

Learning from Deaths/Mortality report (quarterly)

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 October 2025 to 31 December 2025.

2. Current Position and Progress

- The Patient Safety Team receives information on deaths from Datix filed by the teams and from other sources such as police, coroner office and medical examiner office.
- Only a very small number of cause of deaths (CoD) have been made available through the Coroner offices in Chesterfield and Derby
- Medical Examiner offices at Acute trusts provide independent scrutiny of non-coronial deaths including those in the community. They carry out a proportionate review of medical records and liaise with doctors completing the Medical Certificate of Cause of Death (MCCD). They give families and next of kin an opportunity to ask questions and raise concerns. There is an agreement in place for CoD information to be released to the DHcFT Patient Safety team for patients open to our service in the six months prior to their death. This agreement is in place with University Hospitals of Derby and Burton (UHDB) and Chesterfield Royal Hospital (CRH) via working relationships between the corresponding Patient Safety teams. This has been slow to come into force due to numerous technical issues for the various Electronic Patient Record (EPR) systems and a shortage of medical examiners. All medical examiners are now in place and electronic system issues are reportedly resolved. However, CoD information sharing remains slow. This will be actioned by Patient Safety now that the main areas have been resolved
- Regular audits continue to be undertaken to ensure compliance with policy and procedure for the reporting of Trust and National Learning from Deaths on red flag deaths (ie avoidable deaths). This includes auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed on 23 January 2026 which identified two deaths as having complaints; one had been Datixed and the other was not required to be Datixed as the complaint was not upheld
- A process is now embedded 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 procedure
- In line with changes being made to the assurance and oversight of learning post-incident, the Trust Mortality Committee was replaced with the Learning the Lessons Oversight Group which formed part of the Executive Incident Review Group. Given the structure and organisational changes an active decision was made to hold the Oversight Group. Operational services have now established Care Group meetings with a Division Learning the Lessons Oversight Group which will feed into the Trust Executive Incident Review Group. The Patient Safety team will continue to support Operational services to fully embed these meetings
- We are in the process of re-establishing the Regional Mortality Review Networking Group at DHcFT. The aim is to strengthen regional links, share learning from mortality reviews and support continuous improvement in patient safety. The next planned meeting is due to take place in March 2026
- We are developing an Incident Review Tool (IRT) audit process to strengthen our approach to incident learning under the Patient Safety Incident Response Framework (PSIRF). The purpose is to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services and that there is alignment between the IRT process and broader PSIRF requirements.

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 October 2025 to 31 December 2025:

	Oct	Nov	Dec
Total Deaths Per Month	162	187	199
LD Referral Deaths	1	1	5

Correct as of 23 January 2026

Between 1 October 2025 to 31 December 2025, the Trust received 548 death notifications of patients who had been in contact with our services for patients opened or discharged within six months of their death. Of these deaths, 280 patients were male, 266 female and two unknown gender. The youngest age was zero years (as we provide services to children in Community Paediatrics), the oldest age recorded was 101. The Trust has reported seven LD deaths in the reporting timeframe and no deaths of a patients with a diagnosis of autism.

4. Review of Deaths

Of the 548 deaths there were 74 cases that met the criteria for Trust incident reporting system which is shown in the table below:

Total number of deaths between 1 October 2025 and 31 December 2025 reported on Datix.	60 "Unexpected deaths" Nine "Suspected Suicide deaths" Five "Expected - end of life pathway" NB some expected deaths have been rejected so these incidents are not included in the above figure.
Incidents assigned for a review.	74 incidents assigned to the Operational Incident Group.

Only deaths which meet the criteria below should be reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *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. (This criterion only relates to patients open to services within the last six months)
- Domestic homicide - perpetrator or victim (This criterion relates to patients open to services within the last six months)
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatients 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 absconson from an inpatient unit
- Death following a physical restraint
- Death of a patient with a LD
- Death of a patient where there has been a complaint by family/ carer/ombudsman or staff have raised a significant concern about the quality of care provision
- Death of a child (and will likely 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 patient 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
- Diagnosis of psychosis within the last episode of care
- Autism

- Death of a patient who has an eating disorder within the last episode of care or death within six months of discharge
- Death of a patient under the care of the crisis and home treatment team (or equivalent) at the time of their death
- Death of a patient in Substance Misuse services – further guidance within the incident policy or how Substance Misuse deaths are managed.

