Learning from Deaths/Mortality - annual report

1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date, the Trust has met all the required guidelines.

The report presents the data for 1 April 2024 to 31 March 2025.

2. Current Position and Progress

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. This will improve now that the Medical Examiners process of reviewing the Trust's non-coronial deaths is in place. The Trust continues to meet with the Medical Examiners on a regular basis
- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 29 April 2025
- A process has been implemented within the Electronic Patient Record, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release capacity within the service to re-deploy into other priorities, such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services
- The Mortality Case Record review panels were paused whilst processes around Mortality and Incidents were reviewed. Having completed amendments to the incident process and the inclusion of Mortality red flags it was agreed that the format and content of the Mortality Case Record Reviews panels required re-development. Works have commenced to re-design and better utilise the resource to provide a quality and assurance check to deaths closed to the incident review process at Incident Review Tool level. This has been discussed and agreed within the Executive Incident Review group chaired by the Trust Medical Director on 24 April 2025. The Trust Mortality Technical is currently working towards this revision with support from the Operational Patient Safety Manager (System)
- In line with changes being made to the assurance and oversight of learning post incident the Trust Mortality Committee has been replaced with the Learning the Lessons Oversight Committee. This committee will have oversight and governance responsibility for incidents which include Mortality red flags and be responsible for overseeing the dissemination of learning post incident. The committee will work with service line Learning the Lessons groups to develop and drive forward quality improvement programmes across the Trust.

3. Data Summary of all Deaths

Note that Inpatient and Learning Disability (LD) data is based upon whether the patient has an open Inpatient or LD referral at time of death.

The following table outlines information from 1 April 2024 to 31 March 2025:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Deaths Per Month	186	169	176	171	153	179	200	180	208	221	173	166
LD Referral Deaths	4	2	3	0	0	0	1	2	2	4	2	2

Correct as at 10 April 2025

From 1 April 2024 to 31 March 2025, the Trust received 2,182 death notifications of patients who have been in contact with our services. Of these deaths, 1,145 patients were male, 1,035 female, 1,646 were white British and 40 Asian British. The youngest age was zero years, the oldest age recorded was 104. The Trust has reported 22 Learning Disability deaths in the reporting timeframe and two deaths of patients with a diagnosis of autism.

4. Review of Deaths

In line with national requirements, all deaths of a person who has been in contact with services in the six months prior to death are considered at Stage 1 Mortality review against Trust and national Mortality red flags. The table below details deaths which have been reported through the Trust Incident process as meeting a Trust or national Mortality red flag. These deaths are then subject to further scrutiny and consideration under the Operational Incident Review process for further Learning Response. Of these deaths:

- Two patients died on our wards receiving end of life care
- Two patients died following transfer to the acute hospital due to a deterioration in their physical health. One patient whilst on section 17 leave died unexpectedly
- Two patients died receiving end of life care at the acute hospital following transfer. One inpatient death (overdose in the community prior to admission) died following transfer to the acute hospital for further treatment
- One patient died on the ward due to a suspected suicide.

Figures are subject to change and impacted by issues such as data quality checks such as the rejection of Expected Deaths within community settings or Physical Health related Deaths under Substance Misuse services.

Incident Subcategory	Number of deaths
Suspected suicide - laceration	1
Suspected suicide - drowning	2
Suspected suicide - other	4
Death unexpected - accident	7
Suspected suicide - overdose	8
Suspected suicide - ligature	9
Death unexpected - alcohol use	14
Death unexpected - substance misuse	26
Expected - end of life pathway	27
Death unexpected - other	69
Death unexpected - medical condition/natural causes	96
Grand Total	**263**

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure.*

Any patient, open to services within the last six months, who has died and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHcFT hospital.
- Death following an inpatient transfer to acute hospital.
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit

- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/carer the Ombudsman or where staff have raised a significant concern about the quality-of-care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient, whether they were open to the Trust at time of death or not
- Death of a patient with autism
- Death of a patient who had a diagnosis of psychosis within the last episode of care
- Death of a patient who had a diagnosis of an eating disorder within the last episode of care or within six months of discharge
- Death of a patient open to Crisis Home Resolution team or equivalent at the time of death.

