

## **Learning from Deaths/Mortality report**

### **Purpose of Report**

The 'National Guidance on Learning from Deaths' requires each trust to collect and publish specified information on a quarterly basis. This report covers the period 1 October 2025 to 31 December 2025. The Quality and Safeguarding Committee was requested to accept this Mortality Report as assurance of the Trust's approach and agree for the report to be considered by the Trust Board of Directors and published on the Trust's website as per national guidance.

### **Executive Summary**

The Trust received 548 death notifications of patients who had been in contact with our services in Quarter 3 of 2025/26. There is very little variation between male and female deaths; 280 male deaths were reported, compared to 266 females.

There have been seven Learning Disability deaths in the reporting timeframe and no deaths of patients with a diagnosis of autism.

There have been two inpatient unexpected deaths due to physical health causes and one unexpected death during home leave.

The Trust commissioned 10 Learning Responses surrounding deaths through Case Record Review. In addition, there were one Patient Safety Incident Investigation commissioned, all of which are ongoing. Five learning responses were completed this period. Following is the learning emerging from Case Record Reviews and Patient Safety Incident Investigations (PSII):

#### **Key themes for improvement:**

- Risk Assessment and Management
- Documentation Quality
- Communication and Information Sharing
- Multi-disciplinary team (MDT) Working and Pathways
- Medication and Physical Health
- Observations and Falls Management
- Carer Involvement
- Crisis Response and Safety Planning
- System-Level Issues.

#### **Strengths Identified:**

- Effective community transitions
- Strong MDT working within Community Mental Health teams (CMHTs)
- Comprehensive assessments and proactive referrals
- Person-centred community safety planning
- Good safeguarding and confidentiality practice

These areas will be progressed through Care Group Learning the Lessons meetings and Divisional meetings which have commenced from January 2026. Where appropriate, improvement groups will be established to oversee implementation. The Divisional Learning the Lessons meeting and Executive Incident Review Group will hold oversight for actions resulting from Learning Responses, quality improvement plans.

The Trust Patient Safety team continues to meet with Medical Examiners to improve the flow of information in relation to cause of death.

Good practice identified through case note reviews is fed back to clinicians/wider team involved as part of our appreciative learning.

The mortality process to ensure compliance with policy and procedure on red flags (ie avoidable deaths) within the Electronic Patient Record (EPR) continues to have weekly audits, with the most recent being on 23 January 2026. The audit identified two deaths as having complaints, one had been Datix reported, the second did not meet the requirement as the complaint was not upheld.

The Trust Patient Safety Team had few challenges with capacity and dynamics within the team which is currently being resolved. An interim patient safety lead is in place. The Trust is actively reviewing the process of investigations under PSIRF, ensuring that there is robust system for tracking the progress in investigations, monitoring the action plan and learning. Since the report was submitted to the Quality and Safeguarding Committee in February 2026 a further discussion with the new operating model managers resulted in having a Learning the Lessons Group in each of the Care Groups (five) and one at the Trust level that will oversee the learning across the organisation and support with triangulation. There is also a plan to train 50 more managers/clinicians on PSIRF. In future the deaths on protectively characteristics will be reported based on population demographics/health inequalities once the data is available.

<b>Strategic Considerations</b>		<b>BAF Risk (eg 1A)</b>	<b>Strategic Delivery Plan Reference</b>
<b>Patient Focus:</b> Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1A	1.1
<b>People:</b> We will attract, involve and retain staff creating a positive culture and sense of belonging.			
<b>Productive:</b> We will improve our productivity and design and deliver services that are financially sustainable.			
<b>Partnerships:</b> We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X	4A	4.1

### **Risks and Assurances**

This report provided limited assurance to the Quality and Safeguarding Committee that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

### **Consultation**

This report has been reviewed by the Executive Medical Director and Executive Incident Review Group membership.

## **Governance or Legal Issues**

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

## **Net Zero Duty Implications**

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

Below is a summary of the related impacts of the report:

None.

## **Public Sector Equality Duty & Equality Impact Risk Analysis**

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

- Between 1 October 2025 to 31 December 2025, there was very little variation between male and female deaths; 280 male deaths were reported, compared to 266 female deaths
- No unexpected trends were identified according to ethnic origin or religion.

## **Recommendations**

The Board of Directors is requested to accept this report with limited assurance of the Trust's approach and agree for the report to be considered by the Trust Board of Directors and then published on the Trust's website as per national guidance.

**Report presented by:** **Lynn Andrews**  
**Chair, Quality and Safeguarding Committee**

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