5. Inpatient Deaths

During the review period there have been three inpatient deaths for the period which relates to two male patients who died due to physical health causes following transfer to the Acute hospital and one male patient who died during home leave due to morphine toxicity.

6. Learning Responses for 2023/24, 2024/25 and 2025/26

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 meeting the Trust 'red flag' will have an Incident Review Tool completed. This is then reviewed, and a decision is 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
2025/26	116 deaths	20	5

Please note: 64 deaths are currently awaiting a decision.

7. Duty of Candour (DoC) for 1 October 2025 to 31 December 2025

The Trust achieved 100% compliance with Duty of Candour within this reporting period with four incidents meeting the threshold (where the date of the incident is within this reporting period). Where an incident is subject to learning response Duty of Candour is assessed at the date which the report is approved. Therefore, such incidents can sit outside of the specified reporting period. For transparency these incidents will be included within this report. There have been two incidents assessed as DoC which occurred outside of the reporting period. The Trust has a 50% compliance for these. DoC was not achieved due to the patient being deceased with no known family to engage. Learning identified for this period includes:

- Low staffing levels
- Professional boundaries
- Inappropriate medication safety in the community.

The Trust is active in promoting DoC and encourage all staff to be trained on DoC. 121 staff have been trained in DoC for this period. To date 304 staff have completed training this financial year with 1,007 staff compliant since the initiative began.

8. Learning from Deaths Procedure

The Trust has now completed a move in terms of its mortality process; a process has been implemented within the EPR 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 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. Weekly random audits continue for deaths against the red flags to provide assurance that the new process is working as intended.

The Patient Safety team has been revising the function of its Mortality case record review process and developing an Incident Review Tool (IRT) audit process which will be allocated to Medical and Nursing colleagues.

This has been delayed due to capacity and service restructuring however forms part of an improvement plan under development for the Patient Safety team. All national mortality red flags sit within the Trust's overarching red flags for the reporting of deaths as an incident.

The process will work to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services, and that there is alignment between the IRT process and the broader PSIRF requirements.

9. Analysis of Data

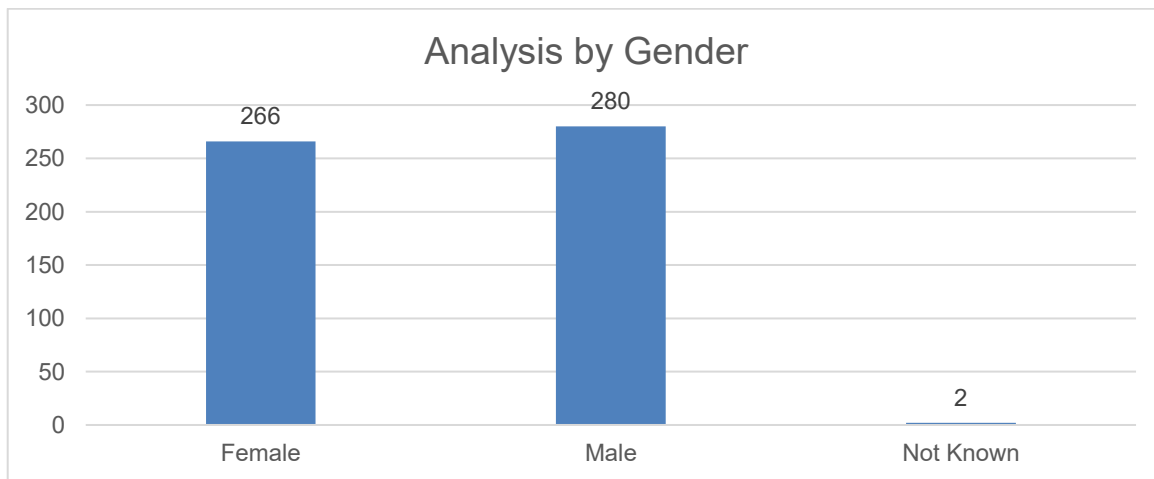
9.1. Analysis per notification system since 1 October 2025 to 31 December 2025

System	Number of Deaths
SystmOne (Trust EPR)	548
Grand Total	548

The data above shows the total number of deaths reported by each notification system. All of the death notifications were pulled from SystmOne (Trust EPR). This clinical record system is aligned to the population we serve.

