Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Learning From Deaths Report – Quarter 1 2025/26**

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

Board Lead:	**Chief Medical Officer**
Author:	**Jonathan Carruthers, Clinical Outcomes Manager**
	Helen Cobb, Head of Clinical Governance
	Dr Rustam Rea, Deputy Chief Medical Officer
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper summarises key learning identified in mortality reviews completed for Quarter 1 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 1 of 2025/26 there were 634 inpatient deaths of which 630 (99%) were reviewed within 8 weeks, including 266 level 2 and 7 structured judgement reviews (table 1). The 4 remaining mortality reviews have since been completed outside the expected 8-week window.
3. One death of a baby due to E. coli sepsis following a suction rectal biopsy was classified as ‘avoidable’. A summary of the case and the learning are provided in the paper.
4. The latest Summary Hospital-level Mortality Indicator (SHMI) data for January 2024 to December 2024 is 0.91 which remains consistent with previous quarters. This is banded ‘as expected’ based on NHS Digital’s 95% control limits (87-115), adjusted for over-dispersion.
5. The Trust’s Hospital standardised mortality ratio (HSMR) is 92.8 (95% CL 88.5 – 97.3) for July 2024 to June 2025. The HSMR is banded as ‘lower than expected’.

Recommendations

6. The Trust Board is asked to note the Learning from Deaths update for Quarter 1 (2025/26).

Contents

Learning From Deaths Report – Quarter 1 2025/26

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 1 of 2025/26: April 2025 to June 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.[1]

3. Mortality reviews during Quarter 1 of 2025/26.

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

3.2. During Quarter 1 of 2025/26 there were 634 inpatient deaths of which 630 (99%) were reviewed within 8 weeks, including 266 level 2 and 7 structured judgement reviews (see table 1). The 4 remaining mortality reviews have since been completed outside the expected 8-week window.

3.3. One death was confirmed as 'avoidable'. Information relating to this case and learning points are detailed in point 3.5 where a baby died of sepsis secondary to E. coli bacteraemia which developed the day following a suction rectal biopsy (SRB).

3.4. Seven structured judgement reviews (SJR) were completed during Quarter 1. The reasons for completing an SJR included:

- Death of individuals with a learning disability
- Concerns raised by staff or families
- Concerns raised during the Medical Examiner scrutiny
- A Coroner's inquest into a death

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

Table 1: Mortality reviews completed

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%)**

*Including reviews completed after 8 weeks.

Confirmed avoidable death case summary

3.5. This case summary arises from a Patient Safety Incident Investigation (PSII) 2425-024 and subsequent Inquest.

3.6. A baby girl was born by Caesarean section at 36+1 weeks' gestation at the John Radcliffe Hospital. Following birth, she was transferred to the Newborn Care Unit with transient hypoglycaemia. She did not require intubation or cardiac support. She developed abdominal distension at 20 hours of age and received antibiotics for possible sepsis.

3.7. She was reviewed by the Paediatric Surgical Team who requested upper and lower gastrointestinal contrast studies to examine the digestive system. Following these, at 28 hours old, she passed her first meconium stool. She subsequently had intermittent stool washouts for several days, before she began to pass stools normally and improved her feeding, she was then monitored closely. She had a suction rectal biopsy with post-procedural prophylactic metronidazole on day 9 of life to rule out Hirschsprung's disease. She was discharged home approximately 12 hours later the same day.

3.8. At the baby's post-natal review by a community midwife the following day (day 10), the baby was found to be unresponsive and rapidly deteriorated. Full cardiopulmonary resuscitation was started by the midwife, supported by paramedics, and she was transferred to the John Radcliffe Hospital Paediatric Emergency Department. Despite continued efforts at resuscitation the baby died that evening in the Paediatric Critical Care Unit.

Summary of key findings

3.9. The baby died of sepsis secondary to E. coli bacteraemia which developed the day following a suction rectal biopsy (SRB).

