

Learning from Deaths Report Q3 2025/26

Public Board

30 July 2026

Presented for:	Assurance
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Previous Committees:	Mortality Improvement Group 12 May 2026 Quality Assurance Committee 18 June 2026

Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Quality of care
Link to CQC Well-led Statement	Learning, Improvement and Innovation
Regulatory Impact	Regulation 12: Safe care and treatment

Key points	Purpose
1. This report provides an update on Quarter 3 Learning from Deaths activity, including Structured Judgement Reviews, mortality screening, Medical Examiner escalations, mortality indicators and learning from specialist review processes.	Assurance
2. A total of 175 Structured Judgement Reviews were recorded in Quarter 3 2025/26, with the majority of reviews reflecting good or excellent care. Nine reviews recorded an overall care score of 2. Full detail is contained within the report.	Information
3. Key learning themes relate to recognition and escalation of deterioration, documentation and handover, diagnostic delay, clinical monitoring, care coordination and adherence to specialist guidance.	Information
4. Following the internal audit of the Mortality Framework, an improvement plan is in place to strengthen the quality, consistency and assurance of Structured Judgement Reviews, including use of the SJR tool, action tracking, reviewer training and quality assurance processes.	Assurance
5. Public Board is asked to receive the report and take assurance from the Learning from Deaths activity undertaken during Quarter 3 2025/26, including mortality screening, Structured Judgement Reviews, Medical Examiner escalations and specialist mortality review processes. The Board are also asked to note the key learning themes identified and the improvement actions being taken through the Mortality Framework	To note

Improvement Plan to strengthen the quality, consistency and assurance of the review process.	
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<u>Risk Appetite Framework</u>			
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	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Moving Towards

1. Summary

This report provides an update on Learning from Deaths activity during Quarter 3 2025/26, including Structured Judgement Review (SJR) outcomes, mortality screening, Medical Examiner escalations, mortality indicators, and learning identified through specialist mortality review processes.

During Quarter 3 2025/26, 175 SJRs were completed. The majority identified care as good or excellent, with 71 cases scoring overall care as good and 62 as excellent. Nine cases recorded an overall care score of 2. Themes identified from these cases included recognition and escalation of deterioration, documentation, diagnostic delay, clinical monitoring, and adherence to specialist guidance.

The report provides assurance that learning from adult, paediatric, Emergency Department, Critical Care and Major Trauma mortality review processes is being identified, shared and acted upon through established governance arrangements.

Actions arising from mortality reviews include strengthened communication with clinical teams, reinforcement of documentation and escalation expectations, specialty-specific learning through mortality and morbidity meetings, and ongoing monitoring of improvement actions through clinical governance processes.