9.2. Analysis by Gender

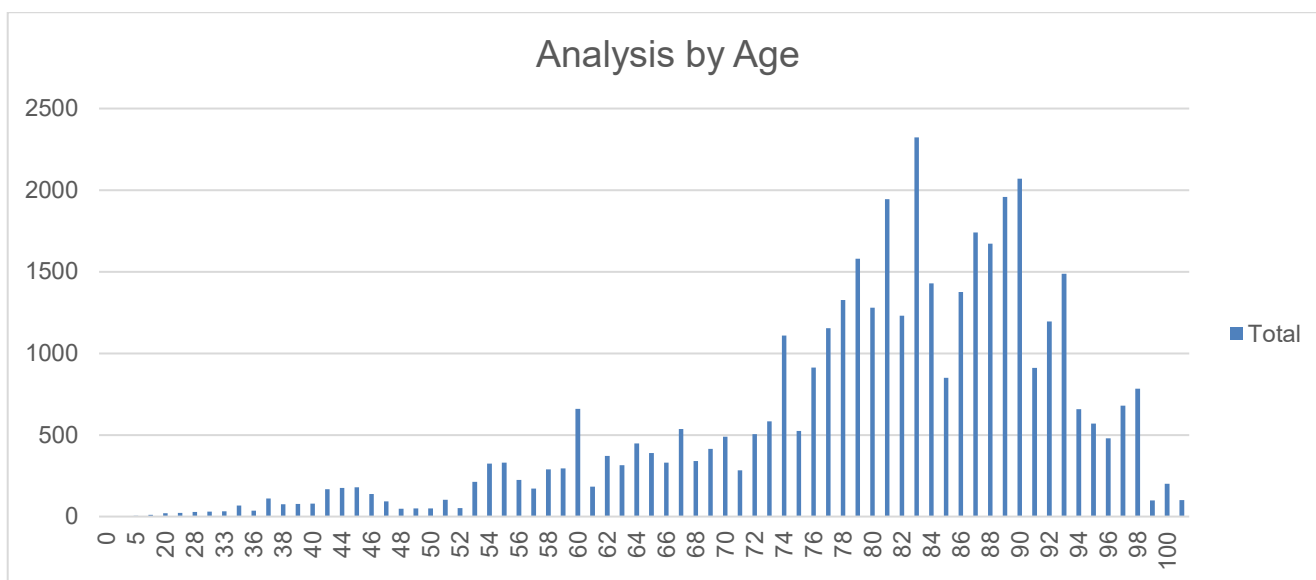
The data below shows the total number of deaths by gender during 1 October 2025 to 31 December 2025. There is very little variation between male and female deaths; 266 female deaths were reported. compared to 280 males.



Gender	Number of Deaths
Male	280
Female	266
Not Known	2
Grand Total	548

9.3. Analysis by Age Group

The youngest age was classed as zero (as we provide community paediatric services), and the oldest age was 101 years. Most deaths occurred within the 81 to 90 age groups:



9.4. 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 Learning Disabilities Mortality Review (LeDeR) programme that is led by the Integrated Care Board (ICB). 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.

	Oct	Nov	Dec
LD Deaths	1	1	5
Autism	0	0	0

Since 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, 16 patients have been referred.

During 1 October 2025 to 31 December 2025, the Trust has recorded seven LD deaths. The Trust now receives a quarterly update from LeDeR (Learning from Deaths and Lives – people with learning disability and autistic people) which highlights national good practice and identified learning; this is shared in the monthly Mortality meeting. Benchmarking will take place in relation to the use of Datix to manage the reporting requirements around Learning Disability deaths.