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

3.11. There were no local or national guidelines for the procedure, however the procedure for the patient differed from usual practice. 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 without knowing of the planned SRB).

3.12. There was insufficient communication between the Paediatric Surgical team and the Neonatal Medicine team.

Summary of areas for improvement and safety actions

3.13. To develop and ensure compliance with new guidelines for SRB in infants in the Trust, including pre-procedure antibiotic prophylaxis and post procedural care, to aid safe communication between teams involved.

3.14. To include the need for informed, written consent within the guidelines for this procedure including a patient/parent information leaflet.

3.15. To present the guideline at a National Meeting to seek feedback from colleagues in Paediatric Surgery.

3.16. 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.

3.17. Develop a simple aide-memoire for parents with the signs of sepsis or other severe disease in newborn infants.

3.18. To develop dedicated space for procedures within the Newborn Care Unit that provides greater privacy and focus.

3.19. To transition from paper to electronic notes in the Newborn Care Unit to enhance communication between teams.

4. The Medical Examiner (ME) system

Background

4.1. 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.

Quarter 1 update and progress

4.2. 100% of Trust deaths were reviewed by the ME.

4.3. 100% of adult Hospice deaths were also reviewed by the ME.

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

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

4.6. The process for raising concerns and positive feedback from the ME to the OUH has been strengthened as per previous reports and the process is working well. All ME feedback forms are collated and presented to MRG each month. 45 feedback forms were received during quarter 1. Most forms received highlighted concerns from the families or concerns from the Medical Examiner. Three forms highlighted positive feedback relating to care, and these were shared with the area(s) involved.

4.7. Completed forms are shared with the relevant Divisions to investigate and feedback to families where requested. Divisions review cases highlighted during the quarter. Divisions have been requested to include a section in future quarterly mortality reports to MRG reporting any significant learning identified from ME feedback. Work is on-going to further strengthen this process.

4.8. Learning from the ME feedback during Quarter 1 included the following themes:

4.8.1. The importance of clear and effective communication with relatives. The Palliative care team are providing sessions on this as part of their annual plan.

4.8.2. Pain management at end of life. To support this the following actions have been completed:

- Intranet site updates
- EPR prompts
- Use of point of care electronic guidelines to provide essential guidance for symptom management
- Guidance documents for staff and families
- Dying matters symposium (completed 7 May 2025).

5. Child death overview process (CDOP) Quarter 1 update

5.1. There were 14 child/neonatal deaths in the OUH in Quarter 1. All cases (100%) underwent a multidisciplinary review. Learning included the opportunity to consider tissue donation routinely in all child deaths.

5.2. Following a PSII review, a formal standard operating procedure has been developed relating to diagnostic rectal suction biopsy in neonates (see section 3.5 above).

5.3. The team celebrated the appointment of the Trust's first nursing bereavement key worker, a significant development for supporting families after child deaths. A training and induction plan is in place.