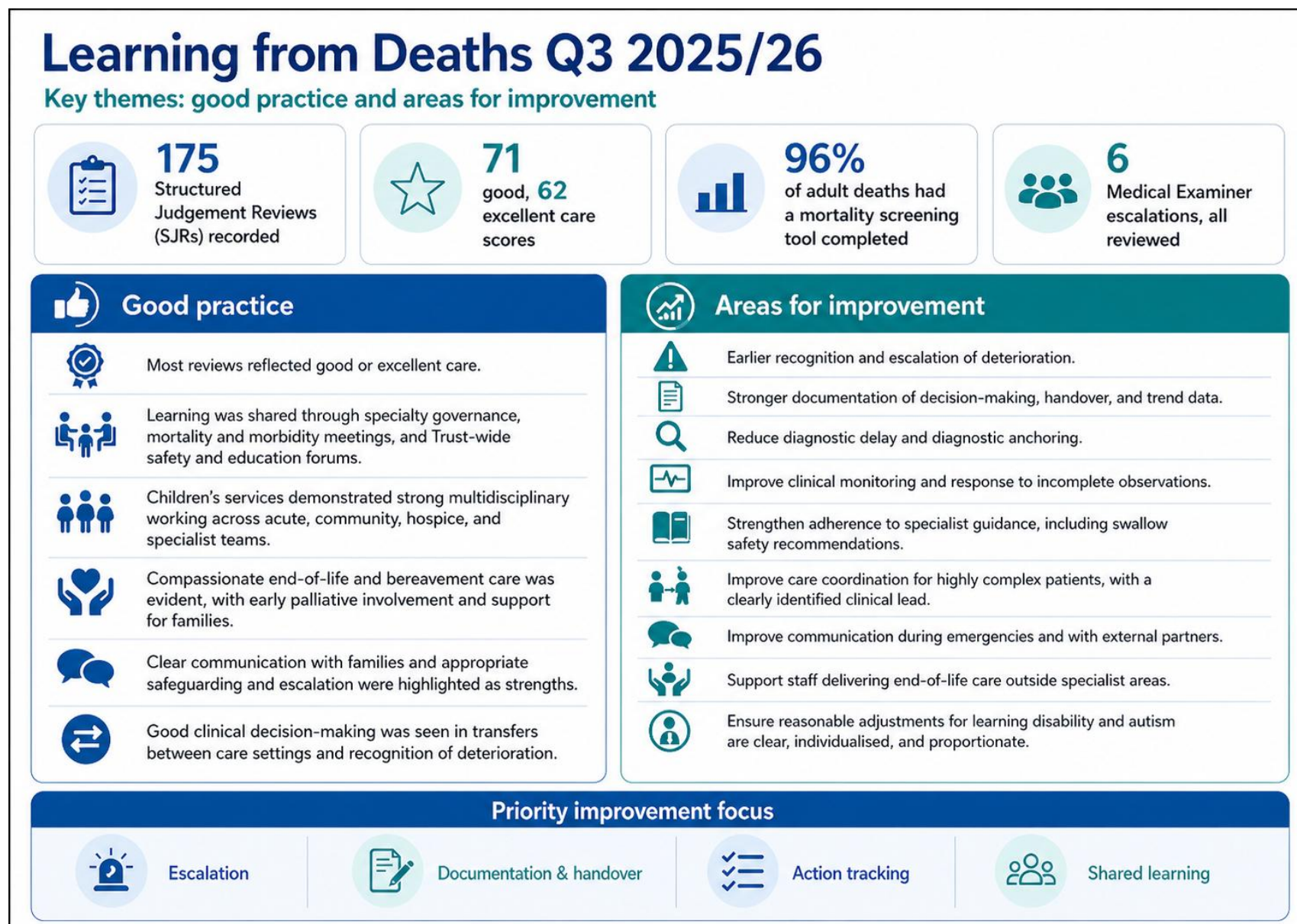


Figure 1 Learning from deaths Quarter 3 2025/26 infographic

2. Learning from Deaths

The NHS Learning from Deaths programme requires trusts to review deaths systematically, identify learning and improvement actions, and provide Board-level assurance that care quality and patient safety are continually improving. Learning from Deaths is central to national patient safety policy and the Care Quality Commission's assessment of organisational leadership and safety culture.

This report outlines the Trust's Learning from Deaths activity for Quarter 3 2025/26, including Structured Judgement Review outcomes, thematic learning, and actions taken. It provides assurance that deaths have been reviewed proportionately, learning has been identified and shared, and improvement actions are being tracked through established governance arrangements.

A total of 175 Structured Judgement Reviews (SJRs) were recorded in Quarter 3. Thirteen patients were subject to more than one SJR linked to their NHS number (no patient had more than two) which demonstrates good practice.

Table 1: Structured Judgement Reviews in Q3 2025/26 by specialty

Acute Medicine	8
Cardiac Surgery	2
Cardiology	15
Clinical Haematology	18
Clinical Oncology	6
Colorectal Surgery	7
Diabetes	2
Elderly Medicine	12
Emergency General Surgery	5
Emergency Medicine (A&E)	12
Endocrinology	2
Ear Nose and Throat (ENT)	3
Gastroenterology	3
General Medicine	9
Hepatobiliary Surgery	2
Hepatology	14
Infection and Travel Medicine	2
Neurology	2
Neurosurgery	4
Orthopaedic Trauma	8
Pancreatic Surgery	1
Renal Services (Adult)	2
Respiratory Medicine	15
Spinal Surgery	1
Stroke Services	10
Surgical Gynaecological Oncology	1
Thoracic Surgery	3
Transplantation Surgery	4
Upper GI Surgery	2

Table 2: Structured Judgement Reviews in Q3 2025/26 by overall care score

Overall Care Score 1	0
Overall Care Score 2	9
Overall Care Score 3	33
Overall Care Score 4	71
Overall Care Score 5	62

Of the 9 SJRs completed with an overall care score of two, there were 8 patients (with one patient having had two reviews recorded on the system; both with a care score of 2). All patients were recorded as Non-Elective admissions. A full overview of each case is included in Table 3.

Section 2 - Table 3: Structured Judgement Reviews in Q3 2025/26 with an overall care score of 2 recorded

This table has been redacted from submission to Public Board to ensure anonymity to patients and their families. Full detail has been received and considered at the Quality Assurance Committee.

Findings and actions from the review of deaths in Table 3

Review of individual cases identified recurring themes relating to delayed recognition and escalation of deterioration, documentation gaps, diagnostic delay, and adherence to swallow safety recommendations. These themes were observed across multiple specialties and care settings, suggesting opportunities for system-wide learning rather than isolated clinical issues. In a number of cases, earlier senior clinical review, clearer documentation of decision-making, and more timely investigation may have supported alternative clinical management or end-of-life care pathways.

Improvement actions have focused on strengthening escalation processes, reinforcing expectations regarding documentation and handover, reducing the risk of diagnostic anchoring, and improving compliance with specialist guidance. Learning has been disseminated through specialty governance processes, mortality and morbidity meetings, and Trust-wide safety forums, with implementation and impact monitored through established clinical governance arrangements.

