals with co-existing drug and alcohol use disorders who have died, to inform targeted improvement actions.
- The SJR process is being further developed, including a review of training provision, the allocation process for SJRs, and opportunities for medical investigators to undertake or support reviews to enhance clinical input and consistency.
- Mortality governance arrangements have been strengthened, with the re-establishment of monthly mortality review meetings and a quarterly forum focused on thematic learning. These forums include Care Group representation and provide oversight of both local and national learning.
- Mechanisms for sharing learning are being reinforced through the Improvement and Learning Group, supporting thematic analysis of deaths and enabling the organisation to better use mortality data to identify trends and inform improvement priorities.

6. Recommendations

The Trust Board is asked to receive the report and assurance that the Learning from Deaths framework is being effectively implemented, embedded, and monitored across the Trust.