

Q4 2024/25 Quarterly Report on Learning from Deaths

Public Board

25th September 2025

Presented for:	Information and assurance
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Previous Committees:	Quality Assurance Committee, 21 st August 2025

2025/26 Commitments	Category	✓
Support our patients to get home a day sooner	Care	
Be in the top 25% trusts for patient experience and efficiency in outpatient	Quality	
Support each other to act with kindness and compassion	Team	
Recognise and act upon moments that matter to our patients	Compassion	✓
Support our staff to spend every pound wisely	Finance	
Make best use of our estate, equipment and digital assets	Resources	✓
Reduce our carbon footprint by creating greener patient pathways	Sustainability	

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk		Choose an item.	Choose an item	Choose an item.
Operational Risk		Choose an item.	Choose an item	Choose an item.
Clinical Risk		Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	Moving Towards
Financial Risk		Choose an item.	Choose an item	Choose an item.
External Risk		Choose an item.	Choose an item	Choose an item.

Key points	
1. This is the quarter four 2024/25 report on Learning from Deaths. The report is in accordance with the national guidance on learning from deaths, published March 2017.	Assurance
2. In quarter four 2024/25, four deaths were escalated through the 'potential patient safety incident' reporting processes.	Information

1. Summary

The purpose of this paper is to provide assurance that the Trust has appropriate processes in place to report on and review patient deaths and ensure that lessons are being learned and improvements outlined.

The latest Summary Hospital-level Mortality Indicator (SHMI) published in July 2025 for March 2024 – February 2025 is 1.1371 (decrease from 1.1428 in March 2025). The Hospital Standardised Mortality Ratios (HSMR) for May 2024 – March 2025 is 109.3 (reduced from 110.2). Both indices will continue to be monitored by the Mortality Improvement Group.

In Q4 2024/25, four deaths were escalated through the 'potential patient safety incident' reporting processes

2. Background

National Guidance was published by the National Quality Board in March 2017 entitled “A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care”; this guidance was presented to the Quality Assurance Committee in April 2017. In light of this guidance and the previous work of the Mortality Improvement Group, the Trust launched an updated Mortality Review Procedure in June 2017. This was reviewed in 2021 and an updated Mortality Review Policy was approved in January 2022 to include the role of the Medical Examiner, and a revised Structured Judgment Review management and monitoring process.

3. Review of national indicators

The July 2025 Summary Hospital-level Mortality Indicator (SHMI) publication for the 12-month rolling period March 2024 to February 2025 for the Leeds Teaching Hospitals NHS Trust (LTHT) was 1.1371, banded “as expected” and was a decrease from the SHMI published in March 2025 1.1428, which was banded “as expected”.

The SHMI has fallen back into line at Leeds General Infirmary (LGI) from “above expected” to “as expected” with this change occurring in the data set for June 2025. while remaining “as expected” for St James’ University Hospital (SJUH) site when broken down at site level (other sites do not have sufficient numbers of deaths to be included). All ten of the Diagnosis Group level SHMI were banded ‘as expected’ for this reporting period. The Mortality Improvement Group continues to monitor the Ten Diagnosis Group level SHMI.

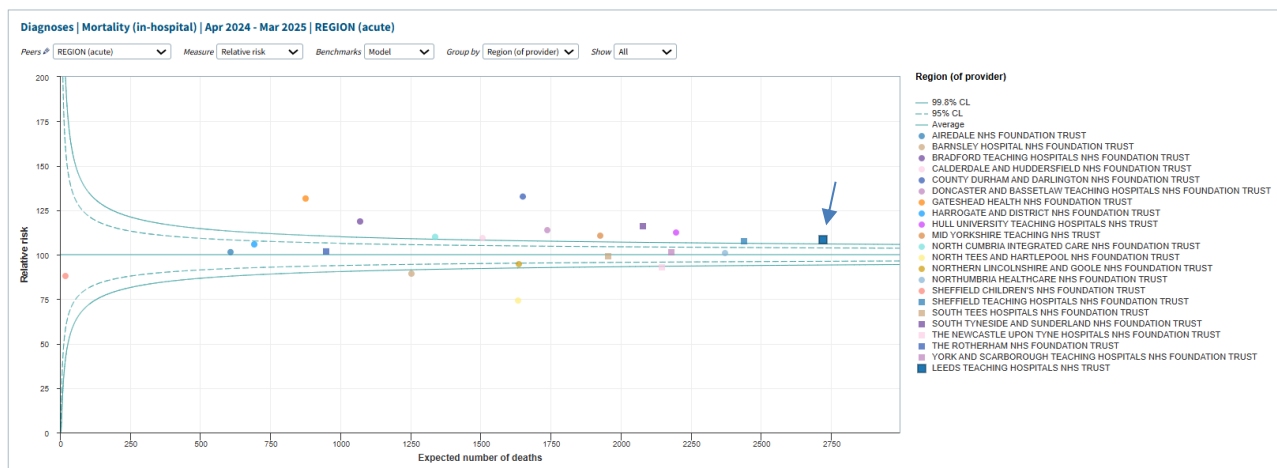
Table 1: National Mortality Indicators

	Figure (July-25 Publication)	Banding	Trend
SHMI	1.1371 (Mar 24 to Feb 25)	'As expected'	↓
HSMR+ (basket of 41 diagnoses)	109.3 (Mar 24 to Mar 25)	'As expected'	↓