9.5. Analysis by Ethnicity

White British is the highest recorded ethnicity group with 424 recorded deaths; 23 deaths had no recorded ethnicity assigned. The following chart outlines all ethnicity groups:

Ethnicity	Count of Ethnicity
Asian or Asian British - Bangladeshi	1
Mixed - Any other mixed background	2
Mixed - White and Black Caribbean	3
Black or Black British – Caribbean	3
Black or Black British - Any other Black background	4
Asian or Asian British – Pakistani	5
Asian or Asian British – Indian	5
White – Irish	5
Not stated	8
White - Any other White background	14
Not Known	23
Other Ethnic Groups - Any other ethnic group	51
White – British	424
Grand Total	548

9.6. Analysis by Religion

Christianity is the highest recorded religion group with 225 recorded deaths, 157 patient deaths were recorded as having no religious affiliation. The chart below outlines all religion groups:

Religion	Number of Deaths
Catholic: non Roman Catholic	1
Baptist	1
Protestant	1
Methodist	2
Roman Catholic	2
Jehovah's Witness	2
Catholic religion	3
Religion not given - patient refused	4
Religion NOS	4
Sikh	4
Muslim	5
Christian religion	9
Church of England, follower of	10
Church of England	13
Patient religion unknown	31
(blank)	74
Not religious	157
Christian	225
Grand Total	548

9.7. Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 396 recorded deaths, 121 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Not stated (person asked but declined to provide a response about their sexual orientation)	1
Person asked and does not know or is not sure (about their sexual orientation)	1
Homosexual	1
Female homosexual	1
Homosexuality NOS	3
Sexual orientation unknown	11
Sexual orientation not given - patient refused	13
(Blank)	121
Heterosexual	396
Grand Total	548

9.8. Analysis by Disability

The table below details the top 10 categories by disability. Memory impairment was the highest recorded disability group with 88 recorded deaths. 133 deaths had no disability recorded:

Disability	Number of Deaths
Hearing disability	15
Disability Questionnaire - Mobility and Gross Motor	16
Disability Questionnaire - Progressive Conditions and Physical Health	23
Disability status not given - patient refused	25
Disability Questionnaire - Personal, Self Care and Continence	27
No current problems or disability	29
Patient reports no current disability	40
Gross motor disability	76
Memory impairment	88
(blank)	133
Grand Total	472

There have been 220 deaths with a disability assigned and the remainder were blank or had no assigned disability.

7. Closed Learning response outcomes for the period

Closed learning responses within the PSIRF are designed to move away from blaming individuals towards a systems-based approach, aiming to identify underlying causes and implement meaningful improvements. During the review period five learning responses were completed. Key themes include:

- **Risk Assessment and Management.** Risk not updated after deterioration; high-risk indicators underestimated; escalation to Mental Health Act Assessment (MHA) missed; rationales for decisions not recorded
- **Documentation Quality.** Records inconsistent/outdated; risk assessments not reviewed; long-unused care plans; incomplete safety plans; discharge letters missing key clinical information
- **Communication and Information Sharing.** Critical risk information not shared across teams; inconsistent liaison with Substance Misuse services; low carer involvement; external agencies not fully informed
- **Multidisciplinary Team (MDT) Working and Pathways.** Weak crisis MDT processes; inconsistent nursing input; unclear pathways for substance misuse and out-of-hours escalation; late/incomplete discharge planning
- **Medication and Physical Health.** Poor escalation of missed depots; limited coordination with primary care; inadequate physical health monitoring after incidents
- **Observations and Falls Management.** Falls assessments inconsistent; neuro observations not aligned with policy; lack of standard falls-prevention equipment
- **Carer Involvement.** Requests not acted upon; carers excluded from key decisions like observations and discharge planning
- **Crisis Response and Safety Planning.** High-risk cases not escalated; nighttime monitoring lacked rationale; follow-up after crisis deferred; safety plans not tailored to known behaviours
- **System-Level Issues.** Need for standard inpatient operational policies; weak out-of-hours escalation structure; poor documentation of decision rationale; some cases triggered DoC.

Strengths Identified

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

8. Moving Forward

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.

There is an improvement plan in place for January-August 2026 which incorporates the following improvement actions:

- 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 on 11 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 Trust-level that will oversee the learning across the organisation and support with triangulation. These Learning the Lessons Groups aim to be fully embedded by August 2026, with clear evidence of the dissemination of learning from patient safety incidents throughout the organisation through meeting minutes and newsletters, and of assurance being provided to board around how learning themes are being addressed in practice
- There is also a plan to train 50 more managers/clinicians to complete Patient Safety Incident Investigations
- The Trust is working with an external consultant to develop a series of e-learning and teaching session plans based on the PSIRF and Human Factors. This will support employees within the organisation to develop a greater knowledge and understanding of the organisation's incident review and learning processes at all levels
- In future reports, the deaths on protective characteristics will be reported based on population demographics/health inequalities once the data is available.