Section 2 - Table 4: Structured Judgement Reviews in Q3 2025/26 with an overall care score of 3 recorded who also had a datix completed within Q3 2025/26

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There were 33 Structured Judgement Review records completed within Q3 2025/26 that received an overall care score of '3'. Of the patients assessed within those 33 reviews, eight patients also had incidents reported to datix within the same quarter.

Section 2 - Table 5: Problems in care leading to harm – as % of total SJRs

Type 1: Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)	15 (8.6% of SJRs)
Did the problem lead to harm? (Probably / Yes)	10 (5.7% of SJRs)
Type 2: Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic)	7 (4% of SJRs)
Did the problem lead to harm? (Probably / Yes)	4 (2.3% of SJRs)
Type 3: Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)	9 (19.4% of SJRs)
Did the problem lead to harm? (Probably / Yes)	7 (4% of SJRs)
Type 4: Problem with infection management	3 (1.7% of SJRs)
Did the problem lead to harm? (Probably / Yes)	3 (1.7% of SJRs)
Type 5: Problem related to operation / invasive procedure (other than infection control)	4 (2.3% of SJRs)
Did the problem lead to harm? (Probably / Yes)	3 (1.7% of SJRs)

Type 6: Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)	12 (14.6% of SJRs)
Did the problem lead to harm? (Probably / Yes)	8 (4.6% of SJRs)
Type 7: Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))	5 (2.8% of SJRs)
Did the problem lead to harm? (Probably / Yes)	1 (0.5% of SJRs)
Type 8: Problem of any other type not fitting the categories above	4 (2.3% of SJRs)
Did the problem lead to harm? (Probably / Yes)	1 (0.5% of SJRs)

3. Learning from specialist areas

3.1 Children's Hospital

Section 3.1 - Table 6: Children's Hospital deaths by specialty and number of reviews completed.

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During Quarter 3, a total of 20 patient deaths were recorded across paediatric, neonatal, and critical care services. The majority of deaths were anticipated, with extensive multidisciplinary involvement, timely recognition of deterioration, and strong alignment with best practice for end-of-life care. Child death reviews were completed in line with policy, with no widespread systemic failings identified. Learning was primarily focused on process improvement, communication, documentation, and coordination of complex care, rather than clinical errors.

Section 3.1 - Table 7: Key Themes of Good Practice Children's Hospital	
Across services, the following strengths were consistently identified:	
High-quality multidisciplinary working	Strong collaboration between acute, community, hospice, and specialist teams (including PICU, neonatology, oncology, cardiology, surgery, safeguarding, learning disability and autism services).
Compassionate end-of-life and bereavement care	Early palliative involvement, sensitive withdrawal of care, use of hospices, support from Family Care Nurses, bereavement services, and respectful consideration of cultural and family wishes.
Effective communication with families	Clear, honest discussions regarding ceilings of care, consistent updates, use of interpreters, and continuity of communication across teams.
Appropriate escalation and safeguarding	Timely involvement of safeguarding, SUDIC processes, police liaison, and external agencies where required.
Good clinical decision-making	Appropriate transfers between care settings, recognition of deterioration, and adherence to best practice frameworks for critically unwell children and neonates.

Section 3.1 - Table 8: Themes for Learning and Improvement Children's Hospital	
While no single recurring clinical safety theme was identified, several cross-cutting learning themes emerged:	
Care coordination for highly complex patients	Complexity increased when care spanned multiple sites, services, or agencies. In some cases, the absence of a clearly identified lead consultant or coordinating team contributed to fragmented oversight. Earlier identification of a single clinical lead and structured multidisciplinary oversight is essential for complex, long running cases.
Documentation and information continuity	Inconsistent documentation within electronic records (including MDT decisions and timelines) made retrospective review difficult. Handover periods were identified as times of increased risk when deterioration occurred. Critical decisions, trend data, and ceilings of care must be clearly documented and visible across teams to support continuity and safety.
Communication during emergencies and with external partners	Challenges were noted in emergency communication where English was not the family's first language. Delays or ambiguity occurred when external agencies (e.g. police, ambulance services, walk in centres) were not fully aligned with specialist pathways for complex children. Clear escalation routes and early specialist engagement are vital, particularly for medically complex children and during emergency presentations.
Supporting staff delivering end-of-life care outside specialist areas	General wards that infrequently experience deaths required additional support. Staff exposure to prolonged distress, verbal abuse, or challenging interactions was noted in some cases. Teams outside specialist palliative settings benefit from proactive support, escalation pathways for staff safety, and timely specialist input.
Learning disability, autism, and reasonable adjustments	Extensive adaptations improved engagement and safety in some cases, while in others overly complex adaptations risked delaying essential treatment. Reasonable adjustments must be individualised, clearly documented, and balanced with the need to deliver timely, evidence based care.

