ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Committee Supporting Paper	**Agenda Item**	Agenda Pack B
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Dr Diarmid Sinclair, Chief Medical Officer		
Meeting	Board of Directors	**Date**	29 January 2026

Suggested discussion points (two or three issues for the meeting to focus on)

The following report, received and discussed by the Quality Committee, is presented today to be noted by the Board of Directors:

Mortality Report – The Quality Committee were assured that the organisation is fully sighted on Learning from Deaths.

Previous consideration (where has this paper previously been discussed – and what was the outcome?)

Quality Committee held 21 January 2026.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE and CONSIDER the appended report for information

Alignment to strategic objectives (indicate those that the paper supports)	
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
Alignment to the plans: (indicate those that this paper supports)	
Safety and quality plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

N/A

System / Place impact (advise which ICB or place that this matter relates to)

N/A

Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

Refer to Agenda Pack B

Rotherham Doncaster and South Humber NHS Foundation Trust

Mortality Report

September and October 2025

Executive Summary

Mortality Information

- **94 deaths** were reported during September and October 2025 (52 in September, 42 in October).
- The **majority of deaths were expected natural deaths**, primarily in older adults.
- **Doncaster Adult Mental Health & Learning Disabilities Care Group** reported the highest number of deaths, reflecting service size and case mix rather than emerging safety concerns-of note this care group provides a different range of services compared to other care groups such as drug and alcohol services.
- **Structured Judgement Reviews (SJRs)** were required in three cases (all October), in line with Learning Disability (LeDeR) policy.

Review and Assurance Processes

- **79 deaths (84%)** were reviewed and closed with *no concerns in care identified*.
- **5 deaths** were returned for further information.
- **5 deaths** had learning responses pending at the time of reporting.
- **1 death** escalated to LFPSE for further discussion

Learning Disability and LeDeR

- All deaths of people with a learning disability are escalated for **SJR and LeDeR review**, in line with Trust policy.
- Between April 2024 and October 2025, **40 deaths** of people with a learning disability were reported. Our data shows a gender imbalance with more men than women dying over the period but the numbers are small and not significant. Further work is being done to quantify the gender split of the caseload.

Coroners' Inquests and External Learning

- **32 inquests** were held during September–October 2025 that involved patients know to the Trust.
- The Trust attended **7 inquests**, with legal representation required on four occasions.
- No **Regulation 28 (Prevention of Future Deaths)** notices were issued to the Trust during this period.
- Common themes emerging from inquests nationally and locally included:
    - **Poor communication** between agencies and with families

- **Incomplete or unclear documentation**, particularly around safety planning
- **Inconsistent risk assessment and escalation processes**

Conclusion

Mortality data for September–October 2025 is consistent with expected patterns for the Trust's services and population. The Trust has processes for learning to be identified and acted upon, and no new areas of significant concern have emerged.

Mortality Report – PLFD

(Data focus September – October 2025)

1. Situation

The Chief Medical Officer for the Trust chairs the bimonthly Prevention of & Learning from Deaths Group, (PLFDG) previously the Mortality Surveillance Group (MSG).

A report is then provided to the Quality Committee (QC) and forms part of the Chief Medical Officers Quarterly report to the Board of Directors (Public).

2 Background

This report provides the Quality Committee with salient features and issues in relation to mortality surveillance management with a focus on data for September and October 2025.

3 Assessment

3.1 Mortality Reporting and Management

During the months of September and October 2025, there were 94 deaths in total reported in the Trust.