We expect that LTHT would have a higher number of observed deaths than some other organisations due to being a tertiary centre and Major Trauma Centre (MTC). Expected deaths do not account for patient acuity and instead are based on diagnosis group, which may have an impact on having a lower expected rate despite treating particularly unwell patients. The Mortality Improvement Group continues to monitor the Trust's Mortality Indicators and will continue to undertake coding reviews alongside this process to ensure its quality and accuracy and the accuracy of our Mortality statistics. Structured Judgement Reviews (SJR) will also be requested and monitored through the new SJR storage system provide assurance that the care we are providing is safe and effective.

In November 2024, Telstra Health UK implemented several changes in its Dr Foster model, including updates to the diagnosis groups included in the HSMR cohort as well as changes to the factors contributing to the risk adjustment model. The Mortality Improvement Group continues to monitor the impact these changes have on the Trust's mortality metrics.

Figure 1.0 LTHT Dr Foster SMR vs. Peers (Apr 24 to Mar 25)



4. Update on Mortality Review Process

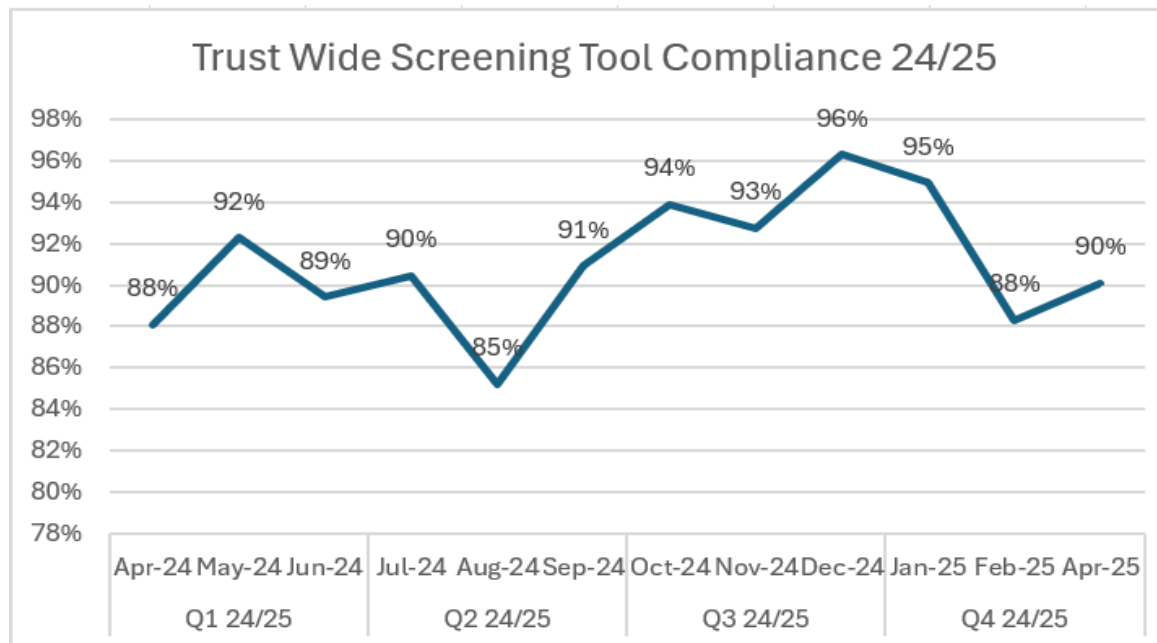
The National Guidance on Deaths in Care released in March 2017 requires that all Trusts collate and publish specified mortality information on a quarterly basis; within LTHT this included the screening of deaths process. The Trust Mortality Review Policy has been refreshed to outline a revised process for monitoring Mortality Reviews (namely Structured Judgment Reviews) to better enable themes of learning to be identified, and this was approved in January 2022. The Structured Judgment Review (SJR) allocation process is coordinated by the Quality Governance Team and also includes cases highlighted for SJR through the Medical Examiners (ME) office; this commenced in May 2022.

4.1 Number of Deaths Eligible for Screening and Compliance

Table 2: Number of Deaths Eligible for Screening as of 27 July 2025.

CSU	Number of Deaths Eligible for Screening	Number Screened	Number Triggered
	Q4 2024/25	Q4 2024/25	Q4 2024/25
Specialty & Integrated Medicine	275	240	18
Cardio-Respiratory	153	128	17
Oncology	75	68	14
Abdominal Medicine and Surgery	61	51	23
Centre for Neurosciences	68	59	10
Trauma and Related Services	40	26	13
Urgent Care	35	31	9
Head and Neck	5	3	1
Chapel Allerton Hospital	0	N/A	N/A
Women's	15	N/A	N/A

Figure 2.0: Trust wide Compliance with Mortality Screening Tool



Please note that there was a technical error with the mortality screening tool form in February 2025 which restricted the completion of the screening tool for a number of days. This was identified and resolved.