6. Example learning and actions from mortality reviews (adults and children) completed in Quarter 1

6.1. Examples of learning during this quarter are summarised in the table below.

Table 2: Learning and Actions from mortality reviews

Division (Service)	Learning	Action
Medicine, Rehabilitation and Cardiac (MRC) Directorate (Acute General Medicine) A learning response and mortality review was conducted for a patient who deteriorated and died.	A patient was admitted to the Horton with abdominal pain. There was a routine request for an ECG, which was completed later in the evening. It was not reviewed until the following morning on the ward round and showed a myocardial infarction. The patient required urgent transfer to the John Radcliffe for Cardiac intervention. The patient died 2 weeks later. It was identified that there was no clear reporting time framework in EAU for an ECG.	All ECGs must be signed off by a doctor within 15 minutes of completion. This will be audited by Resident Doctors and presented at the local Governance meeting in December 2025. A procedure has also been developed and is now in use.
Surgery, Women's and Oncology (SUWON) (Oncology and Surgery) Level 2 mortality review (completed due to care concerns)	A theme from Oncology mortality reviews highlighted that improved communication between Oncology and Surgery is needed, with clear awareness of escalation and referral pathways for surgical emergencies, particularly out of hours and on Bank Holidays.	Responsibility should rest with the on-call Consultant of the week for managing and escalating unwell patients, while ensuring the tumour-specific team remains appropriately involved. Further work is expected in relation to this action, and an update will be provided in the Quarter 2 LFD report.
Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Ophthalmology, Children and Neonates (NOTSSCAN) (Neuro Intensive Care) Level 2 mortality review (100% of deaths are reviewed at L2 in this area)	Theme identified across several mortality reviews within Neurosciences: Clear and consistent documentation relating to Venous Thromboembolism risk and prescribing of low molecular weight heparin.	A mandatory field will be implemented on the ward round proforma. This must be completed daily, with regular audit ensuring compliance. Results will be monitored as part of Divisional Governance updates to provide assurance.
Clinical Support Services (CSS) Directorate (Critical Care) Level 2 mortality review (100% of deaths are reviewed at L2 in this area)	Documentation of ceilings of care are not transferring from Critical Care to the hospital electronic patient record.	Dissemination of instructions for the use of RESPECT across Critical Care areas. RESPECT forms are filled out on EPR to ensure comprehensive discharge documentation and verbal handover to the accepting team when a patient is not for re-escalation to ICU.

7. Patient Safety Incident Investigation (PSII) of incidents resulting in death during Quarter 1

7.1. There were three new incidents with an impact of death declared as a PSII during Quarter 1 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 with ovarian cancer had multiple delays to surgery and later died.
- A baby was admitted to the Neonatal Intensive Care Unit, received therapeutic cooling and subsequently died. This event is being investigated by Maternity and Newborn Safety Investigations Branch (MNSI).

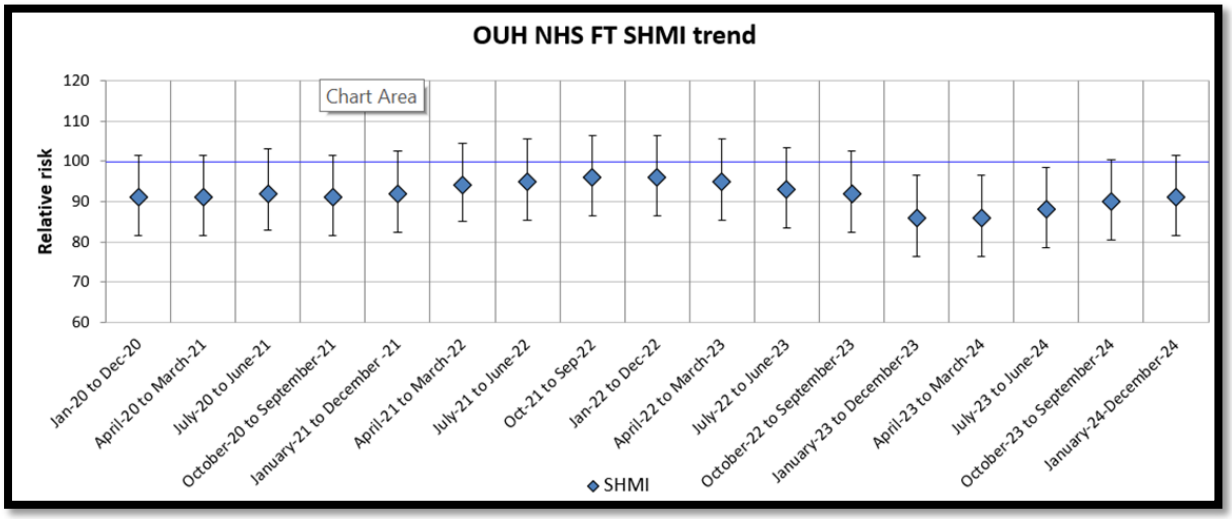
7.2. The findings of all PSIIs with an impact of death are presented to MRG (as well as at clinical governance forums).