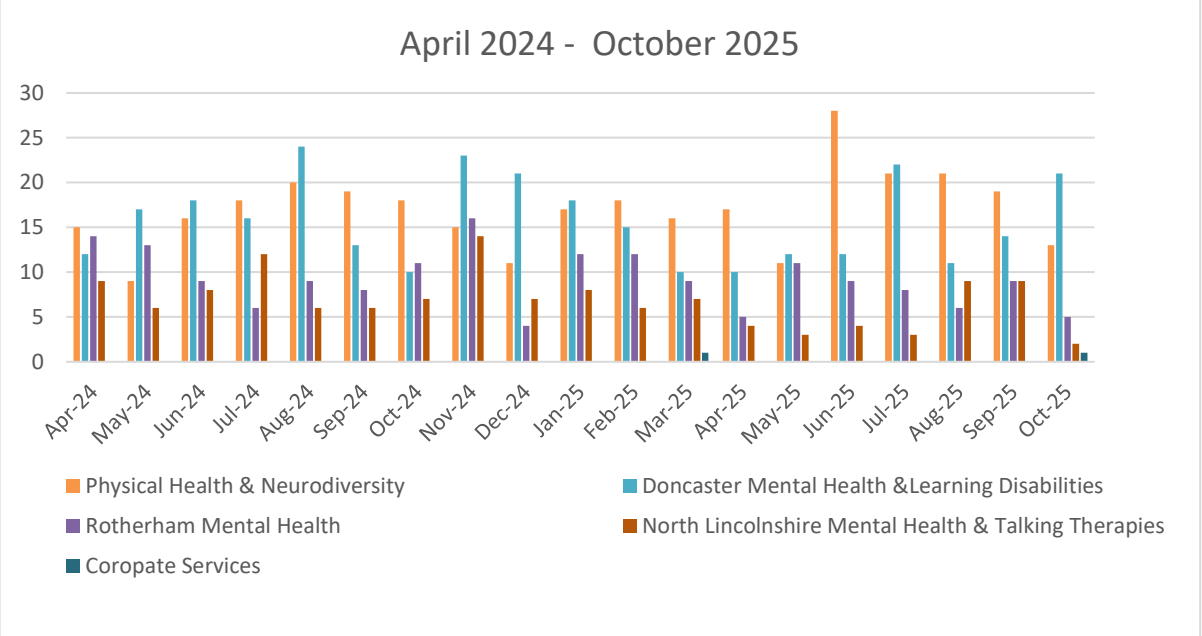
Table 1- Status of deaths reported during September and October 2025

Outcome of review	September	October
Reviewed by MOG and were closed as no problem in care was identified	45	34
Reviewed by MOG but require further information and have been returned to the author	3	2
Reviewed and requires a Structured Judgement Review (SJR)	0	3
Reviewed and required further discussion in a Learning from Patient Safety Event meeting.	1	0
Awaiting further information from the coroner on cause of death	1	0
Adverse outcome	0	0
Awaiting review by MOG	0	0
Learning Response to be done	2	3
Total	**52**	**42**

Deaths by Care Group from April 2024 – October 2025

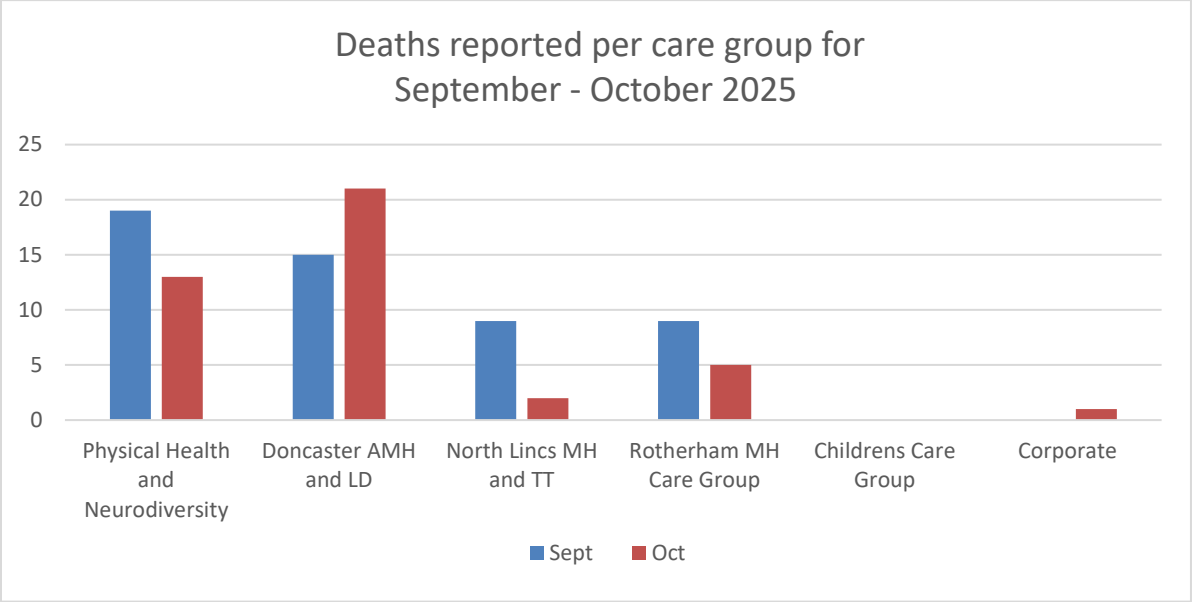
Graph 1 –
This graph offers figures for all deaths reported by the five care groups within the Trust from April 2024 up to October 2025