Figure 3.0: Percentage of Reviews Triggered from Screening process

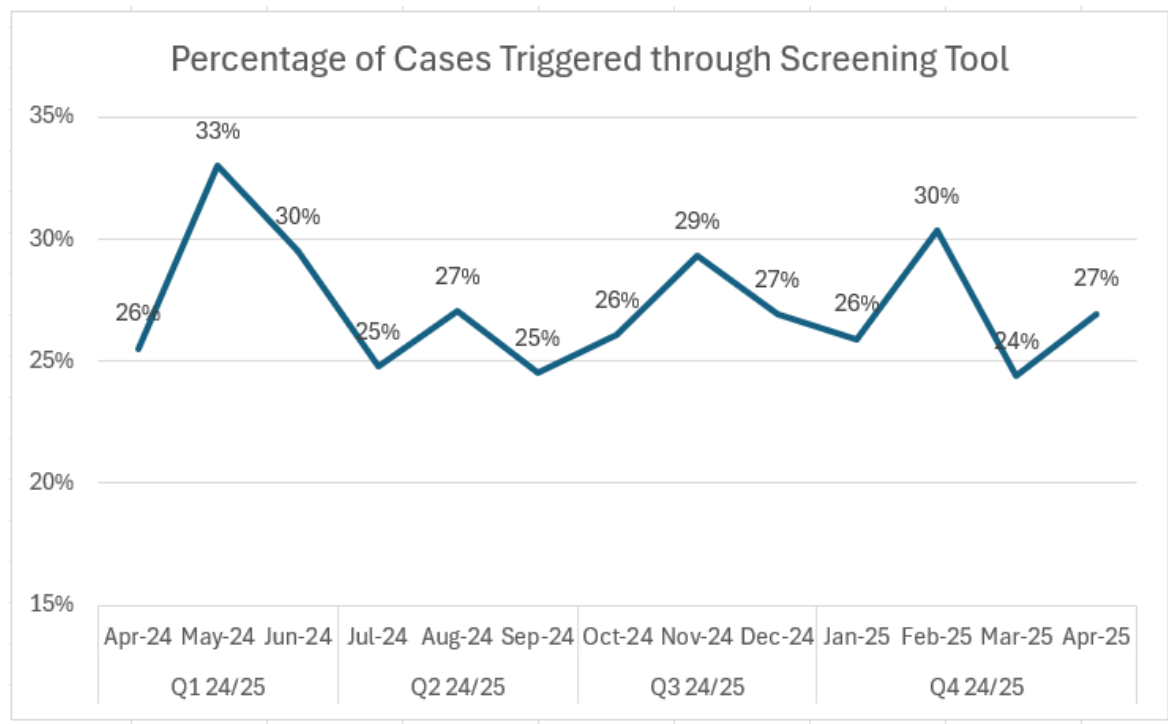
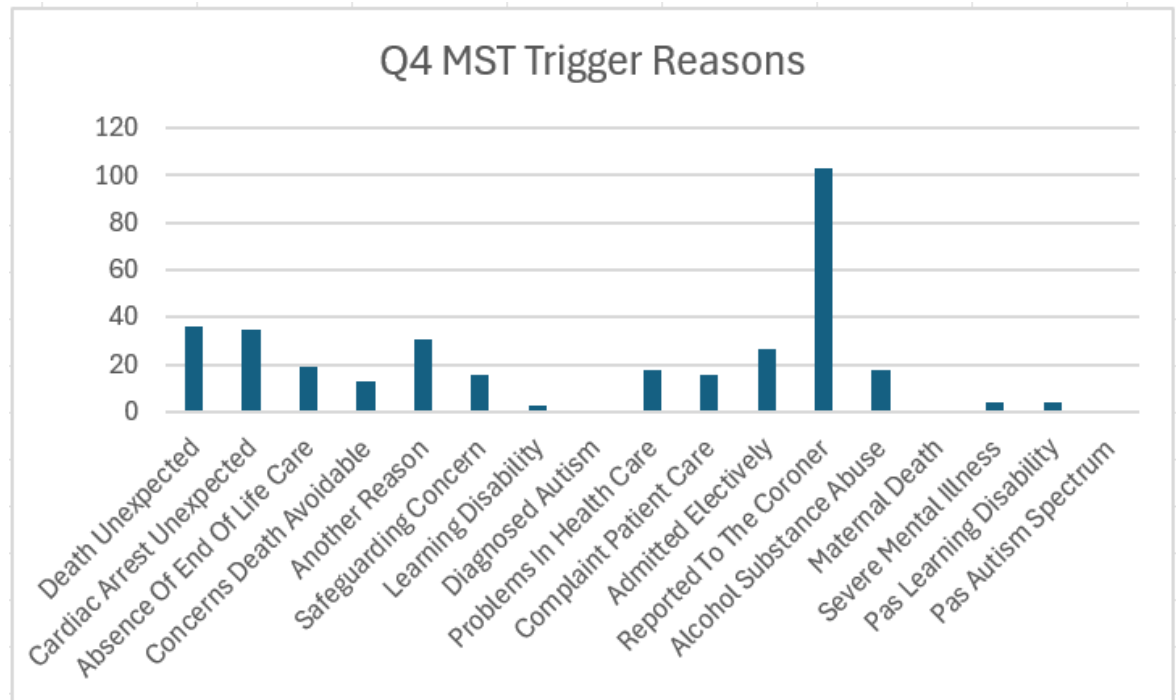