Section 3.1 - Table 9: Actions Taken and Ongoing Work Children's Hospital	
Actions identified during reviews have been specific, proportionate, and focused on system improvement, including:	
Strengthening care coordination	Proposal escalated for a complex paediatric care coordination model or identified clinical lead for highly complex cases.
Improving documentation and handover	Reinforcement of MDT documentation standards. Emphasis on escalation during handover when deterioration occurs. Digital review requested to address issues with electronic record chronology and visibility.
Enhancing emergency and external communication	Engagement with ambulance services regarding communication with non English speaking families. Reminder to walk in centres and primary care to liaise with specialist teams (PCAL) prior to referring medically complex children.
Clinical process improvements	Education on recognition of empty inhalers in acute asthma. Clarification and dissemination of PICU consent and testing processes (completed). Review of radiology and police sampling escalation processes.
Learning disability and autism support	Mandatory Oliver McGowan training. Development and rollout of organisational pathways, reasonable adjustment alerts, and staff education sessions.
Staff support and safety	Review of trust processes for managing abusive or threatening behaviours from families. Continued palliative care support for general wards delivering end of life care.

Assurance and Embedding Learning

- Identified learning has been shared through governance and education forums at specialty and trust level.
- Actions are tracked through established clinical governance processes.

3.2 Emergency Department

Learning from Emergency Department deaths contributes to the Trust's Learning from Deaths programme by identifying themes relating to diagnosis, escalation, and timely treatment that may have wider organisational relevance.

The Emergency Department reviews all deaths for consideration of a Structured Judgement Review (SJR). Many patients are managed under shared-care arrangements or present with conditions arising in the community rather than as a consequence of care provided within the Emergency Department.

Between October and December 2025, 72 deaths were recorded across the Emergency Departments at LGI and SJUH, with eight cases undergoing SJR. Findings were reviewed through the January Mortality and Morbidity Meeting, with learning focused on communication and clinical awareness.

Key learning included:

- Raising awareness of the early signs and symptoms of viral encephalitis, including new confusion and sleep disturbance, which may be subtle but warrant consideration of this serious diagnosis.
- Reinforcing the "Think Aorta" approach, recognising that sudden onset severe chest pain should prompt consideration of aortic dissection, even in the absence of classical features, with appropriate imaging undertaken where indicated.
- Emphasising the importance of timely administration of antibiotics in patients with clinically apparent sepsis and avoiding unnecessary delays whilst awaiting diagnostic investigations.

Actions have been communicated to clinical teams through established governance and educational routes.

3.3 Adult Critical Care

Critical Care is not routinely designated as the lead service for Structured Judgement Reviews (SJRs), as patients are often managed under shared-care arrangements involving multiple specialties.

At LGI Adult Critical Care, 77 deaths were recorded between October and December 2025, with nine cases undergoing SJR. The service continues to demonstrate strong multidisciplinary working, with learning shared routinely across specialties including Radiology, Stroke, Cardiology and Vascular Surgery through established governance arrangements.

A bi-monthly Mortality and Morbidity Meeting supports review of cases and identification of learning. During the reporting period, learning arising from SJRs related to communication processes, inter-specialty information sharing, and diagnostic review. Specific actions included reviewing communication pathways with specialty teams, addressing issues relating to clinical handover and referral processes, and sharing learning with Radiology and other specialties through mortality and morbidity forums. A review of tracheostomy-related incidents has also informed ongoing data collection and future educational activity.

At SJUH Critical Care, 54 deaths were reviewed, of which 30 met mortality screening criteria and five were identified as appropriate for SJR. No significant recurring themes were identified; however, reviews reinforced the importance of effective communication and collaborative working between specialty teams, which was demonstrated consistently across cases.

3.4 Major Trauma Centre

All major trauma deaths are subject to case record review. There were 14 deaths recorded in Q3. It was noted that learning was difficult to identify due to trauma booklets being paper based. MTC have requested an electronic solution to the booklets, which cannot currently be provided on PPM. No other learning points were clearly identified.

4. Mortality Indicators

In Q3 2025-26 LTHT begun the implementation of the 'HED' (Healthcare Evaluation Data) System which had recently been procured as a replacement to Dr Foster.

Leeds Teaching Hospitals NHS Trust has access to [Healthcare Evaluation Data \(HED\)](#). A web-based analytical performance and benchmarking system.