Graph 1



Deaths reported per Care Group for September and October 2025

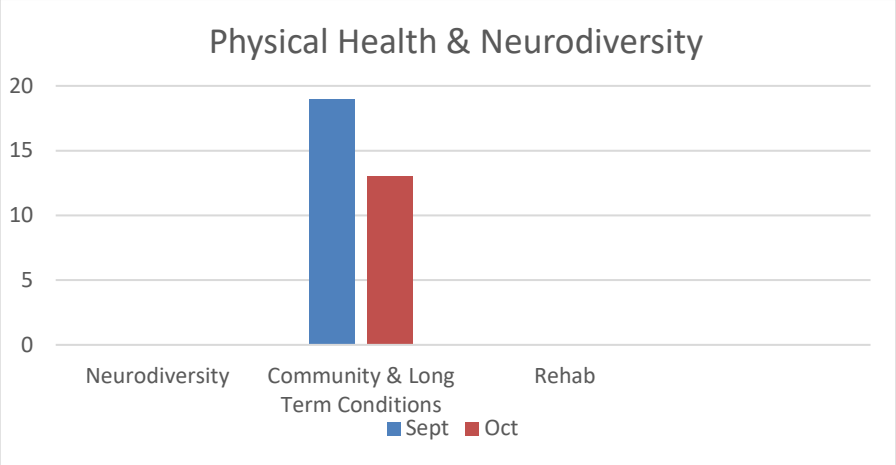
Graph 2



The highest number of deaths reported during the months of September and October are from the Doncaster Adult Mental Health and Learning Disabilities Care Group.

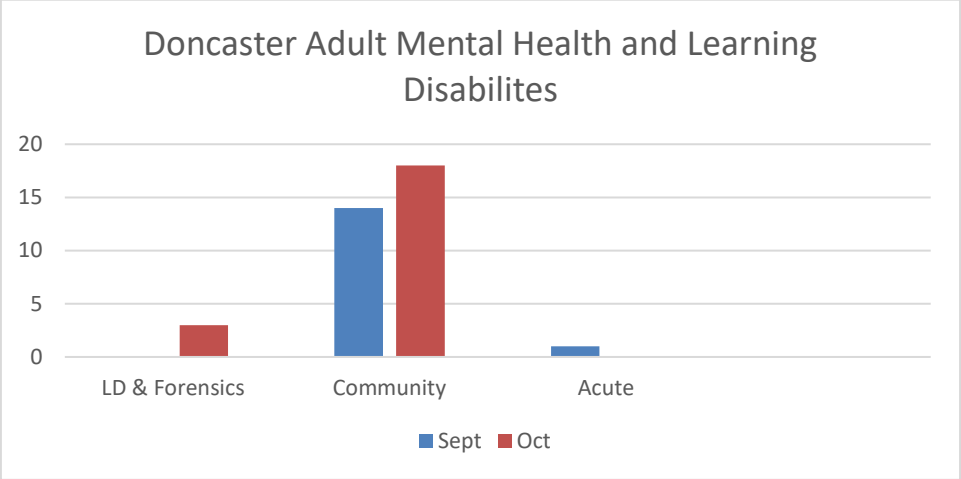
The graphs below, 2a -2e, detail the numbers of deaths reported per individual care groups

