Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 21 January 2026

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Title:	**Learning From Deaths Report – Quarter 2 2025/26**

Status:	**For Information**
History:	**Quarterly reporting**

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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper summarises key learning identified in mortality reviews completed for Quarter 2 of 2025/26; the latest available Dr Foster Intelligence mortality data; and provides assurance on the actions taken in relation to any highlighted concerns.
2. During Quarter 2 of 2025/26 there were 618 inpatient deaths of which 615 (99.5%) were reviewed within the target of 8 weeks, including 278 level 2 and structured judgement reviews (table 1). The three remaining mortality reviews have since been completed outside the expected 8-week window.
3. There was one potentially avoidable death of a 61-year man who was admitted via ED for a knee joint aspiration. The VTE policy was not followed, and he was only given one dose of anticoagulants before discharge. He collapsed at home and died. Part 1a cause of death was pulmonary embolism. A summary of the case and the learning are provided in the paper.
4. The Summary Hospital-level Mortality Indicator (SHMI) for August 2024 to July 2025 is 0.91 ‘as expected’ which remains consistent with previous quarters. Of the 10 published SHMI subgroups, none were statistically higher than expected.
5. The Trust’s HSMR+ for October 2024 to September 2025 was 93.1 (88.8-97.6), ‘lower than expected’.

Recommendation

6. The Trust Board is asked to note the Learning from Deaths update for Quarter 2 (2025/26).

Contents

Learning From Deaths Report – Quarter 2 2025/26

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 2 of 2025/26: July 2025 to September 2025.

1.2. This report provides a quarterly overview of Trust-level mortality data; the latest available Dr Foster Intelligence (Telstra) mortality data; and assurance on the actions taken in relation to any highlighted concerns.

2. Background and Policy

2.1. Oxford University Hospitals NHS Foundation Trust (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 in the NHS Outcomes Framework.[1]

3. Mortality reviews during Quarter 2 of 2025/26.

3.1. A summary of the Trust's learning from deaths processes including mortality reviews, is provided in Appendix 2.

3.2. During Quarter 2 of 2025/26 there were 618 inpatient deaths (source: - Divisional MRG reports). See Table 1.

Table 1: Mortality reviews completed *(source - Quarterly Divisional Mortality Reports)*

Reporting period	Total deaths	Reviews completed within 8 weeks			Total reviews completed
		Level 1	Level 2 & SJRs	Total	
2023/24 (Q1-4)	2762	2731 (99%)	1294 (47%)	2731 (99%)	2762 (100%)
2024/25 (Q1-4)	2761	2719 (98%)	1199 (43%)	2719 (98%)	2761 (100%)
2025/26 (Q1)	634	443 (70%)	266 (42%)	630 (99%)	634 (100%)
2025/26 (Q2)	**618**	**421 (65%)**	**279 (43%)**	**615 (99.5%)**	**618 (100%)**

*Including reviews completed after 8 weeks.

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

3.3. The three remaining mortality reviews have since been completed outside the expected 8-week window.

3.4. Eight structured judgement reviews (SJR) were presented at MRG in Q2 and no concerns were identified. The reasons for completing an SJR included:

- Death of individuals with a learning disability
- Concerns raised by staff or families
- A Coroner's Inquest into a death

4. Avoidable Deaths in Q2

4.1. One death in August 2025 was confirmed as 'avoidable'. Following a learning multi-disciplinary review (LMDTR) learning response (this was in lieu of an SJR) this was discussed at MRG in December 2025. This death is the subject of an inquest scheduled for January 2026. A summary of the case and of the learning and actions is presented below.

Synopsis

4.2. A 61-year-old man attended the Emergency Department (ED) on 5 August 2025 with a painful swollen knee. This was diagnosed as prepatellar bursitis (white cell count 11 $\times 10^9$/L; C-reactive protein 2.8 mg/L). Joint aspiration was conducted, and he was discharged on oral antibiotics. He reattended on 7 August 2025 with worsening pain, swelling and erythema (CRP 181 mg/L) and was admitted for intravenous antibiotics. Venous thromboembolism (VTE) assessment was omitted by the on-call doctor and subsequent doctors on shift that evening. On 8 August, the patient was missed off the trauma morning board round. Later the admitting consultant reviewed and confirmed a nonoperative plan, but VTE assessment did not occur. On 9 August, the registrar completed the assessment and prescribed dalteparin; the first (and only) dose was administered around 13:00 on 9 August. The patient improved symptomatically and was discharged on oral antibiotics with GP follow-up. On 10 August he collapsed suddenly at home and died.