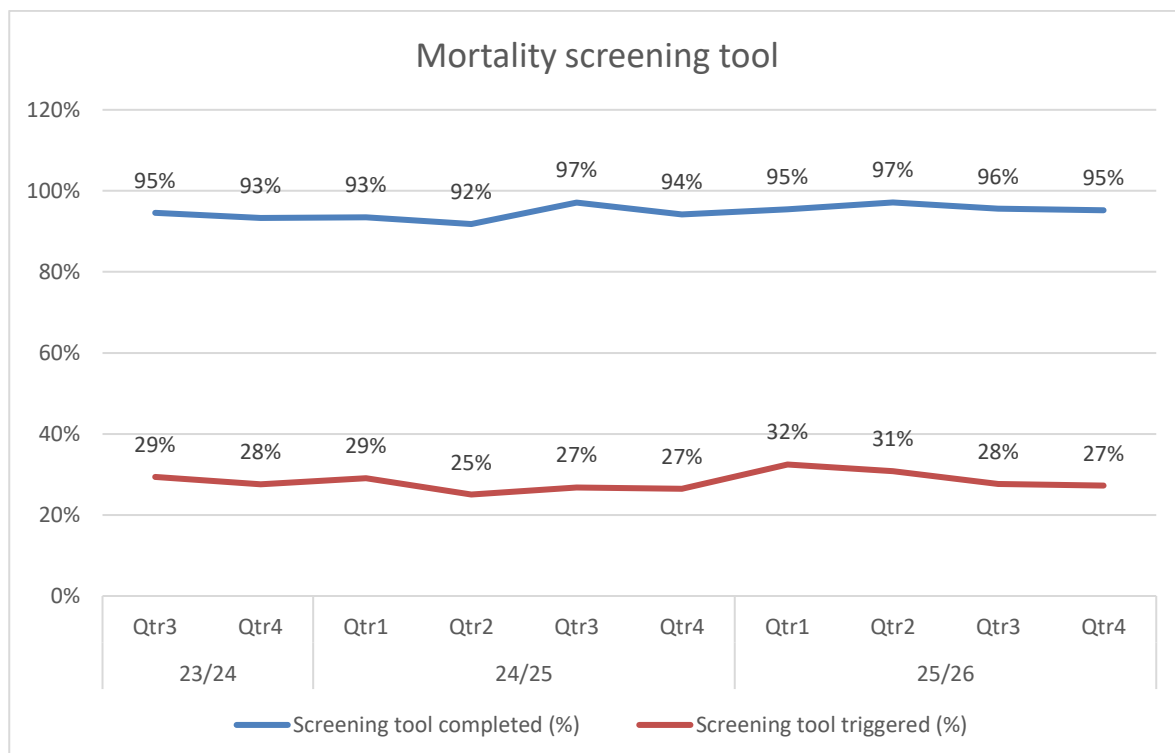
The HED suite of dashboards and modules allows healthcare organisations to utilise analytics which harness HES (Hospital Episode Statistics), national inpatient and outpatient and ONS (Office of National Statistics) Mortality data sets as well as many more to support the range of indicators across key performance areas, including Mortality, Clinical Quality & Safety, Operational Efficiency, A&E, Coding, Market Share and Consultant Revalidation.

For Mortality HED provides:

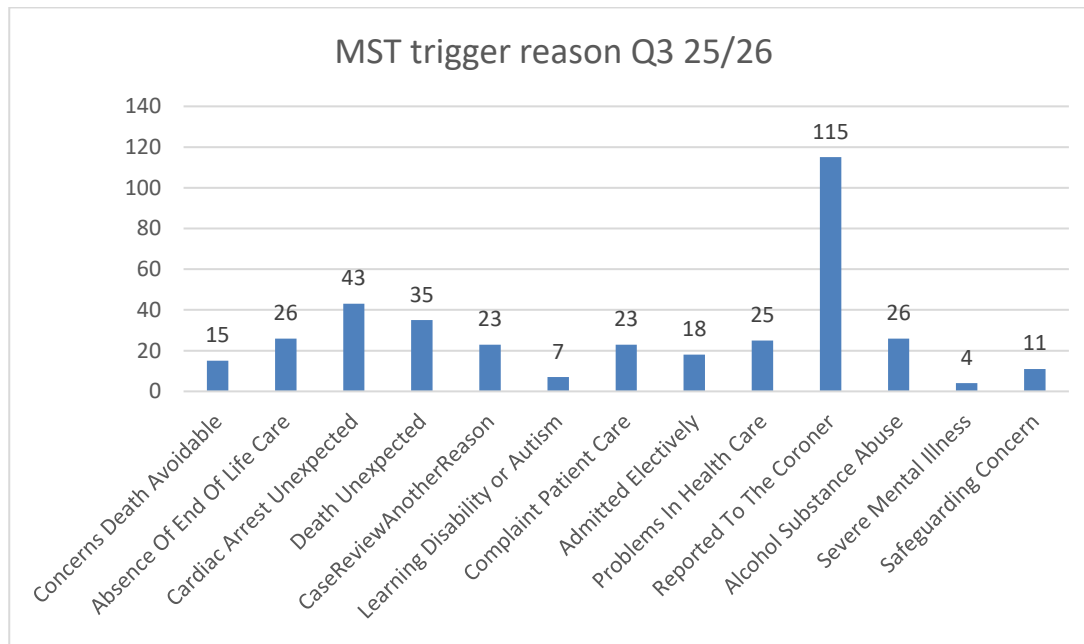
- Dashboard view of Mortality indicators with the ability to set up a customised view
- Mortality background including CCS groups, co-morbidities and other methodology
- HSMR module
- SHMI module(s)
- CUSUM module
- VLAD module
- SSMR & crude mortality
- Paediatric mortality
- Interpreting mortality data in funnel plots & using control limits
- Differences between mortality modules & approaches