2a



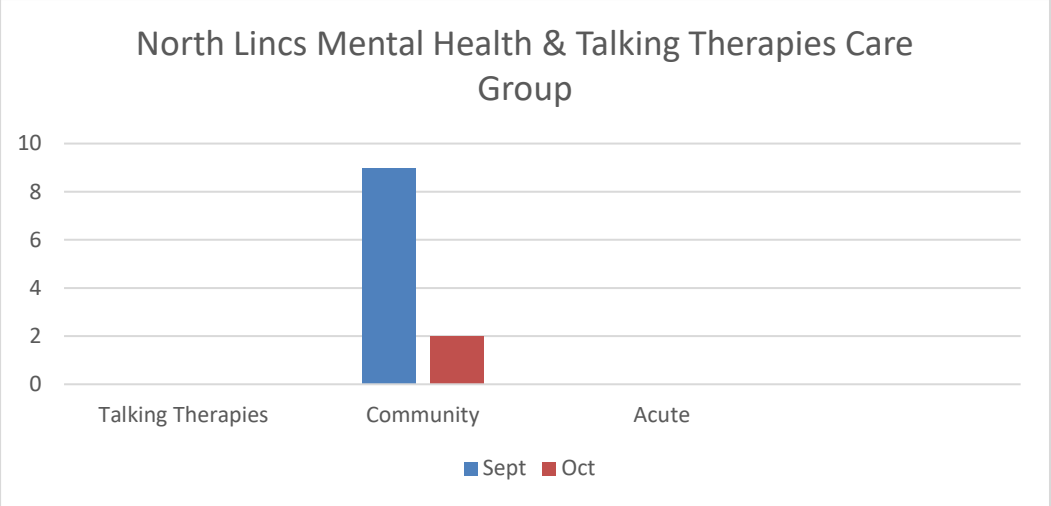
During September 90% of the deaths were reported by St Johns Hospice and 72% during the month of October.

2b



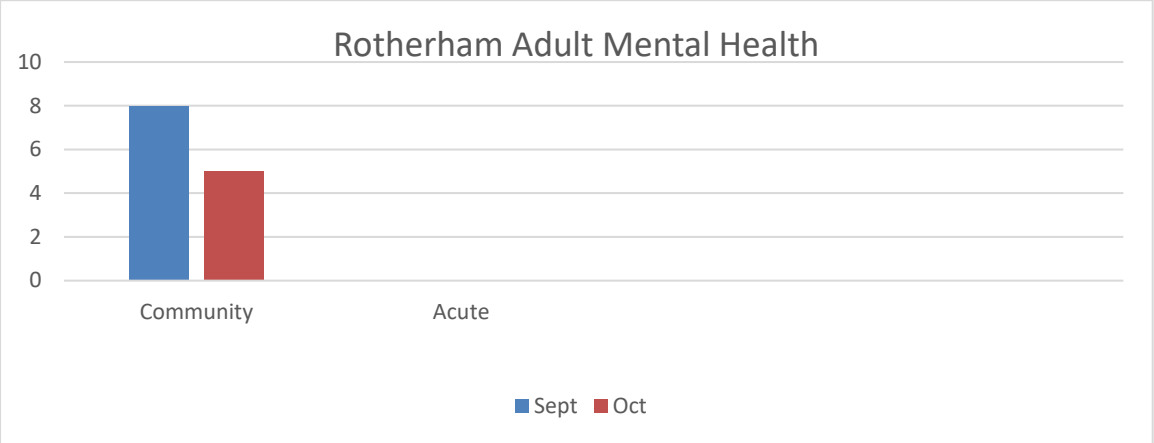
For the Doncaster Adult Mental Health and Learning Disabilities care group, the highest number of deaths were reported by the Community Mental Health Teams during both September and October. Further information is detailed in the additional graphs within this report.