4.3. A Post-mortem recorded the cause of death as 1a pulmonary embolism (PE) with 1b deep-vein thrombosis (DVT).

LMDTR Conclusion

4.4. 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 around 50%.

4.5. In this case there were multiple missed opportunities: VTE risk assessments and prophylaxis were not performed or prescribed promptly by several clinicians during the patient's admission, and the issue was only addressed late in the hospital stay. Several actions have since been implemented to address these gaps.

MRG Conclusion

4.6. It was agreed that this was a potentially avoidable death as there were identified lapses in VTE assessment and prophylaxis.

Summary of areas for improvement and safety actions

4.7. 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.

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

4.9. The HGH trauma service now requiress 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.

4.10. Thromboprophylaxis has been added to the Horton orthogeriatric clerking proforma checklist.

4.11. 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.

4.12. A detailed Trustwide audit of VTE prophylaxis is underway to inform further improvements as required (data collection in December 2025, results being analysed in January 2026).

4.13. A Thromboprophylaxis Education Day has been delivered for nursing staff at HGH.

4.14. 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 Trustwide safety message in December 2025.

4.15. 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.

4.16. A Trust-wide VTE task and finish group is being established to drive further improvements in VTE compliance.

5. The Medical Examiner (ME) system

Background

5.1. At OUH MEs have been scrutinising deaths since June 2020. The purpose of the ME system is to provide greater safeguards for the public by:

- Ensuring proper scrutiny of all non-Coronial deaths.
- Ensuring appropriate referral of deaths to a Coroner.
- A better service for the bereaved, including an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased.
- Improved quality of death certification and mortality data.

5.2. Statutory scrutiny of all deaths including those in Primary Care started on 9 September 2024.

5.3. Any concerns raised by the ME or the bereaved families/carers and other feedback including in relation to excellent practice are fed back to the Clinical Governance Team and shared with the Divisions to inform mortality reviews and any learning.

Quarter 2 update and progress

5.4. 100% of Trust deaths were reviewed by the ME.

5.5. 100% of adult Hospice deaths were also reviewed by the ME.

5.6. All child/neonatal deaths within the Trust are also scrutinised by the ME Service (excluding Stillbirths and termination of pregnancies).

6. Child death overview process (CDOP) Quarter 2 update

6.1. There were a total of 27 child deaths in OUH in Q2. This represents a spike in the number of deaths per quarter (see table 2). Notably this increase did not persist into Q3.

Table 2: Number of child deaths by Quarter from 2024

2024-2025	**Number of child deaths**
Q1	13
Q2	15
Q3	18
Q4	16
2025-2026	**Number of child deaths**
Q1	13
Q2	27

6.2. By exception there were 16 child deaths reported for Q3 2025/26.

6.3. Two of the 27 deaths have not yet been reviewed.

6.4. Key themes of good practice arising from the reviews done include:

6.4.1. Exceptional engagement from paediatric teams, GP's, health visitors, hospices and chaplaincy.

6.4.2. Excellent palliative care and post-death bereavement support.

6.4.3. Upholding family wishes where possible.

6.4.4. Good communication with regional and national specialities to identify a metabolic disorder.

6.4.5. Early use of language line.

6.4.6. Good pre-hospital care by ambulance crew after birth at home.

6.5. Key learning points include:

6.5.1. Chaplaincy should be offered for support in the acute setting.

6.5.2. Verification of Death is the responsibility of the Maternity Group for Delivery Suite deaths. Verification of Death must be by a medic who has seen signs of life in a baby.

6.5.3. The Family Liaison Nurse role is critical for supporting long term Paediatric critical care patients.

6.6. A baby was transferred to a Hospice after death without full discussion and authorisation by the ME. A ME SOP for Neonatal rapid release and transfer to hospice after death has been developed. An overarching SOP for ME processes for all child deaths is under development.

6.7. Parental wishes for no resuscitation if no signs of life not conveyed to the neonatal team. Liaison between Neonatal and Maternity teams has been strengthened to ensure antenatal plans are clear and are shared for low gestational age babies.