8. National mortality benchmark data

8.1. There have been no mortality outliers reported for OUH from the Care Quality Commission (CQC) or NHS Digital during Quarter 1 2025/26.

8.2. The Summary Hospital-level Mortality Indicator (SHMI) for January 2024 to December 2024 is 0.91 which remains consistent with previous quarters. This is banded 'as expected' based on NHS Digital's 95% control limits, adjusted for over-dispersion.

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



8.3. The Trust's HSMR is 92.8 (95% CL 88.5 – 97.3) for July 2024 to June 2025. The HSMR is banded as 'lower than expected'.

Chart 2: Rolling 12-month HSMR

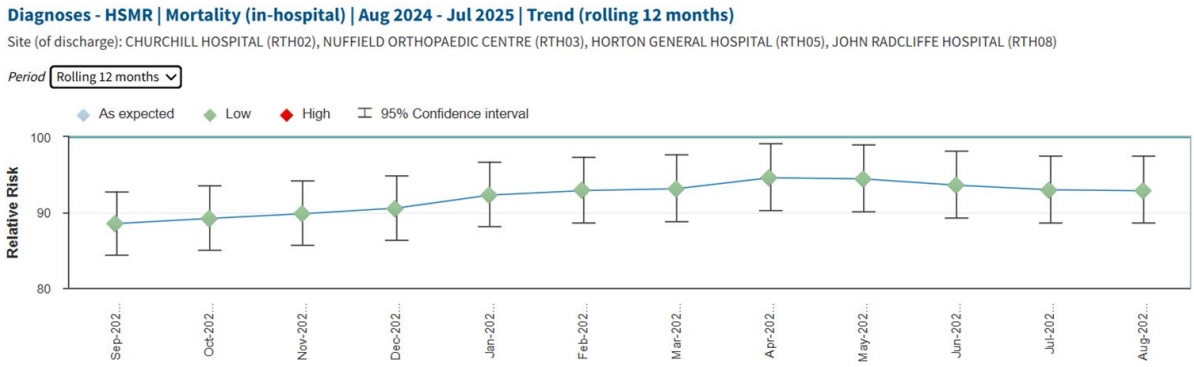
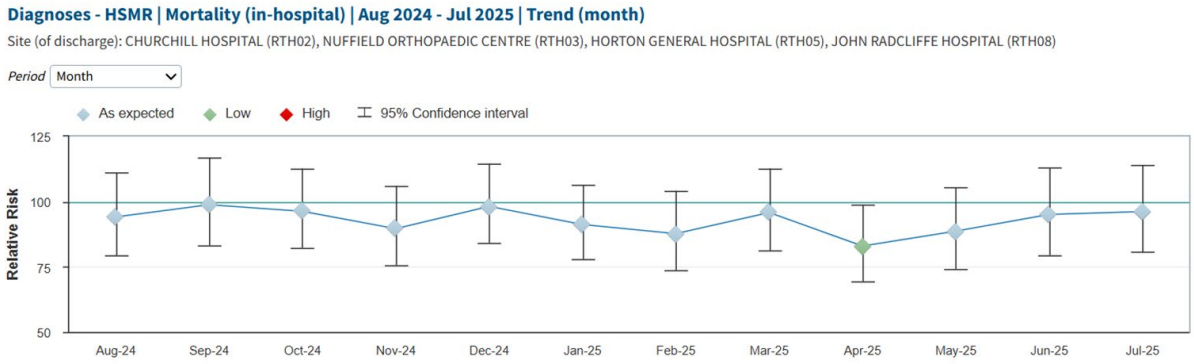