2c



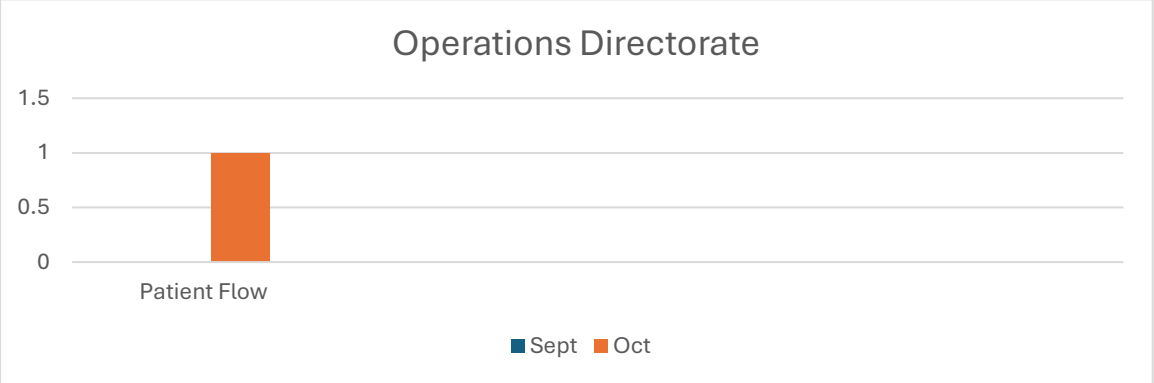
All deaths reported by the North Lincolnshire Care Group for both September and October were made by the community mental health teams.

2d



100% of deaths reported by Rotherham Adult Mental Health Care Group were from the Community Mental Health Teams.

2e

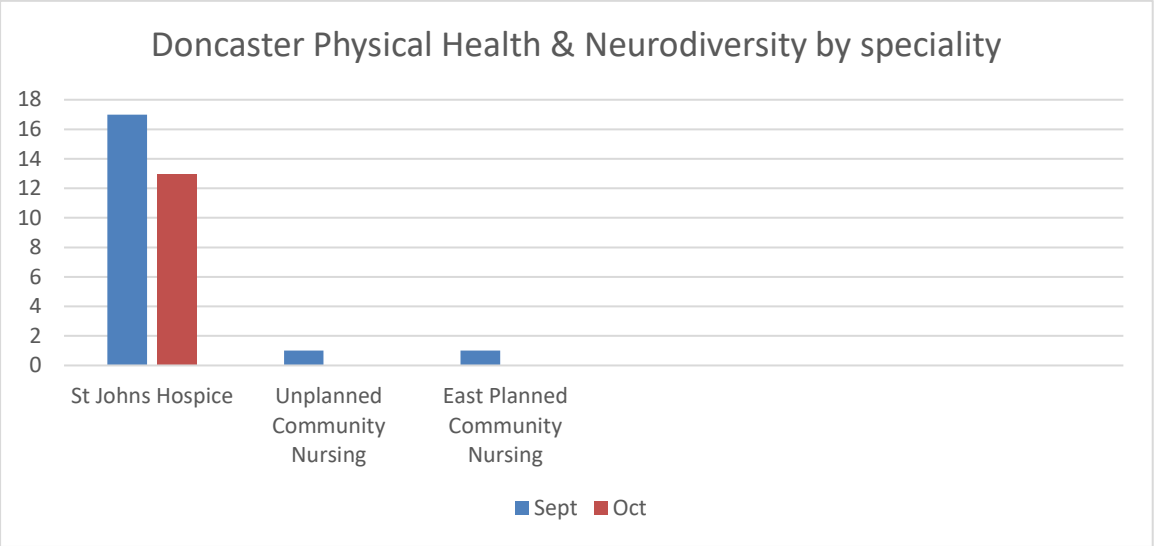


One death during October reported on RADAR was added by the patient flow team. The coroner has requested detailed statements in respect to this person's unexpected death.