6.8. Issues with the Trust's external provider of telephone translation services hampered communication. These issues are being addressed by the Patient Experience team.

6.9. A difficult airway was not identified on antenatal scans. This has been followed up with the local district general hospital obstetric team for learning.

7. Example learning and actions from mortality reviews (adults and children) completed in Quarter 2

7.1. Examples of learning during this quarter are summarised in table 3.

Table 3: Learning and Actions from mortality reviews

Division (Service)	Learning	Action
Medicine, Rehabilitation and Cardiac (MRC)	Consistency needed in use of the 'Recommended Summary Plan for Emergency Care and Treatment' (ReSPECT) process across teams.	Implement ReSPECT training across the Division (Ongoing).
MRC – Horton	Telemetry failures meant staff could not reliably detect/document arrhythmias (Ventricular Tachycardia episodes not clearly escalated).	Oak High Care Unit telemetry upgrade expedited.
Surgery, Women's and Oncology (SUWON) Oncology	Good practice identified: meticulous, multidisciplinary documentation; excellent communication with family.	No corrective action—shared as good practice.
SUWON Palliative Care	Families do not always understand the rationale for repositioning at end of life (EOL).	Add explanation to "What to Expect When Someone Is Dying in Hospital" leaflet.
SUWON General Surgery	Need for clear decision-making for complex patients with multiple pathologies. Any concerns, except those immediately life threatening, should be escalated within the department before	Escalation process discussed at SEU M&M and second CT grade clinician added to night shifts to aid with clinical decision making.

Division (Service)	Learning	Action
	escalating to other specialties.	
SUWON Urology	Recognition of community DNACPR orders and appropriate use of ReSPECT.	ReSPECT training commenced.
Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Ophthalmology, Children and Neonates (NOTSSCAN) Neurosurgery	Need to add venous thrombo-embolus (VTE) prophylaxis clarity to neurosurgical documentation; audit showed variability in prescribing low molecular weight heparin documentation.	VTE section added to the proforma, and a further audit is underway.
NOTSSCAN Neurosurgery	Need for earlier consultant review and urgent advice from registrar before surgical decisions in elderly low-GCS (Glasgow coma score) trauma cases.	Reinforce pathway: referring team must contact onsite registrar and OUH consultant before committing to invasive intervention.
NOTSSCAN Horton - Trauma	Delayed VTE risk assessment led to two missed doses of dalteparin; patient later died from PE/DVT (hospital acquired thrombosis).	Immediate education and regular audit steps initiated by DMD; VTE team engaged; Inquest scheduled.
NOTSSCAN Trauma – Trust wide	Need for clearer messaging on VTE risk and prevention, based on Hospital Acquired Thrombosis (HAT) case.	Trauma team produced short VTE safety video disseminated Trust-wide.
Clinical Support Services (CSS) Oxford Critical Care (OCC & CICU)	Protracted referrals to Specialist Nurse for Organ Donation (SNOD) delaying consideration of organ donation.	SNODs to review and help streamline the process.
CSS Oxford Critical Care	Out-of-hours (OOH) referrals lacked clarity around suitability for multi-organ support.	Improve clarity in OOH referral pathways and decision-making; reinforce MDT requirement.
CSS	Ambulance transfer decision (HGH ED → ICU) resulted in cardiac	Review transfer criteria and improve guidance around decision-making for high-risk transfers.

Division (Service)	Learning	Action
Critical Care / HGH ED	arrest outside ICU in a severely acidotic patient.	
CSS Palliative & End-of-Life Care	Unclear coding for palliative care admissions.	Clarify coding definitions Trust-wide to support accurate classification
CSS Palliative & End-of-Life Care	Questionable appropriateness of OGD + massive transfusion for patient with advanced gastric cancer likely EOL.	Case referred for further M&M review by Oncology; reinforce decision-making principles for invasive interventions in EOL contexts.

8. Patient Safety Incident Investigations (PSII) of incidents resulting in death during Quarter 2

8.1. There were two new incidents with an impact of death declared as a PSII during Quarter 2 2025/26:

- A baby was born in poor condition following an acute placental abruption requiring emergency caesarean section. They were admitted to Intensive care where they later died.
- A patient had a witnessed fall from standing and sustained a subdural haematoma.