5. Learning Responses for 2023/24 and 2024/25

The table below outlines the number of deaths that have been recorded through the Trust incident reporting system Datix and the learning response that has been commissioned. All deaths reported through the Datix system that meet the Trust 'red flag' will have an Incident Review Tool completed. This is then reviewed and a decision made as to whether a further Learning Response is required.

Financial Year	Datix	Case Record Review	Patient Safety Incident Investigation
2023/24	119 deaths	39	16
2024/25	141 deaths	23	3

Please note: 56 deaths are currently awaiting a decision.

6. Duty of Candour (DoC) for 2023/24 and 2024/25

During 2023/24 there were five deaths which met the criteria for DoC. There have been no deaths determined to be Duty of Candour for 2024/25. However, it should be noted there are Learning Responses for this period which remain active.

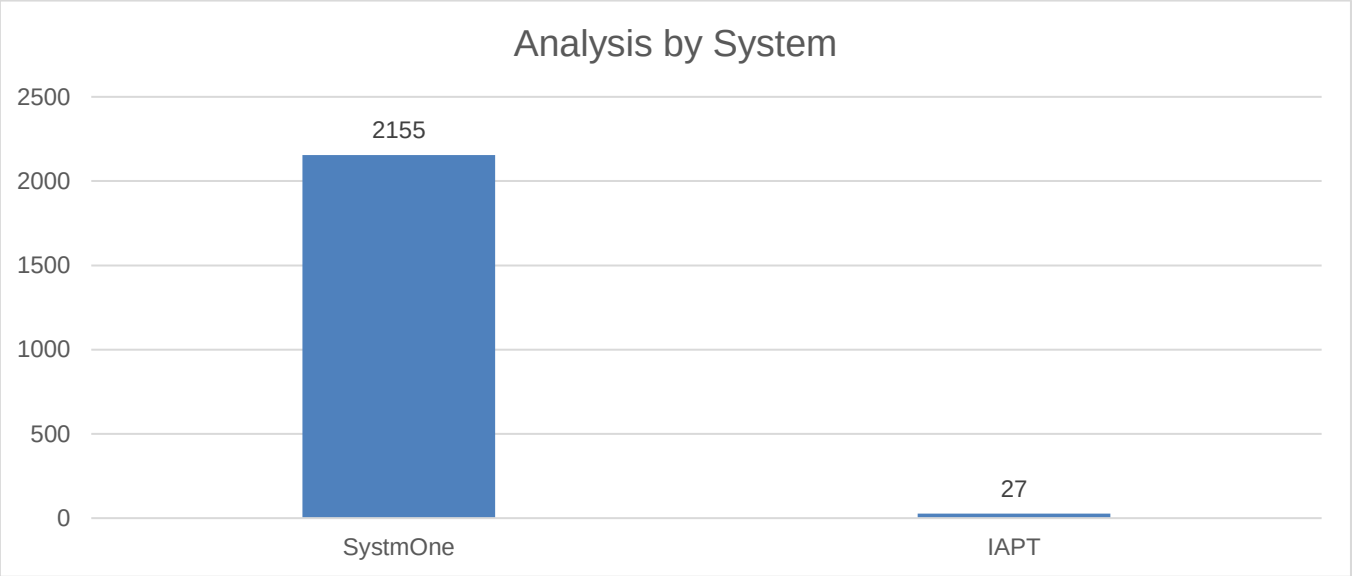
7. Learning from Deaths Procedure

The Trust has now completed a move in terms of its mortality process, a process has been implemented within the Electronic Patient Record which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services, ensuring better sharing of information and identification of priorities for both services.

There is a process for weekly random audits of deaths against the red flags to provide assurance that the new process is working as intended.