Chart 3: Non-rolling HSMR by month

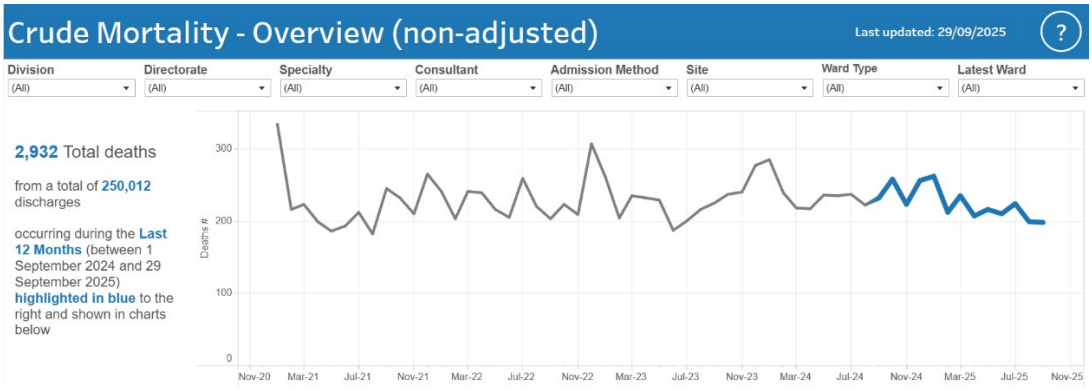


8.4. A summary and comparison of the methods used to calculate the SHMI and HSMR is included in Appendix 1.

9. Detailed analysis of deaths during reporting period

9.1. Crude mortality: Chart 2 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)

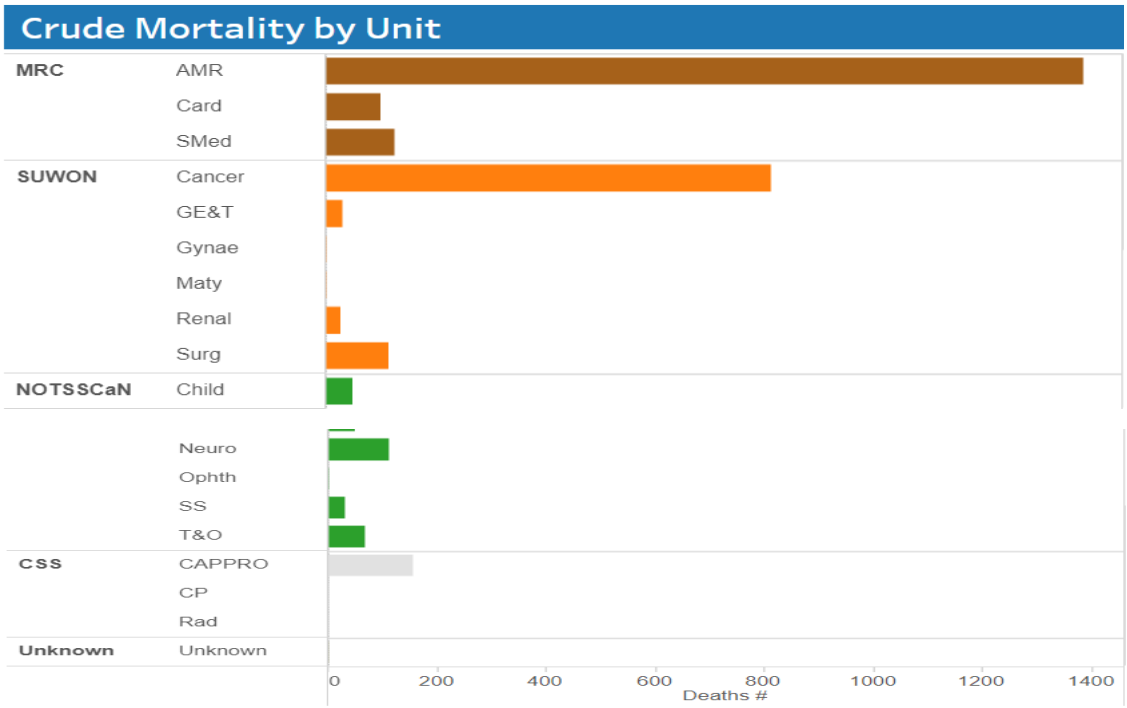


9.2. The highest number of deaths occur in the Acute Medicine and Rehabilitation (AMR) Directorate under the Medicine Rehabilitation and Cardiac (MRC) Division (table 3 & Chart 3). This is consistent with previous reports.