Figure 4.0: Mortality screening tool trigger reason



4.2 Completion of Clinical Reviews

The Quality Governance Team was notified of 124 mortality reviews were completed during Q4 2024/25. In Q3, 138 SJRs were completed on the online system. The team received a completed return form from most specialties with a caveat that Oncology was experiencing difficulties appointing a mortality lead and this would be addressed in the near future. Incomplete returns were received from Neurosciences, with only stroke medicine completing the return template in time and TRS with only Trauma and Orthopaedics returning the form

on time. No return was received from Head and Neck CSU. SIM and Cardiorespiratory both returned a complete number of requested reviews over Quarter 4.

All patient deaths are subject to alternative review methodology in the Leeds Children's Hospital, and the Major Trauma Centre. This approach has been agreed by the Mortality Improvement Group to account for the regulatory and service specific requirements in these areas.

5. Summary of Investigations and Learning following a patient death

The Trust is required to report quarterly on the number of deaths reviewed through the Patient Safety Incident Response Framework (PSIRF). These deaths are identified via the Trust's 'potential patient safety incident' reporting processes and are discussed at the Weekly Quality Meeting where a decision is made as to the type and level of review required. Incidents that are escalated are as defined within our Patient Safety Incident Response Plan 2024-26.

This report includes all information obtained from Datix in Quarter 4 2024-2025 from 01/01/2025 up to and including 31/03/2025.

During this period: Four deaths were escalated. Table 4 below provides details of these incidents, and the level of review recommended following discussion at the Weekly Quality Meeting. Two of the four deaths escalated were referred to the coroner.

Where reviews have concluded from previous reports, the outcome and learning are included below in Table 5.

Table 3 - Deaths escalated - Quarterly trend

Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2023/24	2023/24	2023/24	2023/23	2024/25	2024/25	2024/25	2024/25
1	4	4	0	0	5	7	4

Table 4 - Details of deaths identified via the incident escalation function - Quarter 2 2024/25

ID	Level of Review	Datix Category	PSIRP Priority (Local or National)	Description	Additional Information
615473	Structured Judgement Review (SJR)	Treatment/ Unexpected Cardiorespiratory arrest	National – Incidents meeting the “Learning from Deaths” criteria	Patient fall/collapse in SDEC SJUH whilst waiting to be admitted to an in-patient bed.	Referred to coroner and under further investigation. Review concluded (included in Table 5)

616020	Hospital Acquired Infection Review/After action review.	Infection/ E.coli (BSI) – hospital acquired	National – Maternity/Neonatal deaths	Extremely premature baby born at 23 weeks (at home). Breakdown of skin whilst in hospital.	Not referred to coroner. Review concluded (included in Table 5)
618446	Structured Judgement Review	Patient Care and Nutrition/ NG feed related issues	National - Incidents meeting the “Learning from Deaths” criteria	Patient aspirated following dislodged NG feeding tube.	Referred to coroner. Take through inquest now concluded. No concerns. Review concluded (included in Table 5)
619438	Hospital Acquired Infection Review – Post Infection Proforma (PIP)	Infection/ Pseudomonas (BSI) – hospital acquired	National – Maternity/Neonatal deaths	Extremely premature baby (23 weeks) with respiratory distress syndrome	Not referred to coroner. Review concluded (included in Table 5)

Findings and actions from Completed Reviews

Findings and actions from all Patient Safety Incident Investigations are discussed at various Quality meetings including the Trust Quality Governance Forum and Quality Assurance Committee.

Since July 2024 a Patient Safety Learning Hub has been developed. The meeting encourages representatives from all CSUs to attend to discuss how lessons learned from incidents, audits, safety alerts and other sources can be shared effectively across the Trust and in a manner where the learning can be retained.

The Trust has led on the establishment of a shared learning group involving WYATT Trusts. The purpose of this is to set up a network to discuss common challenges relating to quality and safety, focusing on sharing key learning points and themes arising from Patient Safety Incident Investigations and Never Events, reporting to the WYAAT Medical Directors group.

Key topics for sharing learning and ideas from across the West Yorkshire region on locally reported Patient Safety Incident Investigations and Never Events have been discussed, in addition to a review of regular incident reporting profiles.

An overview of completed learning review outcomes following the death of a patient are summarised in the table below. The table includes details of key findings, lessons learned, identified improvements and actions to address the care and service delivery issues identified.

Learning reviews are conducted in line with the Trust's Investigations Procedure with the focus being on learning to avoid reoccurrence of incidents.

Table 5 - Details of completed reviews.