8. Analysis of Data

8.1. Analysis per notification system since 1 April 2024 to 31 March 2025

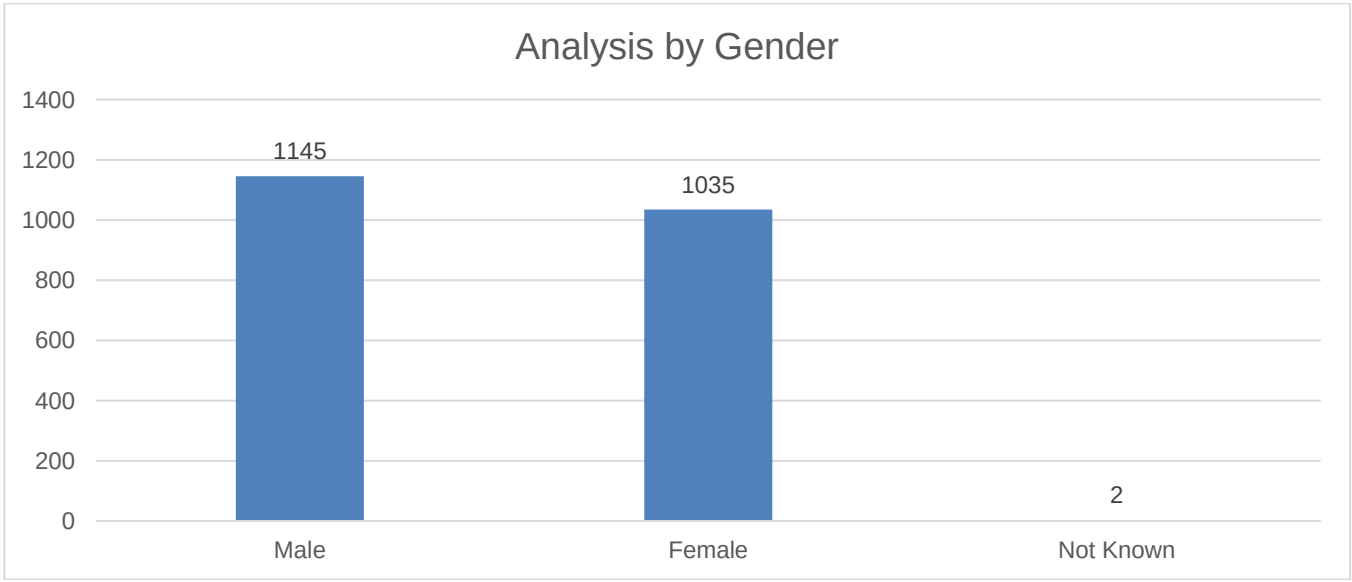


System	Number of Deaths
SystmOne	2,155
IAPT	27
Grand Total	**2,182**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.