8.2. The findings of all PSIIs with an impact of death are presented to MRG (as well as at clinical governance forums).

9. PSIIs presented to MRG in the last 3 months:

9.1. One PSII was presented to MRG in the last quarter.

9.2. PSII Report 2526-011 case overview:

9.2.1. A 66-year-old man was admitted with abdominal symptoms; he had an unclear pre-hospital history of falls. He sustained two falls on the Emergency Assessment Unit (EAU) (the first fall was unwitnessed; the second fall was witnessed during handover). He deteriorated rapidly after the second fall. A CT showed acute-on-chronic subdural haematoma which required emergency surgery. The patient sadly died later from pneumonia and poor neurological recovery.

9.3. The investigation identified the following learning to minimise the risk of falls, though it recognised that no even if all these measures were in place it would not have eliminated the risk of falls:

9.3.1. Falls risk assessments and cognitive screening must be completed reliably for all eligible patients.

9.3.2. Improve communication/documentation – including escalation of family concerns and next of kin updates.

9.3.3. Strengthen post-fall neurological observation compliance.

9.3.4. Careful management of environmental factors (curtains, staff visibility, nursing station design), which impacted the ability for clinical staff to observe the patient in this case.

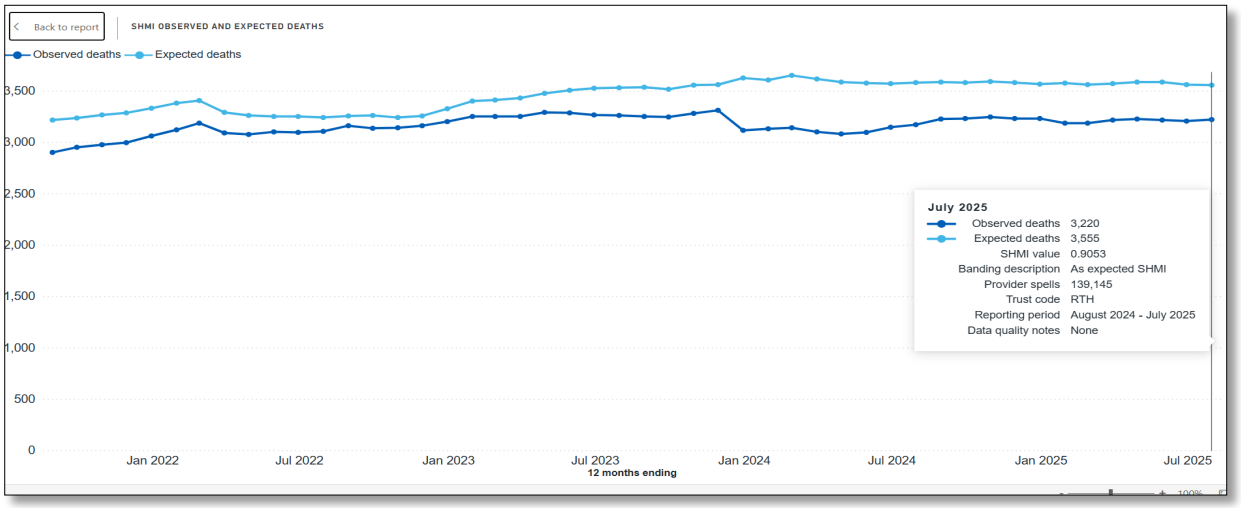
9.3.5. Enhance handover processes and ensure consistent use of EPR (electronic patient record) templates.

10. National mortality benchmark data

10.1. There have been no mortality outliers reported for OUH from the Care Quality Commission (CQC) or NHS Digital during Quarter 2 2025/26.

10.2. The Summary Hospital-level Mortality Indicator (SHMI) for August 2024 to July 2025 is 0.91 'as expected' which remains consistent with previous quarters. Of the 10 groups that NHSE publish SHMI values for, none of these are statistically higher than expected.

Chart 1: OUH SHMI trend (12-month rolling)



The Trust's HSMR+ for October 2024 to September 2025 was 93.1 (88.8-97.6) and banded 'lower than expected'.