Incident ID/PSIRF Priority	Summary of findings, areas for improvement and safety actions
<p>615473 – National – Incidents meeting the “Learning from Deaths” criteria</p>	<p>Summary of Incident</p> <p>Patient was moved from the Emergency Department (ED) at SJUH to Same Day Emergency Care (SDEC) due to full capacity plan being enacted. Patient had a sudden collapse whilst walking to the toilet. Medical staff were in attendance immediately and CPR commenced. The patient regained spontaneous breathing and was moved to resus where they deteriorated and passed away.</p> <p>Key Findings</p> <ul style="list-style-type: none"> • Patient had been admitted to hospital with 3 blackouts (transient loss of consciousness). The common reasons for this are faints, seizures and heart rhythm problems and a rarer cause would be blood clots on the lung (pulmonary embolism). • No concerns in relation to patient care and treatment were identified during review, however the patient experienced an extended wait in ED for a bed due to high levels of acuity of patients in the department. • The coroner reviewed this case and found that the patient passed away due to natural causes. No further concerns were raised.
<p>616020/615127 - National – Maternity/Neonatal deaths</p>	<p>Summary of Incident:</p> <p>An extremely preterm baby born at 23 weeks at home was admitted with no antenatal steroids and hypothermic on admission requiring CPR. Risk factors included, hypothermia, severe lung disease and GI dysmotility which meant the baby's muscles in the digestive tract were not working properly. Baby was intubated on admission, temperature remained unrecordable. Preparations were made to transfer to the neonatal unit in transport incubator.</p> <p>On day 4 of admission during assessment of the baby's skin, pressure damage was noted on back, skin broken and dark in areas. Input received from tissue viability team and wounds dressed. Fungal infection was present, and swab tests confirmed aspergillus falvus (scanty). Patient had acute onset deteriorations and blood cultures taken confirmed E.coli. Baby continued to deteriorate and passed away.</p> <p>Key Findings:</p> <ul style="list-style-type: none"> • Baby was nursed in humidity due to low temperature and Intraventricular haemorrhage (IVH) care bundle used as baby was unstable at times. Whilst baby was stable, they were nursed in both supine and midline positions.

	<ul style="list-style-type: none"> • Baby was wrapped in towel from home/own blankets on arrival which remained insitu for a short period of time. • Regular skin checks were undertaken (routine practice is every 12hrs). There was a 2-day gap of skin checks after which the skin damage was identified. The gap was due to fragility of the baby. • Baby was nursed on silk sheets which are used for extreme preterm babies as felt to be softer. Silk sheets were bought from Amazon, and it is unclear of the washing process prior to use. Boundary underneath the silk sheet was found to be wet and blood stained (? high urine out-put). It is unclear if the wetness of silk sheet had an impact on the skin. • Wounds were dressed and there was regular input from the tissue viability team. • Long line insertion was attempted but failed on 2 occasions due to baby's fragility. Long line insertion was successful on the 3rd attempt. • The sides of the incubator were left down instead of using the ports to attempt line insertion for feeds. The use of ports is important to maintain a baby's temperature. • E-coli was documented as a contributory factor on line 1a of the death certificate with extreme prematurity recorded as 1b. • The use of humidification (usual and correct practice) would likely have worsened the environment for the wound but remains an important part of the overall thermoregulation in such a preterm baby. • The health care acquired E.coli infection was thought to be due to gut translocation. Stopping and starting of feeds may have contributed, however it is normal practice to stop feeds in relation to a high lactate and bloods in stools. <p>Recommendations/Actions</p> <ul style="list-style-type: none"> • Reduced movement of babies to be discussed with the nurse in charge. • Discuss with other neonatal units what sheets are appropriate to use for extreme premature babies. • Neonatal staff to attend tissue viability study day to understand appropriate wound dressing techniques in premature babies. • Use of patient/families own blankets within the neonatal unit is going to be explored in reference to extremely premature babies.
<p>618446 - National - Incidents meeting the "Learning from Deaths" criteria</p>	<p>Summary of Incident:</p> <p>Patient admitted with general decline after 2 falls in the preceding 5 days. They had poor oral intake, increased confusion, and aggression. Patient had a past medical history of dementia. There was reduced urine output and abdominal discomfort.</p> <p>On review in the emergency department (ED), the patient was tender across chest and abdomen with bruising. Trauma CT undertaken with left lateral 9th rib with small pleural effusion, small hiatus hernia and fluid filled oesophagus. The patient remained agitated throughout stay in ED.</p> <p>Patient was admitted with significant hyperactive delirium and 1:1 supervision recommended but insufficient staffing levels meant this could not be provided. DoLs in place and regular psychiatry input. There was</p>