8.2. Analysis by Gender

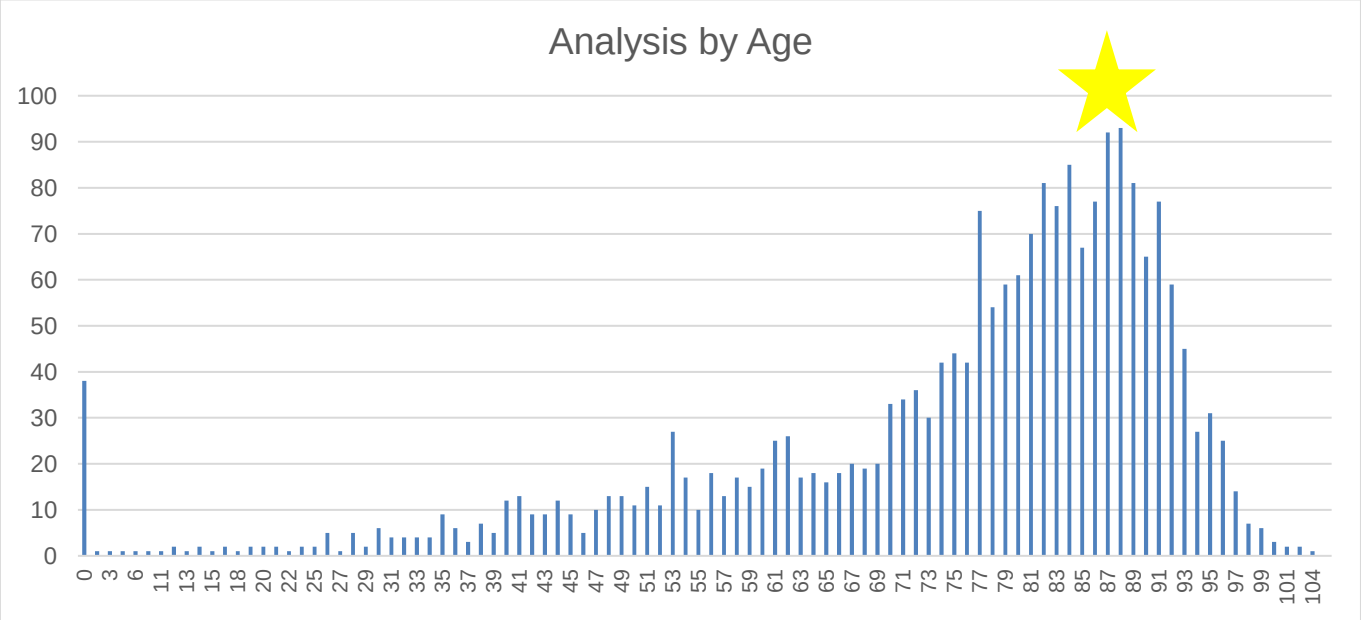
The data below shows the total number of deaths by gender 1 April 2024 to 31 March 2025. There is very little variation between male and female deaths; 1,035 female deaths were reported. compared to 1,145 males.



Gender	Number of Deaths
Male	1,145
Female	1,035
Not Known	2
Grand Total	**2,182**

8.3. Analysis by Age Group

The youngest age was classed as zero, and the oldest age was 104 years. Most deaths occurred within the 82 to 89 age groups (indicated by the star):



8.4. Learning Disability Deaths (LD)

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the LeDeR programme. Scoping is planned with operational services through their Learning the Lessons subgroups to consider the most appropriate management process for Learning Disability deaths moving forward.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
LD Deaths	4	2	3	0	0	0	1	2	2	4	2	2
Autism	0	0	0	1	0	0	0	0	0	0	0	1

Since 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, fourteen patients have been referred.

During 1 April 2024 to 31 March 2025, the Trust has recorded 22 Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

8.5. Analysis by Ethnicity

White British is the highest recorded ethnicity group with 1,646 recorded deaths, 161 deaths had no recorded ethnicity assigned. The following chart outlines all ethnicity groups:

Ethnicity	Number of Deaths
White - British	1,646
Other Ethnic Groups - any other ethnic group	240
Not Known	139
White - any other White background	39
Asian or Asian British - Indian	23
Not stated	22
White - Irish	20
Black or Black British - Caribbean	15
Asian or Asian British - Pakistani	13
Black or Black British - African	8
Mixed - White and Black Caribbean	7
Asian or Asian British - any other Asian background	4
Mixed - any other mixed background	2
Mixed - White and Asian	2
Black or Black British - any other Black background	1
Mixed - White and Black African	1
Grand Total	**2,182**

8.6. Analysis by Religion

Christianity is the highest recorded religion group with 850 recorded deaths, 535 deaths had no recorded religion assigned. The chart below outlines all religion groups:

Religion	Number of Deaths
Christian	828
Not religious	626
(blank)	528
Church of England, follower of	52
Church of England	34
Christian, follower of religion	11
Christian religion	11
Methodist	10
Roman Catholic	10
Sikh	9
Catholic religion	8
Patient Religion Unknown	7
Muslim	7
Religion NOS	5
Atheist movement	4
Hindu	4
Buddhist	3
Jehovah's Witness	3
Islam	3