Chart 2: Rolling 12-month HSMR+

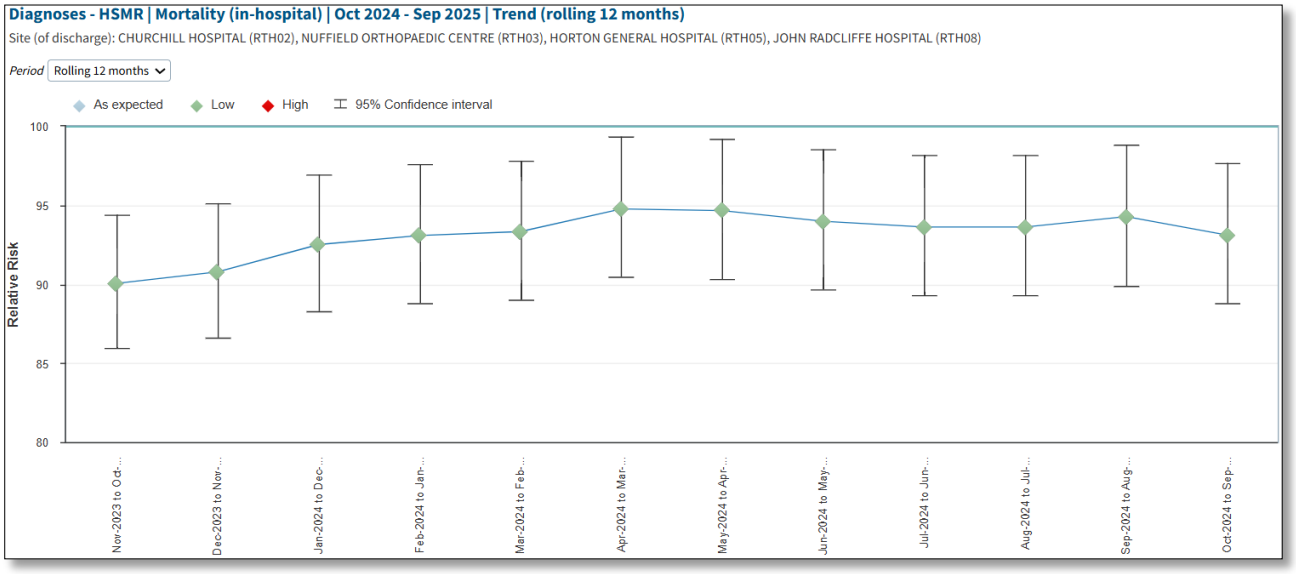
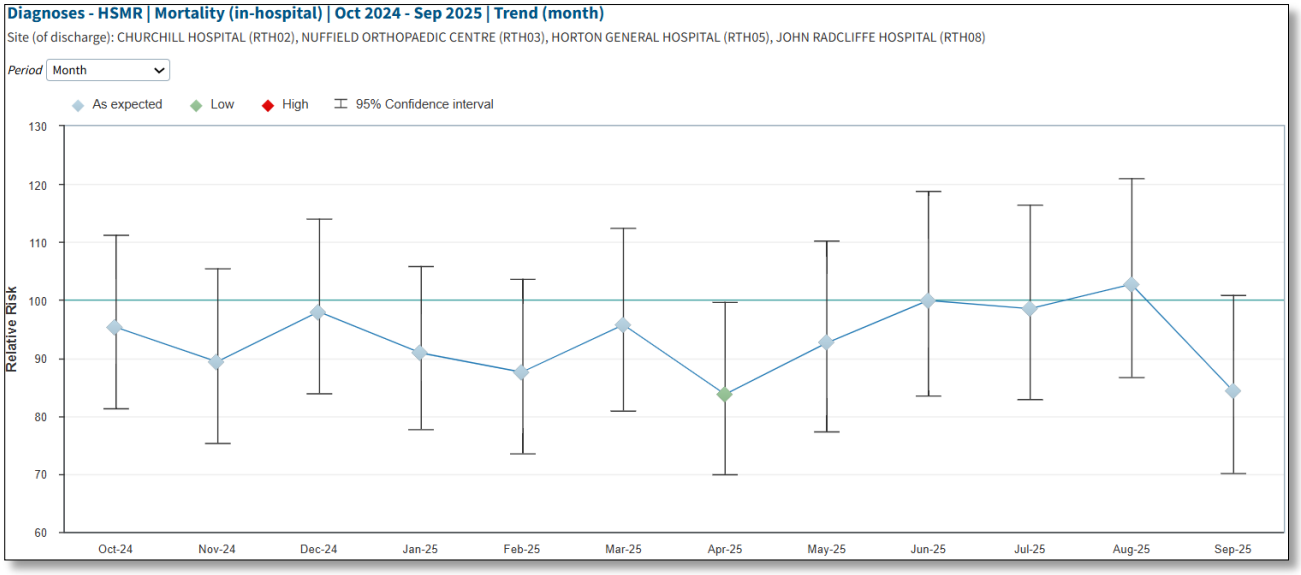


