Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Learning from Deaths Annual Report 2025/26**

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Confidential:	**No**
Strategic Pillar:	**Patients**

Executive Summary

1. This paper presents a consolidated summary of Learning from Deaths for the year April 2025 to March 2026. Quarterly reviews of Learning from Deaths for this period have previously been presented to the Trust Board in November 2025, January 2026, May 2026, and July 2026 – see Board meetings and papers - Oxford University Hospitals (ouh.nhs.uk).
2. During 2025/26 there were 2670 inpatient deaths reported at Oxford University Hospitals NHS Foundation Trust (OUH) with 2660 (99%) of cases reviewed within 8 weeks (as per Trust Mortality Review policy). All deaths (100%) have since been reviewed.
3. Trust HSMR is 93 for April 2025 to March 2026. The HSMR is banded as 'lower than expected' (95% CL 89.3-98.3).
4. The Summary Hospital-level Mortality Indicator (SHMI) for the data period January 2025 to December 2025 is 0.88 (95% CL 0.85-1.17) which is banded as 'as expected.'
5. There were two 'avoidable' deaths confirmed (one in quarter 1 and one in quarter 2) (Section 4).
6. Key learning and actions arising from mortality reviews and learning responses during 2025/26 include:
    a) Work to ensure timely venous thromboembolism (VTE) assessment and prescription of prophylaxis, supported by a VTE Task & Finish Group
    b) Addressing a gap in local and national procedural guidelines, patient information resources and standardised consent for paediatric surgical procedures carried out in non-theatre locations.
    c) Further strengthening planning and safeguards in relation, to Trust-wide medication changes including updates to electronic health records systems, stock control, organisational messaging and high-risk medication alerts.
7. Other key themes and actions arising from mortality reviews are presented.

Recommendations

8. The Public Trust Board is asked to note the contents of this report for information.

Contents

Learning from Deaths Annual Report 2025/26

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for 2025/26.

2. Background

2.1. OUH is committed to accurately monitoring and understanding its mortality outcomes; and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains[1] set out in the NHS Outcomes Framework:

2.1.1. Preventing people from dying prematurely.

2.1.2. Treating and caring for people in a safe environment and protecting them from avoidable harm.

2.2. OUH uses the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. Although these are not direct measures of the quality of care, benchmark outcome data helps to identify areas for investigation and potential improvement.

2.3. The Trust HSMR is 93 for April 2025 to March 2026. The HSMR is banded as 'lower than expected' (95% CL 89.3-98.3). Any negative alerting diagnosis groups are investigated with the Clinical Coding team to ensure coding accuracies. Any learning or coding adjustments are shared with the Mortality Review Group (MRG).

2.4. The Summary Hospital-level Mortality Indicator (SHMI) for the data period January 2025 to December 2025 is 0.88 (95% CL 0.85-1.17) which is banded as 'as expected.'

2.5. There were no diagnoses depicted with a higher-than-expected SHMI.

2.6. The Trust Mortality Review policy requires that all inpatient deaths are reviewed within 8 weeks of the death occurring.

2.7. All patients undergo a Level 1 mortality review. The Level 1 review is allocated to the responsible Consultant via the electronic patient record (EPR).

2.8. In the majority of departments all deaths also undergo a more comprehensive Level 2 review as standard. In departments with high numbers of deaths, a minimum of 25% of Level 1 reviews are randomly selected for a Level 2 review.

[1] About the NHS Outcomes Framework (NHS OF) - NHS Digital

2.9. A Level 2 review is also completed for all cases in which concerns with care are identified at the Level 1 review. The Level 2 review is carried out by one or more consultants not directly involved in the patient's care.

2.10. Any Level 2 mortality reviews which are associated with an Inquest graded as a red or orange are presented at MRG.

2.11. A structured judgement review (SJR) is required if the case complies with one of the mandated national criteria - NHS England » Learning from deaths in the NHS. This includes all Inquests that are 'red' graded, any concerns about the quality of care, and for patients with a learning disability These SJR's are reviewed at MRG.

2.12. The SJR's are completed by a trained reviewer not directly involved in the patient's care.

2.13. All deaths also undergo independent scrutiny from the Medical Examiner's (ME) office, and the Lead ME attends MRG.

2.14. A monthly triangulation meeting with Complaints, Patient Safety and Safeguarding teams identifies any deaths where further review may be necessary that has not been captured through the mortality review process e,g subsequent complaint by the family. Each Division maintains a log of actions from mortality reviews (of any type) and monitors progress against these action plans. Actions are recorded using the Ulysses system. The clinical units are responsible for disseminating learning and implementing the actions identified.