Agnostic movement	3
Catholic: non Roman Catholic	2
Rastafarian	1
Protestant	1
Anglican	1
Spiritualist	1
Atheist	1
Quaker	1
Nonconformist	1
Agnostic	1
Congregationalist	1
Church of Scotland, follower o	1
Follower of Church of Nazarene	1
Jewish	1
Baptist	1
Pagan	1
Grand Total	**2,182**

8.7. Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 1,448 recorded deaths, 725 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	1448
(blank)	615
Sexual orientation not given - patient refused	71
Sexual orientation unknown	19
Not stated (person asked but declined to provide a response about their sexual orientation)	12
Unknown	7
Bisexual	3
Female homosexual	2
Male homosexual	2
Lesbian or gay	1
Homosexual	1
Person declined to disclose	1
Grand Total	**2182**

8.8. Analysis by Disability

The table below details the top eight categories by disability. Gross motor disability was the highest recorded disability group with 430 recorded deaths:

Disability	Number of Deaths
Gross motor disability	430
Intellectual functioning disability	125
Emotional behaviour disability	73
Hearing disability	57
Disability Questionnaire - Behavioural and Emotional	37

Disability Questionnaire - Mobility and Gross Motor	20
Disability Questionnaire - Memory Adult	19
Disability Questionnaire - Progressive Conditions and Physical Health	14

There have been 983 deaths with a disability assigned and the remainder were blank or had no assigned disability.

9. Recommendations and Learning

Learning emerging from Learning Responses at Case Record Review or Patient Safety Incident Investigation level highlights improvements needed in relation to the following areas:

- Improving risk management to ensure that comprehensive risk assessments are completed and reviewed and that these accurately reflect the patient needs, particularly in complex/ high-risk patients and working to identify and mitigate risks early. This aligns to the development of the Trust Risk Assessment, Safety Planning and Suicide Prevention works which includes a training package and revised Suicide Prevention strategy with a Suicide Prevention lead now in place
- Ensuring that care plans are individualised and reflect the holistic needs of patients, including their psychological, emotional, and physical wellbeing
- Improving communication and teamwork, a re-occurring theme which identifies the need to enhance communication between multi-disciplinary teams (MDTs) and the importance of open and transparent communication with patients and families, particularly around critical decisions and care pathways. Promoting the importance of respecting patient preferences and involving patients and their families in care decisions
- Supporting staff with complex case management by identifying gaps in training and guidance, particularly related to safeguarding, risk management and clinical decision-making so they are equipped with the skills and knowledge they need to deal with complex cases
- Patient safety thread and Incident Reporting, to encourage a culture of openness where all incidents, near misses, and concerns are reported and acted upon. Ensuring that incidents are appropriately managed and responded too to support the dissemination of learning to reduce risk to patients.

The table below **Themes arising from Incident Learning Responses** provides more detail in relation to themes and improvement needs:

Improvement issue	Improvement plan
Transfer, Leave and Discharge.	**Transfer of the deteriorating patient** Transfer and return of patients between inpatient services for the Trust and Acute providers, including handover of information, and the way patients are conveyed. A quality improvement project has been undertaken between Derby Hospital and DHcFT to develop a transfer and handover proforma which is now in place. **Self-harm of patients whilst on leave from inpatient services and Section 17 leave arrangements** Issues in relation to leave arrangements for inpatient services including follow up. A further thematic review was completed on conclusion of a cluster of inpatient suspected suicide incidents. An action plan has been developed. This included a review of the pathway of communication and documentation (including risk assessments and care plan) between Crisis Resolution and Home Treatment/Community teams and Inpatient services when a patient is due to be on s17 leave/discharged. This will be reviewed within the Adult Acute Learning the Lessons Subgroup. A further four incidents for Inpatient services are scheduled to be included within an external thematic review commissioned by the Trust for 2025/26.
Suicide Prevention.	**Suicide Prevention training** The Trust has identified the need to re-establish Suicide Prevention training across services, this is being led by the Trust Medical Director and has been incorporated into the new Risk Assessment, Safety Planning training package under-development. A Trust Suicide Prevention Lead has now been appointed and this links into current training development as well as a review of the trust Suicide Prevention strategy.