4.1 Mortality Screening tool

4.1 - Figure 1: Mortality screening tool completion (Trustwide)



4.1 - Figure 2 Mortality screening tool trigger reason



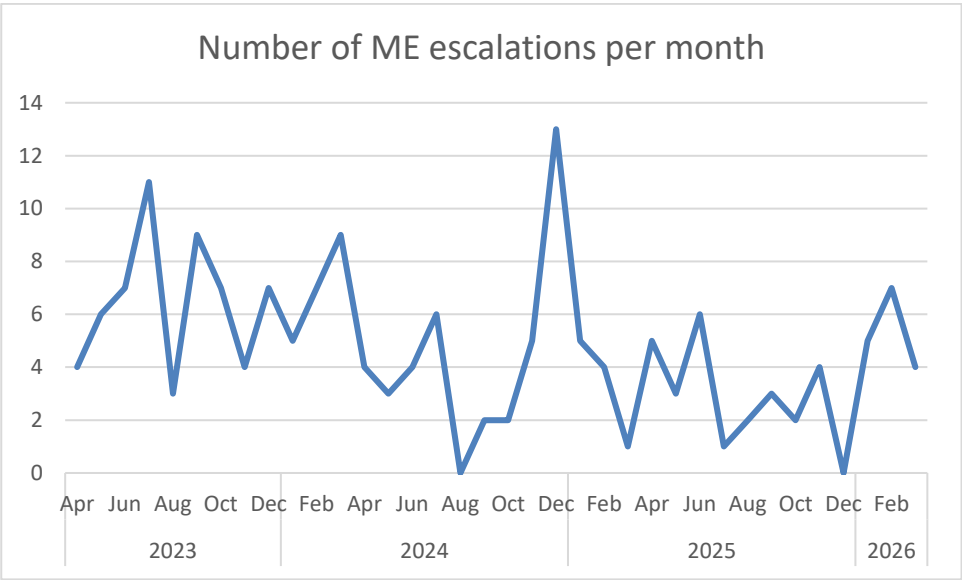
In Q3 2025/26 96% of adult deaths had a mortality screening tool completed. Of the completed screening tools, 28% triggered. The commonest reason for triggering was a referral to the coroner – in the majority of cases the referral did not relate to concerns about the care.

Section 4.1 - Table 10 Number of Deaths Eligible for Screening

CSU	Number of Deaths Eligible for Screening	Number Screened	Number Triggered
Abdominal Medicine and Surgery	87	87	48
Cardio-Respiratory	164	155	41
Centre for Neurosciences	69	65	19
Chapel Allerton Hospital	1	0	0
Children's	2	1	1
Head & Neck	4	3	1
Institute of Oncology	96	91	15
Specialty & Integrated Medicine	294	286	48
Trauma and Related Services	44	39	23
Urgent Care	38	37	15

5 Medical examiner

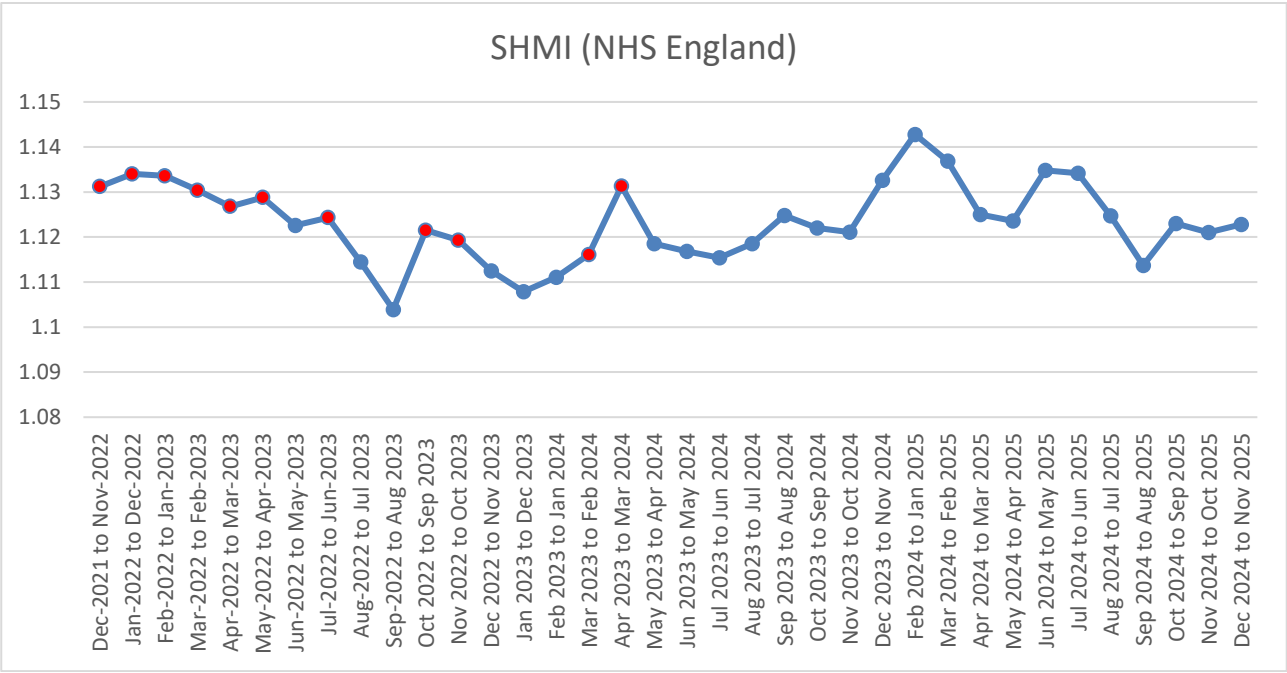
5.1 - Figure 3 Number of ME escalations per month