2.15. Mortality related actions are reported quarterly to MRG and included in Divisional Quality Reports presented to the Clinical Governance Committee (CGC).

2.16. The Divisions also provide updates to MRG on the previous quarter's actions as part of the next quarter's mortality report. MRG reports to the Clinical Improvement Committee (CIC).

2.17. Trust Management Executive reviewed and discussed this paper 27 August 2026.

3. Mortality reviews completed during 2025/26

3.1. During 2025/26 there were 2670 inpatient deaths reported at OUH with 2660 (99%) of cases reviewed within 8 weeks.

Table 1: Number of completed mortality reviews 2025/26

Reporting period	Total deaths	Reviews completed within 8 weeks			Total reviews completed*
		Level 1	Level 2 & SJR	Total #	
2023/24 (Q1-4)	2762	2731 (99%)	1294 (47%)	2741 (99%)	2762 (100%)
2024/25 (Q1-4)	2761	2727 (99%)	1199 (43%)	2727 (99%)	2761 (100%)
2025/26 (Q1-4)	**2670**	**2080 (78%)**	**1191 (45%)**	**2660 (99.6%)**	**2670 (100%)**

Total of level 1 &/or level 2 &/or SJR

*Including reviews completed after 8 weeks – figures compiled using quarterly Divisional reports.

3.2. Divisions with deaths which were not reviewed within 8 weeks (as per policy) were requested to complete a Level 1 screening review; compliance was monitored via MRG. All deaths during 2025/26 have since been reviewed.

4. Avoidable deaths 2025/26: Learning and actions taken

4.1. One death in August 2025 was confirmed as 'avoidable' following a learning multi-disciplinary team learning response (LMDTR) which was discussed at MRG in December 2025. This death was the subject of an inquest that took place in January 2026. Statements and an updated action plan were provided to the Coroner, and no additional concerns were raised at inquest. Duty of Candour was completed, and the family were kept updated throughout the process. A summary of the case and of the learning and actions are presented below.

4.2. A 61-year-old man presented to ED on 5 August 2025 with a painful, swollen knee and was diagnosed with prepatellar bursitis. After joint aspiration he was discharged on oral antibiotics but reattended two days later with worsening symptoms and was admitted for IV antibiotics.

4.3. No VTE assessment was completed during the first two days of admission. On day three, the VTE assessment was completed, and he received a single prophylactic dose. His symptoms improved and he was discharged later that day on oral antibiotics with GP follow-up.

4.4. On 10 August, he collapsed suddenly at home and died. Post-mortem examination recorded the cause of death as pulmonary embolism secondary to deep-vein thrombosis.

4.5. The LMDTR concluded that there were missed opportunities for timely VTE assessment and prophylaxis. It is not possible to answer the question if the two missed doses of dalteparin led to the development of the DVT and PE. VTE prevention therapy, when given as prescribed, reduces the risk of VTE by approximately 50%. In this case there were multiple missed opportunities: VTE risk assessments and prophylaxis treatment were not performed or prescribed promptly by several clinicians during the patient's admission, and the issue was only addressed later in the hospital stay.

4.6. Several actions have since been implemented to address these identified gaps.

4.6.1. A new “VTE assessment / treatment” domain has been created in the Horton General Hospital (HGH) Trauma on-call handover sheet. This is completed by the on-call registrar for all new admissions and reviewed during the morning Screens MDT.

4.6.2. The Orthogeriatric Resident Doctors have amended their clerking proforma to include confirmation that a VTE assessment has been completed and thromboprophylaxis prescribed.

4.6.3. Induction for new starters now includes the critical nature of discussing decisions to withhold VTE prophylaxis with a senior clinician (ST3+) in all cases, with the reasons for any decision to withhold prophylaxis to be clearly documented in the notes.

4.6.4. The HGH trauma service now requires that all new resident doctors confirm in writing that they have read the contents of the induction booklet, which includes expectations regarding VTE assessment and prophylaxis.