3 Deaths per Directorate September and October 2025

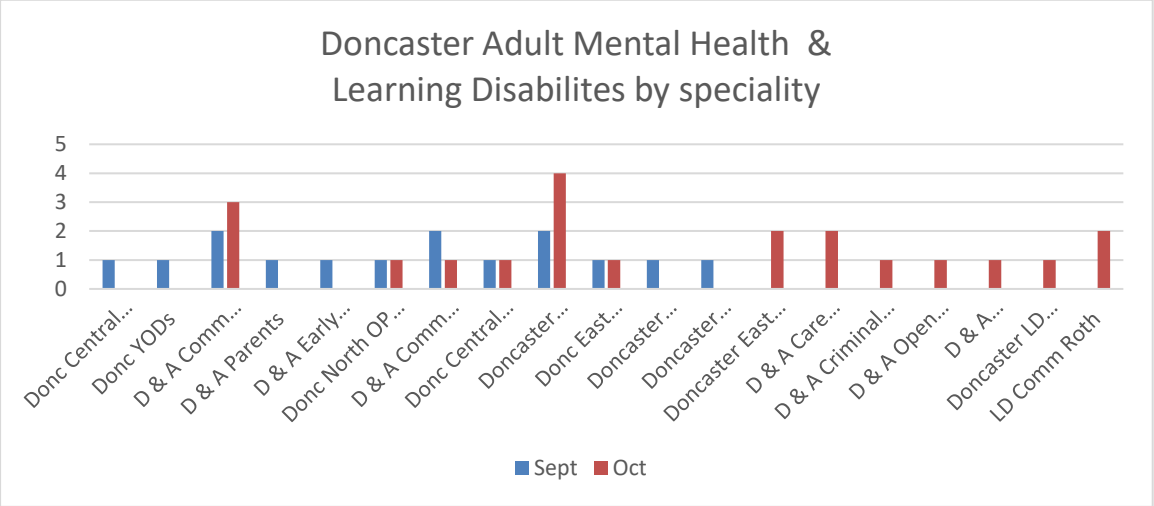
3.1 Graphs 3a – 3d show the number of deaths reported by specialties across the Trust for September and October 2025. The graphs detail specific teams within the Trust who recorded deaths using the RADAR reporting system.

3a



Graph 3a. The highest % of deaths reported within the Doncaster Physical Health & Neurodiversity care group were from St Johns Hospice. There were no concerns associated with the deaths and sadly the nature of the care environment.

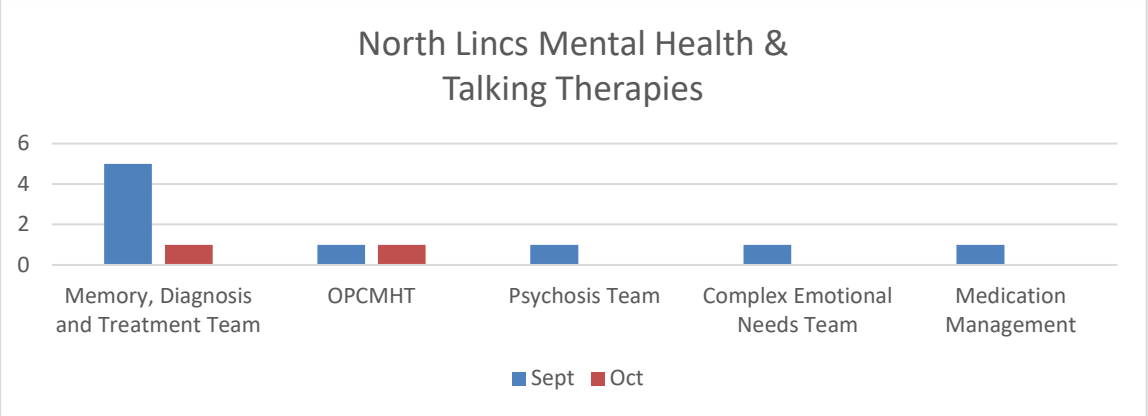
3b



Graph 3b. During September 42.8% of deaths reported were from the Drug and Alcohol services with 52.3% recorded in October.