Chart 3: Non-rolling HSMR+ by month

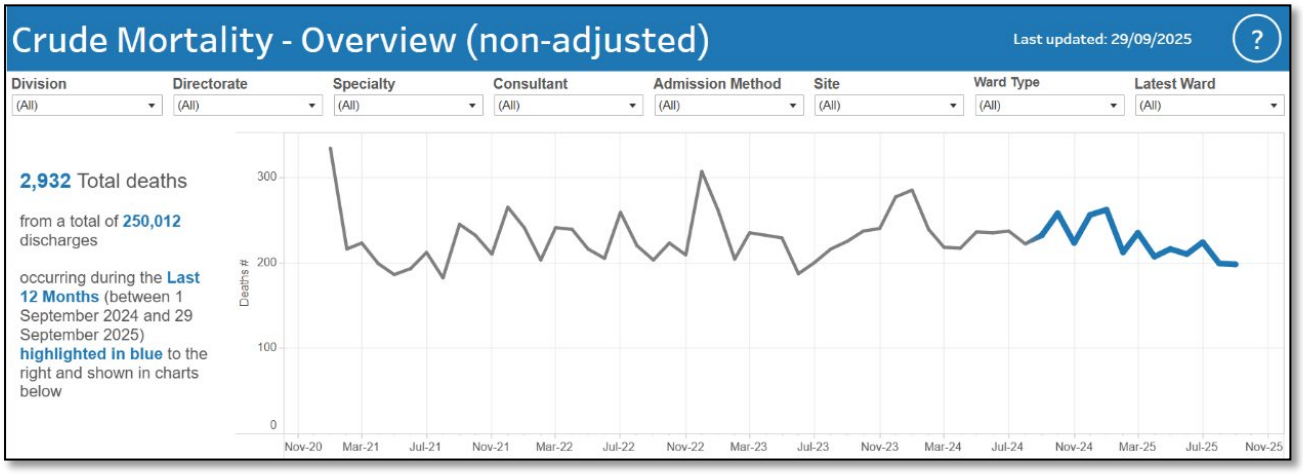


10.3. A summary and comparison of the methods used to calculate the SHMI and HSMR+ is included in Appendix 1.

11. Detailed analysis of deaths during reporting period

11.1. Crude mortality: Chart 4 below shows the latest crude mortality rate for a rolling 12-month period (in blue). Crude mortality gives a contemporaneous, but not risk-adjusted, view of mortality across OUH.

Chart 4: Crude mortality rate by Finished Consultant Episodes (FCEs)