4.6.5. A detailed Trust wide audit of VTE prophylaxis has been conducted, and a Thromboprophylaxis Education Day has been delivered for nursing staff at the HGH. The audit demonstrated sustained performance in patients receiving appropriate prophylaxis, with overall 98.4% (target 95%) of patients receiving appropriate treatment (Medical 98.6%, Surgical 98.1%). A further Trustwide audit is currently underway and will report in the next quarter assessing VTE prophylaxis compliance following the rollout of Enoxaparin across OUH.

4.6.6. Trust-wide learning via a video link reiterating the importance of VTE assessment formed part of a weekly SLIC Learning Slide in October 2025 and was also included in a Trust wide Safety Message in

December 2025 to embed the learning from this patient's death trust-wide.

4.6.7. Additional safeguards including a possible "hard stop" mandating assessment of VTE risk prior to further notes access is currently being considered by the Digital Clinical Advisory Group including a review of the evidence for and against such a change.

4.6.8. A Trust-wide VTE task and finish group has been established to drive further improvements in VTE compliance across the OUH.

4.7. The second confirmed avoidable death concerned a baby girl born by Caesarean section at 36+1 weeks at the John Radcliffe Hospital and admitted to the Newborn Care Unit with transient hypoglycaemia. At 20 hours old she developed abdominal distension and was treated for possible sepsis. Paediatric surgeons requested contrast studies, and at 28 hours she passed her first meconium. She required intermittent stool washouts for several days before her bowel function and feeding improved.

4.8. On day 9, she underwent a suction rectal biopsy with prophylactic metronidazole to investigate possible Hirschsprung's disease and was discharged home around 12 hours later. The following day, during a community midwife visit, she was found unresponsive and rapidly deteriorated. Despite full resuscitation and transfer to the Paediatric Emergency Department, she died that evening.

4.9. Post-mortem examination confirmed sepsis due to E. coli bacteraemia, following the suction rectal biopsy.

4.10. The Patient Safety Incident investigation found:

4.10.1. There was no record of verbal or written consent by the parents for the SRB procedure to be undertaken.

4.10.2. There were no local or national guidelines for the procedure, however the procedure for the patient differed from usual departmental practice as the usual antibiotic prophylaxis was not prescribed and administered prior to the procedure (instead a different antibiotic was prescribed and given after the procedure). There were no post-procedural observations or a post procedural care plan; and the baby was discharged on the same day as the procedure (this had been the plan made by the neonatal team during the morning ward round as they were not aware of the planned SRB).

4.10.3. There was insufficient communication between the Paediatric Surgical team and the Neonatal Medicine team in relation to the SRB.

4.11. Summary of areas for improvement and safety actions:

4.11.1. A new Trust guideline has been developed s for SRB in infants in the Trust, including pre-procedure antibiotic prophylaxis and post procedural care, to aid safe communication between teams involved.

4.11.2. The guidelines require the provision of a parent information leaflet and the need for informed, written consent

4.11.3. The Trust guideline was presented at a National Meeting (British Association of Paediatric Surgeons Annual Conference 2026 – 17th to 19th June 2026) to seek feedback from colleagues in Paediatric Surgery.

4.11.4. To review all invasive biopsy procedures undertaken by the Paediatric Surgical Team and consider the need for any other additional guidelines, checklists and/or patient/parent information leaflets. This action has been completed, and it is confirmed that no other invasive biopsies are undertaken outside of the theatre environment. All biopsies in the theatre environment follow the Trust's procedures including for consent, antibiotic prophylaxis and post-procedural care

4.11.5. A simple aide-memoire for parents detailing the signs of sepsis or other severe disease in newborn infants has been developed to support parents as to when to seek medical assistance.

4.11.6. A dedicated space for procedures within the Newborn Care Unit has been identified that provides greater privacy and focus.

4.11.7. Plan to transition from paper to electronic notes in the Newborn Care Unit to enhance communication between teams. This is under review by the CCIO (Chief Clinical Informatics Officer) currently.

5. Embedding actions: Learning from Avoidable deaths 2025/26

5.1. A key focus during 2025/26 has been to ensure that learning and actions identified through mortality reviews and other learning responses related to patients who have died are translated into sustained changes in practice. This section focusses on the embedding of actions from the two avoidable deaths detailed in Section 4. The Embedding of key learning from other deaths is detailed in section 6.