In Q3 25/26, there were 6 deaths escalated by the medical examiner for review. One escalation related to a death in the community, the others related to falls, frequency of observations and possible missed opportunities for earlier interventions. All 6 cases have had an SJR completed and in three cases the care overall care was scored as 3 (Adequate), and in three cases the care was scored as 4 (Good).

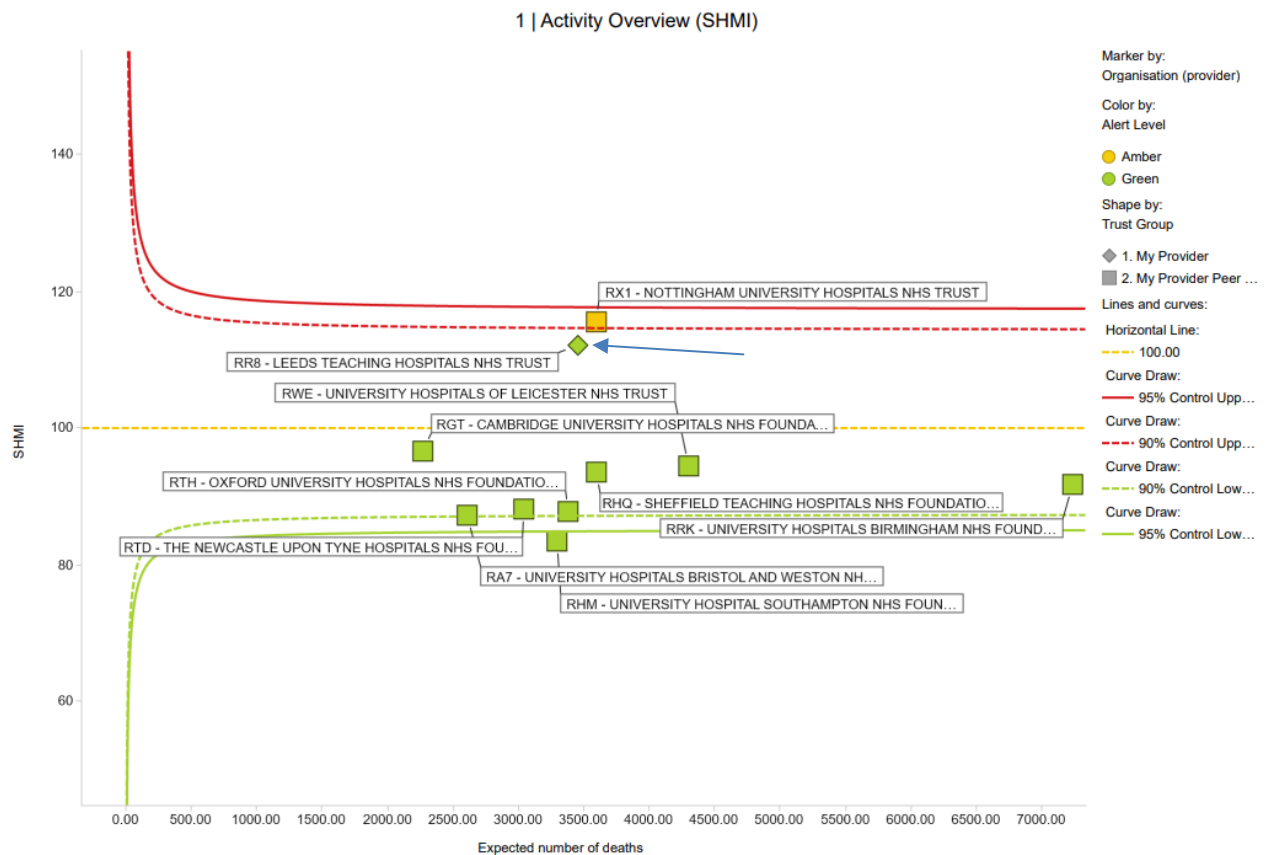
6 Mortality indicators

6.1 - Figure 4 SHMI (NHS England)



The SHMI value for December 2024 to November 2025 1.1228 (as expected).