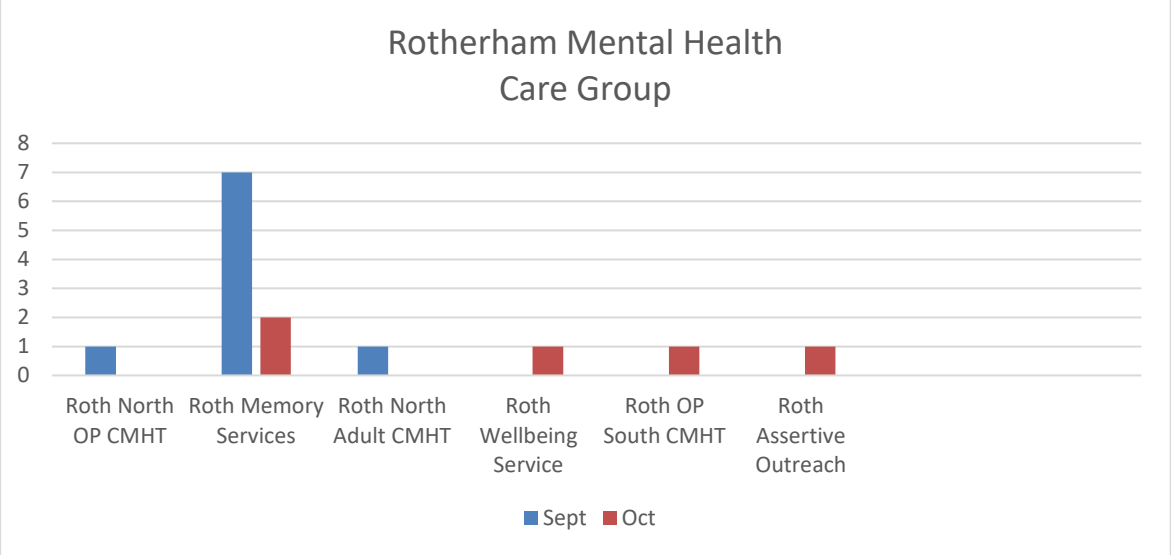
In September 35.7% of deaths were reported by the Older Peoples Community Mental Health Teams compared to 33.3% in October.

3c



Graph 3c shows that the deaths reported from North Lincs Mental Health and Talking Therapies for September were from the Older Adult and Memory & Treatment Teams

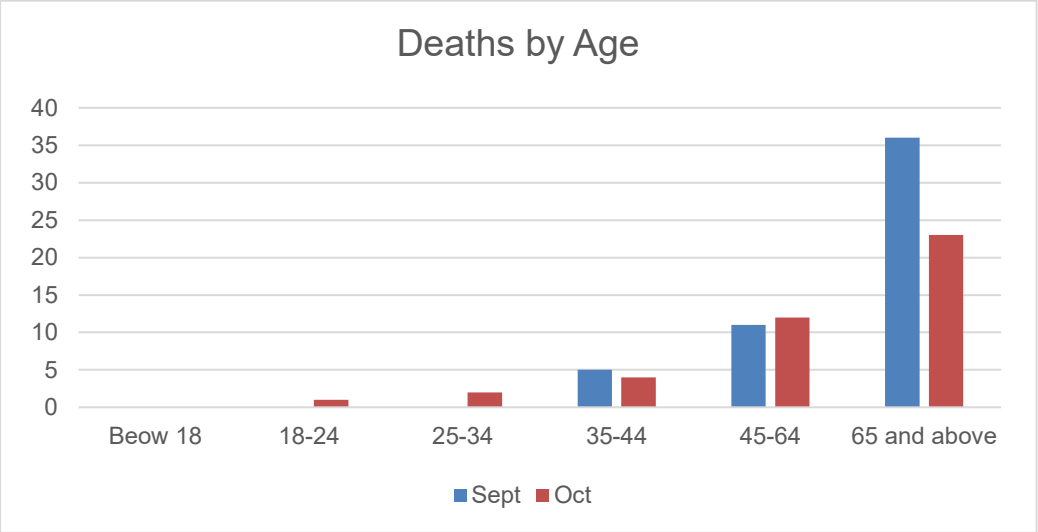
3d



Graph 3d identified that the highest reported deaths for both September and October were from the Older Adults Community Mental Health Teams.