5.2. Actions arising from the two avoidable deaths detailed in section 4 have been progressed through both MRG and also other Trust and divisional governance routes. Learning has been shared more widely through Trust-wide learning mechanisms including SLIC learning slides, Safety Messages and targeted education. Audits have been used to provide assurance that learning has been embedded including local and trustwide audits into VTE assessment and prophylaxis.

5.3. The Trust is also strengthening how actions are closed and embedded by requiring divisions to provide updates on progress, impact and any remaining gaps. This is managed and monitored through the actions module of Ulysses and existing clinical governance oversight meetings with divisions.

5.4. Building on PSIRF principles, learning actions from deaths that have relevance beyond the originating service are presented in SLIC and where appropriate will have planned “closing the loop” (CTL) actions. Services will review progress and report back either via SLIC or MRG. It is intended that the outcomes from these CTL actions will be reported back in future Learning from Death reports.

5.5. This approach supports triangulation with Patient Safety, Medical Examiner feedback, complaints and divisional quality reports, and helps ensure that learning from deaths leads to measurable improvements in systems, guidelines, communication and clinical practice.

6. Examples of further key learning from mortality reviews and how these actions have been embedded in the past year

Telemetry equipment

6.1. A theme from some Level 2 mortality reviews and governance meetings in quarter 1 identified that telemetry equipment failures at the Horton General Hospital (HGH) meant staff could not reliably detect and document arrhythmias on ECG. Consequently, ventricular tachycardia episodes were not clearly escalated.

6.2. As a result, the telemetry upgrade was expedited at the High Care Unit at the HGH. This upgrade has been completed, and the equipment has been replaced.

6.3. A group of Resident Doctors have presented a quality improvement project related to requiring medical sign off all ECGs within 15 minutes to capture any abnormality noted on cardiac monitors. This audit was undertaken in December 2025 and included 30 patients pre policy and post policy. Post policy, the proportion of ECGs signed off increased. The next audit was undertaken in May 2026 and has now been expanded across AGM. 79% of 131 patients were identified as having an ECG signed off within 15 minutes.

Central Venous Lines

6.4. A Level 2 mortality review was conducted in CSS Division for a case in which a patient died due to complications of necessary emergency surgery.

6.5. The patient had a rare undiagnosed cardiac condition, and the death was deemed not avoidable. Incidental to these events, it was noted that the central venous line was 20cm long - this meant it needed to be partially inserted and then sutured at two locations to remain in the correct location.

The second suture was not completed in the emergency and resulted in the line being dislodged. Availability of a shorter line would have allowed a single suture point to have been used.

6.6. As a result of this, the JR now has a stock of 10cm millilumen access catheter central lines within JR theatre 18 with no further issues raised.

Trustwide medication changes

6.7. Following completion of an SJR, MRC Division and Pharmacy teams identified a risk during Trustwide medication changes (in this case the change from Dalteparin to Enoxaparin) and learning actions related to how these changes are made.

6.8. Completed actions focused on strengthening communication & early training for important changes, the need to highlight high risk drugs to ensure review by clinical pharmacists, timely Power plan updates, EPR and CareVue prompts and ensuring appropriate stock and drug strengths are held on the wards. Stock lists have been adjusted accordingly, and EPR prompts are supporting the clinical staff involved in these types of cases.

6.9. In SUWON Division: local mortality meetings and feedback from Medical Examiners identified that families were sometimes unaware of the reasons behind repositioning family members during end-of-life care for pressure area care. To improve understanding and alleviate concerns, the patient information leaflet for end-of-life care has been updated to address the topic and provide assurance. This updated leaflet is shared by the unit with families when end-of-life care patients are admitted.

6.10. The Clinical Outcomes Manager discussed this leaflet at the Thames Valley learning from deaths meeting and the wording relating to repositioning has now been shared across all attendees of the group demonstrating a culture of shared learning.

7. Themes and actions arising from mortality reviews across the year

7.1. Mortality review activity from across the year continues to identify recurring learning themes across divisions. The most prominent themes relate to early recognition and escalation of deterioration, end-of-life care planning, communication and documentation, assessment of frail and vulnerable patients, and the reliability of monitoring systems and clinical processes.

7.2. Actions arising from reviews include reinforcement of escalation pathways, improved use of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) and palliative care referrals, strengthening of handover and documentation processes, review of pathways for frail and vulnerable patients, and targeted improvements to monitoring and equipment reliability.