6.2 - Figure 5 SHMI peer comparison (HES data)



The peer comparison shows that the SHMI value for LTHT is within the expected range, however it is notably higher than most peers’.

7. Looking forward / improvement

During 2025/26, the Trust’s Mortality Framework was subject to an internal audit review, with a particular focus on Structured Judgement Review processes. The final report was issued in February 2026 and gave an overall classification of “Needs Improvement”, with two high-rated findings relating to SJR completion, documentation, action tracking, tool access and reviewer training.

The review recognised that the Trust has strengthened and formalised its Mortality Framework over recent years, with oversight through the Mortality Improvement Group and reporting through the quarterly Learning from Deaths report to the Quality Assurance Committee and Trust Board. However, it also identified variability in use of the SJR tool, local storage of reviews, evidence of discussion through specialty governance routes, and the way learning and actions are documented and monitored.

In response, a Mortality Framework Improvement Plan has been developed to strengthen consistency, quality and assurance across the review process. Key actions include mandating use of the SJR tool as the single source of review, improving monitoring and reconciliation of SJR allocation and completion, introducing quarterly quality assurance audits of completed SJRs, developing a standardised approach to outcome statements and action planning, and strengthening training and support for reviewers.

This improvement work will support future Learning from Deaths reporting by providing greater assurance on the quality of reviews, the completion and monitoring of actions, and the extent to which learning from deaths is shared, acted upon and embedded across clinical services.

8. Quality and Performance Implications

This report provides assurance that the Trust continues to review deaths through established Learning from Deaths processes, including mortality screening, Structured Judgement Reviews, Medical Examiner escalations and specialist mortality review routes. The majority of Structured Judgement Reviews completed in Quarter 3 reflected good or excellent care, and adult mortality screening compliance remained high at 96%.

The report also identifies quality improvement themes with direct relevance to patient safety and care quality. These include recognition and escalation of deterioration, clinical monitoring, documentation and handover, diagnostic delay, communication between teams, adherence to specialist guidance, and care coordination for complex patients. These themes indicate areas where further improvement may reduce the risk of missed opportunities in care, improve clinical decision-making and support more consistent end-of-life care.

There are performance implications relating to the consistency and reliability of the mortality review process. The internal audit of the Mortality Framework identified variation in use of the Structured Judgement Review tool, evidence of discussion through local governance meetings, action planning, action tracking and reviewer training. This may affect the Trust's ability to demonstrate that learning from deaths is consistently identified, acted upon and embedded across services.

An improvement plan is in place to strengthen the quality and consistency of the process, including mandating use of the SJR tool, improving reconciliation of SJR allocation and completion, introducing quality assurance audits, strengthening reviewer training, and developing a standardised approach to outcome statements and action planning. This is expected to improve the quality of review outputs, strengthen governance assurance, and support clearer evidence of learning and improvement from deaths.

9. Financial Implications

There are no direct financial implications from this report.

10. Risk

The Quality Assurance Committee provides oversight of the Trust's mortality review and reporting framework. There was no material change to the risk appetite statement related to the level 2 risk categories set out on the front page of this report and the Trust continues to operate within the risk appetite for the level 1 risk category (clinical risk and regulatory risk) set by the Board.

11 Communication and Involvement

Specialty Mortality Leads and CSU Triumvirate teams were reminded that it was mandatory to log all Structured Judgement Reviews on the online SJR system. The outcome of the internal audit and subsequent action plan has been shared with the Mortality Improvement

Group, Quality Assurance Committee and Audit Committee. Areas that do not use SJR have been engaged with separately in order to identify learning.

12 Improving Health Equity

The report includes learning relevant to health equity, particularly in relation to communication with patients and families where English is not their first language, reasonable adjustments for patients with learning disability and autism, and coordination of care for patients with complex needs. Continued focus on these themes will support more consistent, individualised and equitable care across services.

13 Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

14 Recommendation

Public Board is asked to receive the report and take assurance from the Learning from Deaths activity undertaken during Quarter 3 2025/26, including mortality screening, Structured Judgement Reviews, Medical Examiner escalations and specialist mortality review processes. Board are also asked to note the key learning themes identified and the improvement actions being taken through the Mortality Framework Improvement Plan to strengthen the quality, consistency and assurance of the review process.