Table 3: Crude mortality by Clinical Division, Quarter 1 of 2025/26

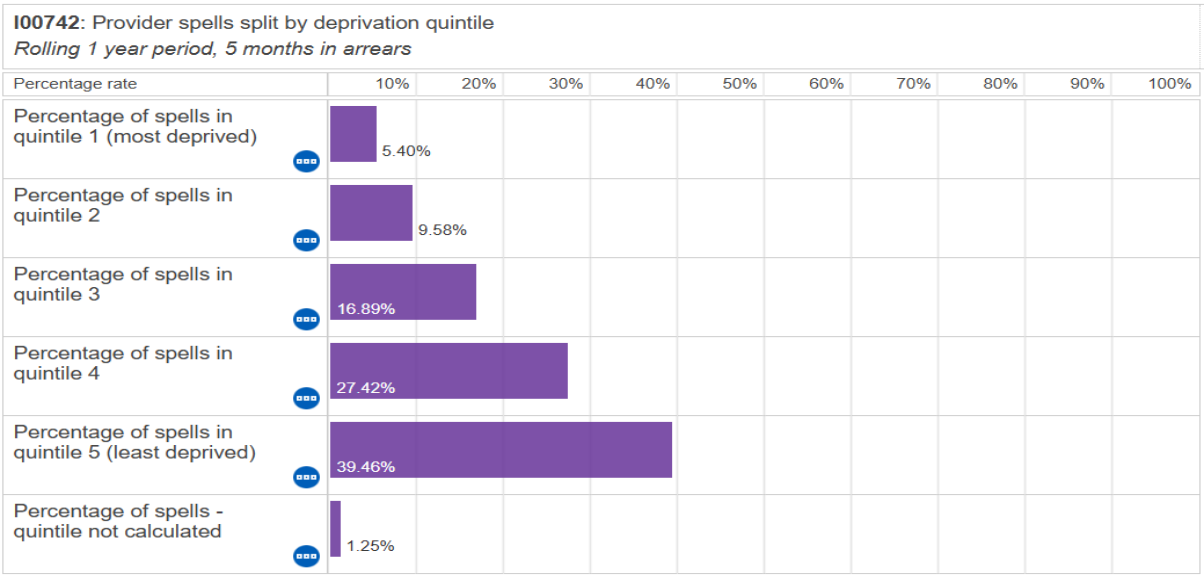
Division	Total Discharges	Number of deaths
NOTSSCAN	16,406	47
MRC	20,973	337
SUWON	19,733	222
CSS	813	27

Chart 5: Deaths by Directorate (annual data)



9.3. Mortality by Index of Multiple Deprivation: Chart 4 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



10. Mortality-related risks on the Corporate Risk Register

10.1. Relevant mortality-related risks from the Corporate Risk Register are listed below:

10.1.1. Failure to care for patients correctly across providers at the right place at the right time.

10.1.2. Trust-wide loss of IT infrastructure and systems (e.g., from Cyber-attack, loss of services etc).

10.1.3. Failing to respond to the results of diagnostic tests.

10.1.4. Patients harmed because of difficulty finding information across multiple systems (including paper and digital).

10.1.5. Potential harm to patients, staff, and the public from nosocomial COVID-19 exposure.

10.1.6. Lack of capacity to meet the demand for patients waiting 52 weeks or longer.

10.1.7. Ability to achieve the 85% of patients treated within 62 days of cancer diagnosis across all tumour sites.

11. Recommendations

11.1. The Trust Board is asked to:

- Note the Learning from Deaths update for Quarter 1 (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.