7.3. Table 2 provides a summary of themes and actions from mortality reviews across 2025/26.

Table 2: Summary of key themes and actions arising from Mortality Reviews 2025/26

Theme:	Key Learning:	Actions:
Recognition and escalation of deterioration	Patients were not always recognised as deteriorating early enough, or escalation pathways were not consistently followed.	Reinforcement of NEWS (National Early Warning Score) / SEND (System for Electronic Notes Documentation) monitoring, earlier senior review, escalation training, ward board-round review of deteriorating patients. A thematic PSII review is being undertaken regarding this topic.
End of life care and advance care planning	Earlier conversations about goals of care, treatment ceilings and palliative care involvement could improve patient and family experience.	Increased use of ReSPECT, earlier palliative care referrals, staff education on end-of-life care. This is monitored via mortality reviews presented to MRG. ‘Dying matters’ symposiums continue to take place across the OUH.
Communication and documentation	Documentation, handover, communication with families and recording of clinical decisions were recurring issues.	Improved handover processes, documentation standards, family communication training, sharing of good practice. Effective communication is monitored regularly via the Medical Examiner feedback process.
Management of frail and vulnerable patients	Frailty, dementia, learning disability and complex needs sometimes required more tailored assessment and pathways.	Review of frailty pathways, Silver Trauma initiatives, earlier multidisciplinary involvement.

Theme:	Key Learning:	Actions:
Sepsis identification and timely treatment	Delays in triage, recognition and antibiotic administration were highlighted in several reviews.	Sepsis action plans, awareness campaigns, monitoring of compliance and governance reporting.
Monitoring systems and equipment reliability	Equipment or system failures occasionally impaired recognition of clinical deterioration.	Telemetry upgrades, monitoring process reviews, assurance reporting. Updates regarding this can be found in section 5.
ReSPECT and treatment escalation planning	Inconsistent completion or visibility of ReSPECT documentation affected decision-making.	Division-wide ReSPECT training and promotion of advance care planning. This will form part of the thematic PSII review.
Diagnostic delays and clinical review processes	Missed investigations, delayed review of results or diagnostic uncertainty contributed to learning.	Defined review timescales, audit of compliance, clearer escalation processes.
System and administrative failures	Workflow failures, missed appointments, lost-to-follow-up patients and process gaps were identified as contributory factors.	Incident reporting, administrative training, tracking systems, audit of follow-up processes.

7.4. Learning from Deaths reports with all identified learning for each quarter can be found here - [Board meetings and papers - Oxford University Hospitals (ouh.nhs.uk).](#)

8. Corporate Risk Register and related Mortality risks

8.1. Relevant mortality risks from the Corporate Risk Register can be seen below.

Table 3: Corporate risk register and related mortality risks:

Risk Title	Risk Rate	Risk Number

Patients may not be directed to the right care pathway impacting on patient outcome, experience and staff morale	Moderate	1111
Ability to meet delivery plan trajectories for the achievement of 62-day cancer target that might impact on patient outcomes.	Moderate	2445
Diagnostic capacity and impact on cancer and elective care targets	High	1136

9. Mortality Review Governance

9.1. A quarterly summary of Directorate and Divisional mortality reports from their respective mortality and morbidity reviews are presented to the monthly MRG. MRG is chaired by the Director of Patient Safety and Effectiveness.

9.2. Monthly MRG summary reports are then presented to CIC which is co-chaired by the Director of Clinical Improvement and a Divisional Director of Nursing.

9.3. CIC reports to CGC. CGC is chaired by the Chief Medical Officer or the Chief Nursing Officer.

9.4. CGC reports via Trust Management Executive (TME) and thence to the Integrated Assurance Committee (IAC) (subcommittee of the Trust Board).

10. Conclusion

10.1. In accordance with national mortality guidance, the OUH has implemented a Mortality Review policy and implemented structured mortality reviews since 2017/18.

10.2. This paper summarises the learning identified in the mortality reviews completed during 2025/26 and demonstrates how this learning is being embedded across the trust.

10.3. Compliance with the learning from deaths policy is well established, with consistently high levels of mortality reviews undertaken within 8 weeks and appropriate Trust wide learning shared accordingly.

11. Recommendations

11.1. The Public Trust Board is asked to note the contents of this report for information.