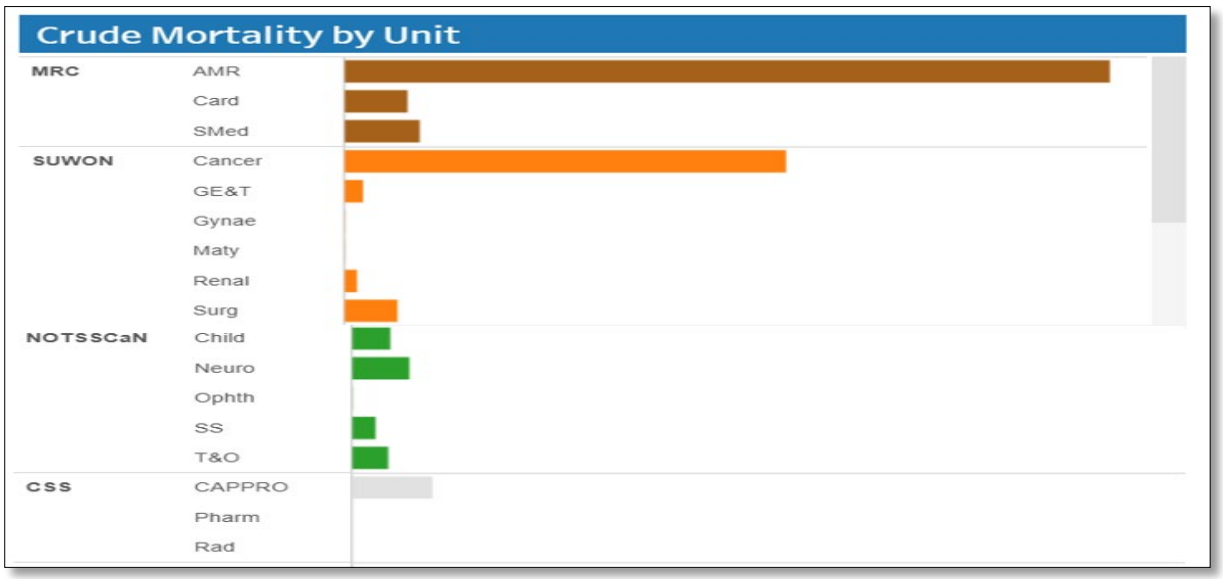


11.2. The highest number of deaths occur in the Acute Medicine and Rehabilitation (AMR) Directorate under the Medicine Rehabilitation and Cardiac (MRC) Division (Table 4 and Chart 5). This is consistent with previous reports.

Table 4: Crude mortality by Clinical Division, Quarter 2 of 2025/26

Division	Total Discharges (From Orbit)	Number of deaths (Reported to MRG)
NOTSSCAN	16,246	66
MRC	22,655	303
SUWON	20,180	204
CSS	812	45
Total	59,893	**618**

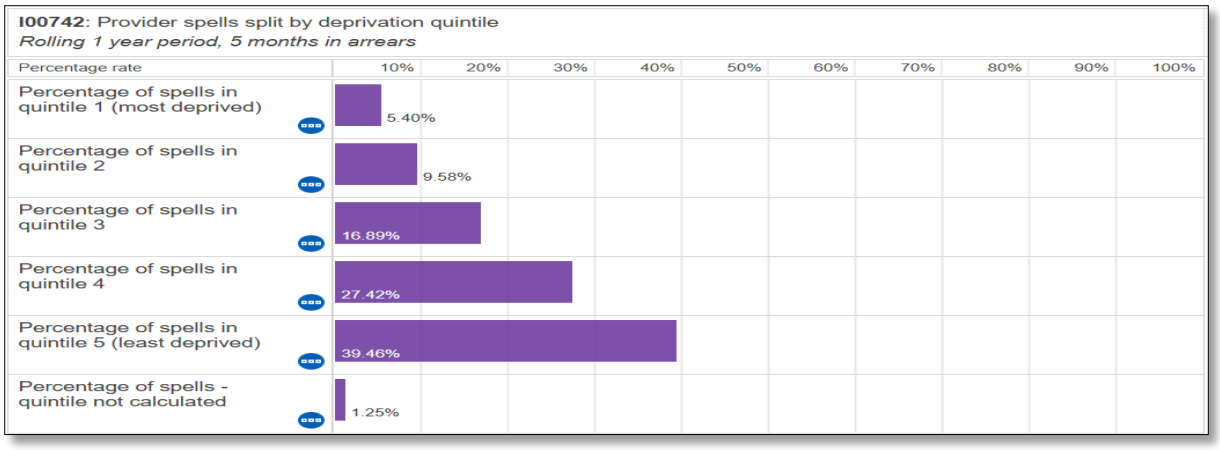
Chart 5: Deaths by Directorate (annual data)



11.3. Mortality by Index of Multiple Deprivation: Chart 6 displays the percentage breakdown of spells by Index of Multiple Deprivation quintile.

This pattern is in line with previous LFD reports. This chart demonstrates that many patients admitted to OUH are in the least deprived areas of the region. Detailed interpretation of this data is difficult without adjusting for confounders such as age which may explain much of the observed variation.

Chart 6: % SHMI spells in each deprivation quintile August 2024-July 2025



12. Mortality-related risks on the Corporate (Trust level) Risk Register

12.1. Relevant mortality-related risks from the Corporate (Trust) Risk Register are listed below in table 5:

Table 5- Mortality related risk on the Corporate (Trust) Risk Register

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

13. Recommendation

13.1. The Trust Board is asked to note the Learning from Deaths update for Quarter 2 (2025/26).

Appendix 1: Key differences between the SHMI and HSMR+

The Trust references two mortality indicators: the SHMI, which is produced by NHS Digital, and the HSMR+ produced by Dr Foster Intelligence.