Improvement issue	Improvement plan
Training and awareness of Emotionally Unstable Personality Disorder (EUPD).	Development of a training and awareness package for all services in relation to EUPD which is being led by the Trust Medical Director.
Multi-agency engagement following incidents.	It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies, when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.
Physical Health management within inpatient environments.	Quality improvement work in relation to improving physical healthcare management, observation, and care planning within Older People's services. A quality improvement programme will be developed with the Trust Physical Healthcare lead. Enhancement of wound care management and infection prevention and control investigation and follow up within inpatient services. Introduction of RESTORE2 into ILS training framework, including review of current ILS provision. Transition agreed to Level 2 and Level 3 resuscitation training and adoption of more recognition of Deteriorating Patient scenarios in training to aid clinicians (Bluebell Ward first adopter). Establish a Physical Health Reporting Working Group to establish the new system one reporting frameworks to improve reports for assurance. Introduction of RESTORE2 into ILS / Level 2 and level 3 training framework, including review of current ILS provision.
MDT process improvements within CMHTs.	Themes in relation to MDT processes within CMHTs and works are currently underway to review the EPR and recording documentation and MDT process to ensure this is fit for purpose and being adhered to.
Self-harm within inpatient environments, including management of contraband.	Adoption of the CQC/MHLD Nurse Directors forum guidance for ligature risk assessment processes. Risk assessment has new section on the risk assessment tool in the EPR. Quality Improvement programme in relation to self-harm via sharps of females within Inpatient services (local priority) - currently on hold. Improvement to environment – now using convex mirrors and zonal observations on female wards, changed ligature environment risk assessment. Improvement to therapeutic engagements. Improvement to risk assessment and management including observation levels - observation booklet in place. To continue commissioned working group to review handheld clinical devices and compliance with observations, including physical health observations. Ligature training package in place and is currently being rolled out including competency assessment. Green zone – within inpatient areas there is an area painted green which holds emergency equipment such as ligature knife, resuscitation equipment so is easily identifiable. Ligature Risk Reduction Working Group.
Dissemination of learning and service improvements following incidents, including	Work is underway to improve the way in which the Trust learns and improves from incidents. This will include a revision to the processes in place in relation to internal investigation recommendations, Case Record Review learning, Incident Review Tool learning and the revised Trust Mortality process. Develop pathway to offer clear governance processes.

Improvement issue	Improvement plan
assurance and governance.	Develop service line learning briefings specific to service learning. Trust-wide learning the lessons to share high-level responses and learning. Develop better ways for monitoring and reporting emerging themes. Joined up working between services. Improved monitoring of high-profile cases and joined up working between services involved. Development of more collaborative Learning Responses.
Application of red flags and flow of incidents resulting in death.	Improvement in the application and identification of red flags for reporting death. Revision of current red flags for relevance given changes both nationally and locally. Redesign the function of the 'Mortality' process within structures through the Learning the Lessons subgroups. Review the purpose and function of the Mortality Case Record Review panel and redesign this to one of audit and assurance.
Interface between Mental Health and Substance Misuse services.	Suspected Suicide of a patient who has a dual diagnosis of substance misuse and mental health but has been rejected by Community Mental Health services is an area which has been noted through Case Record Review. This has been selected as a new local priority for the Trust. Themes will feed into Learning the Lessons subgroups for both services to jointly develop an improvement plan.
Substance Misuse services and Adult Acute Inpatient environments.	Learning Responses for unexpected deaths post-discharge/whilst on leave have highlighted gaps around knowledge, support and process for the management and support of risk in relation to addiction and substance misuse. Currently several actions in place. Improvement plan to be developed and managed through the services Learning the Lessons subgroup.
Risk assessment, management and care planning.	This is an area which repeatedly shows need for improvement and the trust is currently finalising a Safety Planning training package which will consist of four modules and incorporate suicide prevention.