	<p>recognition of poor oral intake (holding food in mouth). NG tube (NGT) was discussed, and decision made for trial of NG feeding. Although NGT was well tolerated, multiple issues obtaining aspirate/pH too high resulted in patient having 6 chest x-rays to check position over a 6-day period. The first x-ray which showed the tube had displaced to lung but was appropriately re-sited.</p> <p>Following numerous episodes of sickness, the patient aspirated whilst being NG tube fed. X-ray undertaken following aspiration showed the tip of the NG tube had looped back into the patient's oesophagus. X-ray from the previous day had shown the NG tube was positioned satisfactorily. The patient vomited whilst the NG feed was infusing.</p> <p>Patient became acutely unwell and passed away.</p> <p>Key Findings:</p> <ul style="list-style-type: none"> • Upon initial vomiting episode the doctor was informed, but no face-to-face review was undertaken. Doctor advised to continue with the feed (tube length stable and pH with satisfactory limits so safe to use NGT at this time). • Ward round the next day showed low grade fever with plan for bloods, urine culture and continued feed. • Patient vomited on a further 2 occasions. NG feed appropriately stopped immediately. There was a delay in escalating the vomiting episodes to the doctors. • Dietitian advised to reduce feed rate, start antiemetics and restart feed. • Later the same day the patient became acutely unwell with further vomiting. Chest x-ray showed the NGT had looped into the oesophagus. • There was prompt recognition of deterioration and end of life care started. The family were kept well informed throughout. • Difficult to say when the NG tube became dislodged but there was evidence that pH was safe to use. • Multiple examples throughout of appropriate NG tube placement being checked. <p>Recommendations/Actions</p> <ul style="list-style-type: none"> • This case highlights the serious risks involved with NG tubes. • If recurring vomiting whilst NG feed is running, patients need face to face medical review and check NGT position (escalate to SpR/Consultant as appropriate).
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<p>619438 – National – Maternity/Neonatal deaths</p>	<p>Summary of Incident</p> <p>Twin baby born extremely prematurely (23 weeks) with a difficult birth with bruising and loop of cord around neck. Baby was ventilated from birth. On the day of deterioration there had been a deterioration in symptoms which felt to be respiratory/mechanical in nature. Baby tested positive for gram negative bacteraemia (<i>Pseudomonas</i>) the same day that they sadly deteriorated and passed away.</p> <p>Key Findings</p> <ul style="list-style-type: none"> • Care was appropriate in extremely premature baby with very low birth weight (595 grams) • Following difficult intubation baby did not consistently maintain spontaneous breathing above the backup rate. • Metabolic acidosis showed partial improvement with correction of bicarbonate and patient was rescreened. Infection markers were raised and therefore baby was started on a 5-day course of antibiotics. • A bilateral intraventricular haemorrhage (IVH) was diagnosed, and a repeat cranial ultrasound showed this had progressed. • Despite extensive neonatal intensive care baby's oxygen levels did not improve. • It was felt that primary cause of death was likely due respiratory/mechanical in origin and that the infection was not primary cause of death, however, may have contributed.
<p>Completed reviews from previous reports</p>	
<p>604868 – PSII 2024/8762 – National – Incidents meeting the “learning from deaths” criteria.</p>	<p>Summary of Incident</p> <p>Patient presented to Emergency General Surgery Ambulatory clinic after being referred by their GP with “right upper quadrant pain ” and “eyes have gone yellow.”</p> <p>Patient was seen in Emergency General Surgery (EGS) by a consultant who identified that they had a history of abdominal aortic aneurysm, hypertension (high blood pressure) and high cholesterol. Patient reported feeling unwell for three weeks, with nausea, dark urine, itching and pain in the right upper quadrant of their abdomen. Patient was deeply jaundiced and had experienced rapid weight loss over the last two weeks. An ultrasound had not identified any new conditions, but the liver was possibly enlarged on examination. The consultant was not initially convinced the problem was gallstone related and wanted to rule out other concerning conditions. An urgent MRI was requested, with a plan for the EGS team to review after this was completed.</p> <p>The MRI was completed the next day and showed a lesion in the pancreas with associated mild bile duct dilatation. Possible diagnoses included pancreatic cancer or inflammation (pancreatitis). A further CT scan of the pancreas was recommended and a referral to the pancreatic multidisciplinary team was made. The patient's case was discussed the following week.</p> <p>The Pancreatic MDT determined that the patient required an urgent procedure to drain the bile and a further CT scan. Patient was referred to the EGS team and admitted. Unfortunately, they were not able to have the</p>

	<p>required procedure, due to a new clotting issue which meant the risk of bleeding was too high. Patient had a CT scan, and an ultrasound guided drain inserted. Unfortunately, the drain fell out the following day. Patient became more unwell and suffered a cardiac arrest and passed away.</p> <p>Summary of key findings</p> <ul style="list-style-type: none"> • There was not an agreed management pathway in LTHT for patients presenting with obstructive jaundice due to probable malignancy (cancer). • There was a lack of clarity regarding the responsibility and role of the pancreatic MDT for further management of patients after referral. • There was not an agreed and formal referral pathway to the Pancreatic Surgical team for advice from EGS. • There was a possible earlier opportunity to involve the renal team (kidney specialists) when the patient was admitted. <p>Recommendations/Actions</p> <ul style="list-style-type: none"> • An agreed pathway to be developed jointly and published by the EGS and Pancreas teams for management of patients with Obstructive Jaundice due to likely malignancy. This should include an agreed escalation plan to the pancreas team if specialist guidance and advice is needed by the EGS team. • The role of the pancreas MDT needs to be clarified, including when they will take over the care of patients. <p>Coroner referral outcome – awaiting date for Inquest</p>
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6. Lessons Learned

Identification of good practice and areas for improvement in care following a patient's deaths are an integral element of the mortality process within LTHT; this is inclusive of potentially avoidable deaths and learning identified following an investigation, as well as learning outlined following SJR.