Both are standardised mortality indicators, expressed as a ratio of the observed number of deaths compared to the expected number of deaths adjusted for the characteristics of patients treated at a Trust.

While both mortality indicators use slightly different methodology to arrive at the indicator value; both aim to provide a risk adjusted comparison to a national benchmark (1 for SHMI or 100 for HSMR+) to ascertain whether a Trust's mortality is 'as expected', 'lower than expected' or 'higher than expected'.

Key differences between the SHMI and HSMR+

Indicator	**Summary Hospital-level Mortality Indicator (SHMI)**	**Hospital Standardised Mortality Ratio (HSMR)**
Published by	NHS Digital	Dr Foster Intelligence
Publication frequency	Monthly	Monthly
Data period to calculate indicator value	Rolling 12-month period for each release, approximately five months in arrears.	Provider-selected period, up to three months in arrears
Coverage	Deaths occurring in hospital or within 30 days of discharge. All diagnosis groups excluding stillbirths. Day cases and regular attenders are excluded.	In-hospital deaths for 41 selected diagnosis groups that accounts for 80% of in-hospital mortality. Regular attenders are excluded.
Assignment of deaths	Deaths that happen post transfer count against the transfer hospital (acute non-specialist trusts only).	Includes deaths that occur post transfer to another hospital (superspell effect).
Palliative Care	Not adjusted for in the model.	Not adjusted for in the model.
Casemix adjustment	8 factors: diagnosis, age, sex, method of admission, Charlson comorbidity score, month of admission, year, birth weight (for individuals aged <1 year in perinatal diagnosis group).	Admission type, age, year of discharge, deprivation, diagnosis subgroup, sex, Elix Hauser comorbidity score, emergency admissions in last comorbidity score, emergency admissions in last 12 months, month of admission, source of admission, interaction between age on admission group and comorbidity admission group.

Appendix 2: Background, Policy and monitoring of mortality related actions

1. Oxford University Hospitals NHS Foundation Trust (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[2] set out in the NHS Outcomes Framework:
    - Preventing people from dying prematurely.
    - Treating and caring for people in a safe environment and protecting them from avoidable harm.
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 help identify areas for investigation and potential improvement.
3. The Trust Mortality Review policy requires that all inpatient deaths are reviewed within 8 weeks of the death occurring.
4. All patients undergo a level 1 review. The level 1 review is allocated to the responsible Consultant via the electronic patient record (EPR). A minimum of 25% of level 1 reviews are then selected at random for a more comprehensive level 2 review (in many departments all deaths undergo a level 2 review) and all (100%) of deaths undergo independent scrutiny from the Medical Examiner's office.
5. A comprehensive level 2 review is also completed for all cases in which concerns are identified at the level 1 review. The level 2 review involves one or more consultants not directly involved in the patient's care. 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 is completed by a trained reviewer not directly involved in the patient's care. More recently an SJR is requested if there is a Coroner's Inquest.
6. Each Division maintains a log of actions from mortality reviews (of any type) and monitors progress against these action plans. The clinical units are responsible for disseminating learning and implementing the actions identified. Actions are recording using the trust incident reporting system (Ulysses).
7. Mortality related actions are reported quarterly to the Mortality Review Group (MRG) and via the Divisional Quality Reports presented to the Clinical Governance Committee (CGC).

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

8. 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).

CDOP background

9. There is a statutory requirement for local panels to review every child death (section 14 of the *Children Act 2004* and *Working Together to Safeguard Children 2018*).
10. Panels are required to review deaths of all children up to the age of 18 years and neonates less than 28 days old. (including babies born before viability, but not those who are stillborn or are terminated pregnancies within the law).
11. The administration of the Oxfordshire CDOP is hosted by the BOB ICB and is chaired by the Director of Quality and Lead Nurse from the ICB. The Designated Doctor for Child Death is a Consultant Paediatrician at OUH and is commissioned by the ICB to undertake this role. The CDOP is committed to ensuring the review process is grounded in respect for the rights of children and their families and focuses, where possible, on preventing future child deaths.