6.1 Lessons highlighted by the CSUs

Table 6: Trends in Relation to Good Practice



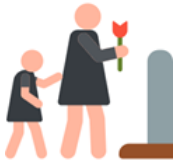
Communication & Collaboration

Good multi-disciplinary team approach was a frequent theme highlighted, as was good communication and engagement with families and patients.



Clinical Management

Themes of good practice in clinical management were identified including early recognition, prompt advice from other specialties, assessments, and early senior review.



Early Recognition and End of Life Care

Multiple specialties continue to highlight good practices relating to end of life care including early recognition of a dying patient, involvement of the palliative care team, exploring patients' wishes and providing good bereavement support and compassionate care to families and patients.

Table 7: Trends in relation to areas for improvement



ED wait times

Few specialties highlighted issues in relation to long wait in ED including delays in assessment, treatment and transfer to a ward.



Discussions related to interventions

Several specialties highlighted cases where more in depth discussion of surgical and non-surgical procedures with patients and/or families could have been considered. Of note were cases of aspiration or obstruction requiring intubation.



Unnecessary Patient Movements

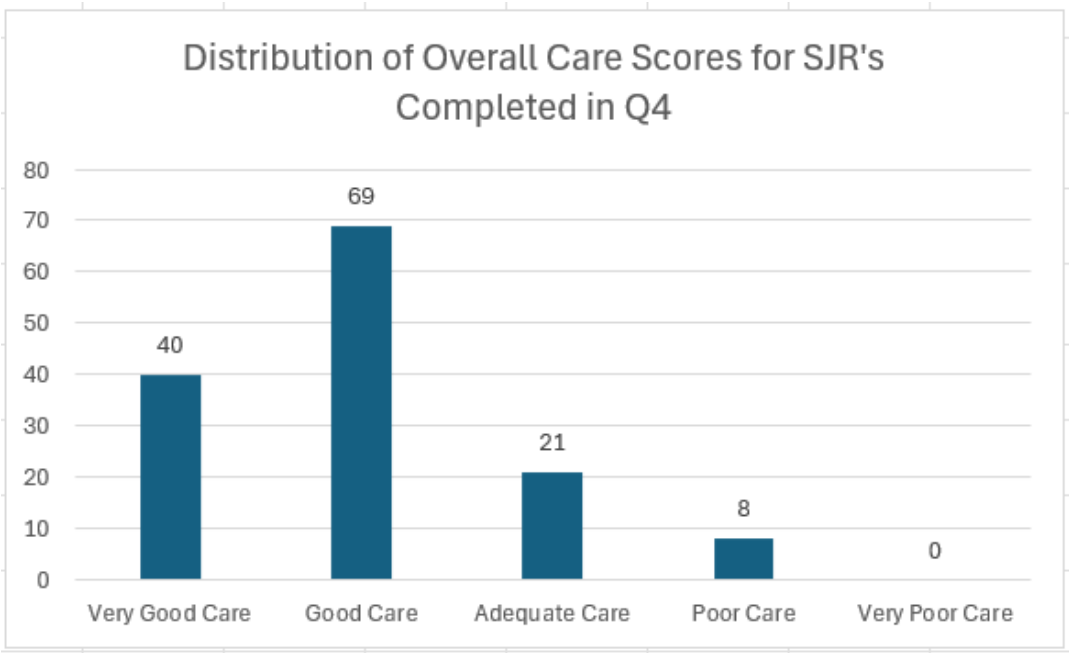
Specialties highlighted the often inappropriate and significant bed waiting times as well as patients being moved unnecessarily leading to detrimental impact on the care received.

6.2 Themes from SJRs

In Q4 24/25, 138 SJRs were completed on the online SJR system. In eight reviews the overall score given by the initial reviewer was 2 (poor care). Learning was identified in relation to:

- Monitoring patients after sedation.
- Ensuring patients receive consultant reviews after long stays in ED
- Ensure bloods are carried out before discharge in patients presenting with cellulitis and confusion.
- Ensuring patients receive adequate IV fluids whilst waiting long periods in ED.
- Ensuring patients do not have long periods of waiting in ED.
- Prompt reviews and diagnosis in patients with temperature or diagnostic spikes.
- Ensure patients are monitored correctly whilst in ED with proper documentation in place.
- On going issues with lumbar and external ventricular drains in patients in department remain high with ventriculitis being a highly morbid condition.

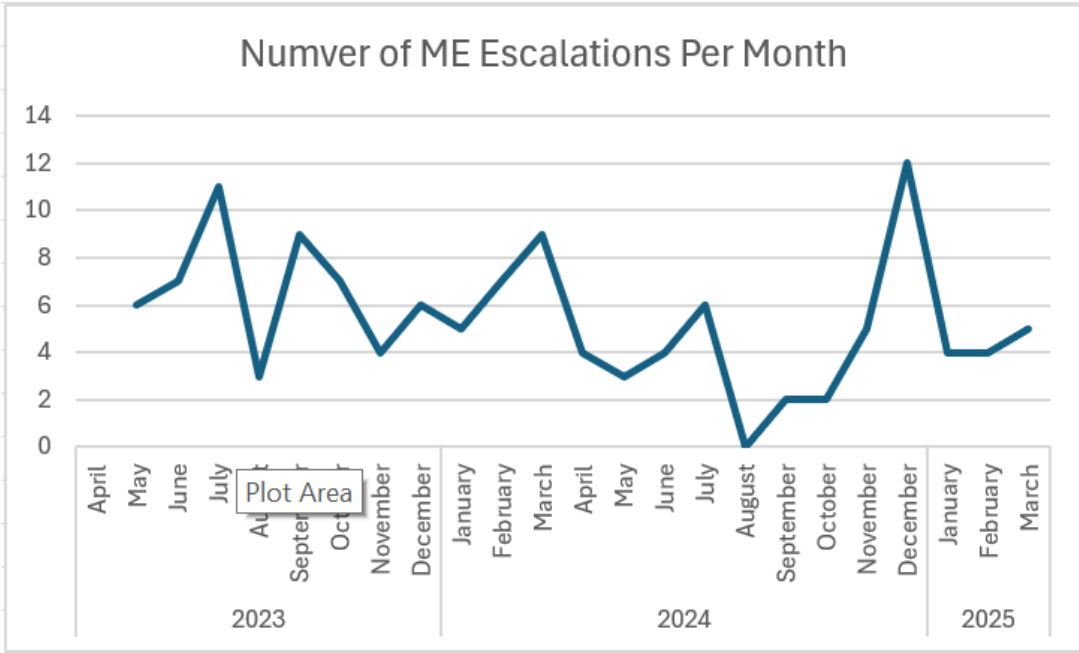
Figure 5 Distribution of Overall care scores for SJRs completed in Q3 24/25



6.3 Themes from escalations from the Medical Examiner service

In Quarter 4 2024/25 13 cases were escalated by the Medical Examiner service for review, one of which related to a death in the community. No common themes were identified.

Figure 6 Number of ME escalations per month



7 Mortality Outlier alerts

Mortality outlier alerts are reviewed and monitored at the Trust's Mortality Improvement Group (MIG), chaired by the Associate Medical Director (Risk Management). The MIG reports into the Clinical Effectiveness and Outcomes Group, and any safety items for escalation would be discussed at the Quality and Safety Assurance Group. There are currently no open Mortality Outlier Alerts.

8 Mortality Work Program

In Quarter 4, the mortality presentations covered mortality in patients admitted learning disabilities as well as the mortality indicators review, Coding KPI updates for Q3 and the update to the terms of reference and workplan for the Mortality Improvement Group as well as an update from Neonates and Cardiac and Circulatory Congenital Anomalies.

8.1 Neonatal Death Data

The team had conducted a review of data in relation to an increased neonatal mortality rate. They had explored with the perinatal leadership fellow management of IUGR infants. The neonate team stipulated that in addition to review of internal deaths they also review cases of death where infants are transferred to other hospitals or hospices to die with 1 grade of care being rated as C and another as D out of 78 reviewed cases.

8.2 Cardiac and Circulatory Congenital Anomalies

Data presented from Dr Foster suggested that LTHT had a higher relative risk status than comparable trusts, but when presented alongside peers, peer data showed they had fewer deaths than those at LTHT, leading to a higher-than-expected risk.

Data further suggested that there had been an increase in admissions over the time that risk had also increased, thus leading to a statistically significant increase in risk as admissions increase. Admissions comprised mostly of elective surgery, and patients largely had complaints regarding malformation of cardiac septa and malformation of aortic and mitral valves.

SJR structure in Cardiac surgery was good, with only 5 cases identified where issues could have been mitigated. All deaths were discussed in monthly governance with attendance from the neonatal team for deaths in babies with heart disease.

In Q1 2025/26 specialty presentations will cover mortality in patients with learning disability and autism, as well as presentations Vascular Surgery as well as updates from the Neonatal team. The Coding team and Quality Governance Analyst continue to work with specialties to monitor and review mortality indicators and coding data as required.

9 Financial Implications

There are no financial implications with this report.

10 Risk

The Quality Assurance Committee provides assurance oversight of the Trust's most significant risks, which cover the Level 1 risk categories (see summary on front sheet).

Following discussion at the Quality Assurance Committee meeting there were no material changes to the risk appetite statements related to the Level 2 risk categories and the Trust continues to operate within the risk appetite for the Level 1 risk categories set by the Board.

11 Communication and Involvement

The Mortality Improvement Group works in collaboration with the Clinical Service Units Mortality Leads, Corporate Services and Medical Examiner. There is senior medical management oversight of learning from deaths activities by the Associate Medical Director (Risk Management). This work is monitored by the Quality and Safety Assurance Group.

12 Equality Analysis

The Mortality Review Policy – Learning from Deaths supports a comprehensive approach to ensuring safe and effective patient care has taken place through a robust mortality review process; particularly in relation to patients with a Learning Disability or Autism

13 Publication Under Freedom of Information Act

This paper is exempt from publication under Section 22 of the Freedom of Information Act 2000, as it contains information which is in draft format and may not reflect the organisation's final decision.

14 Recommendation

The Quality Assurance Group are asked to note the Quarter 4 2024/25 report on Learning from Deaths.

15 Supporting Information

Not applicable.

Simon Brookes
Quality Governance Analyst (Mortality)
July 2025