Deaths reported by Age: September – October 2025

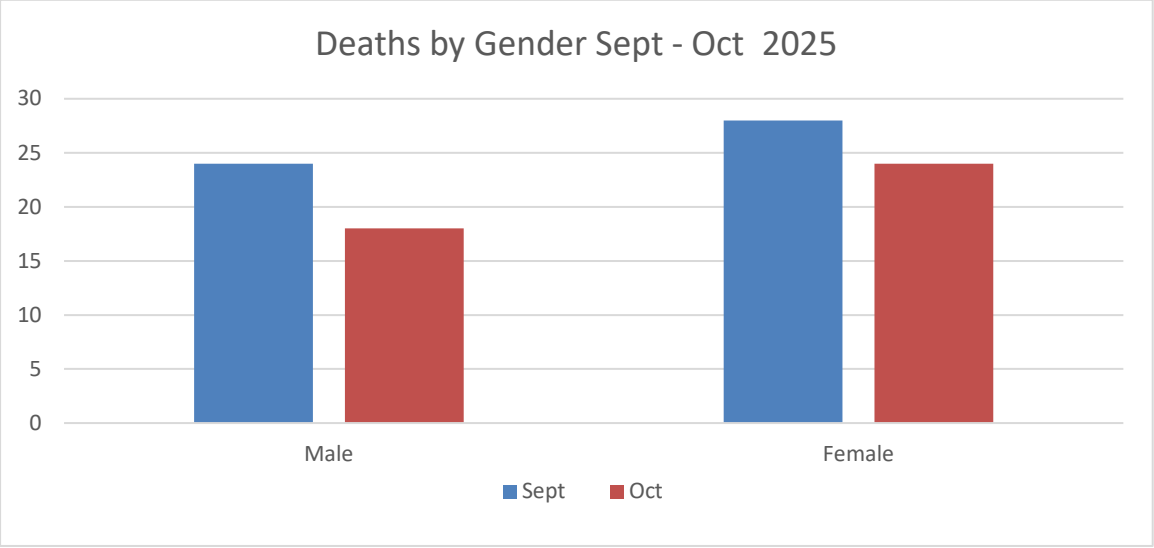
Graph 4



During September and October 2025 there were 94 deaths reported on RADAR. The highest age group being 65 and over with 62.7% of deaths recorded.

Deaths by Gender

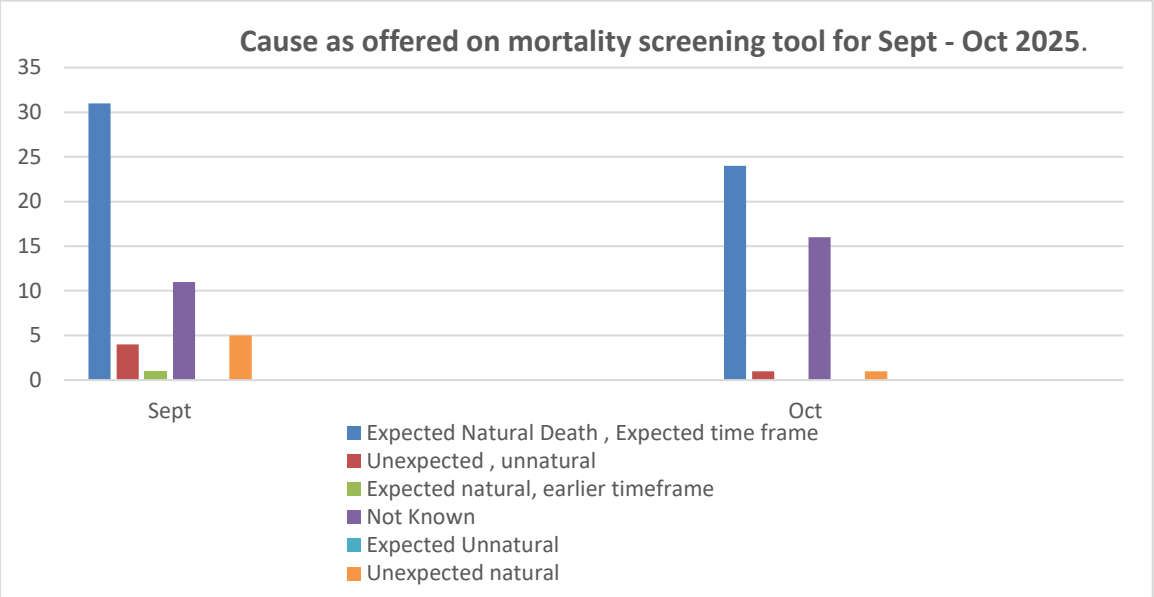
Graph 5



The information displayed in Graph 5 shows that 55.3% of the deaths reported for September and October were female. The highest percentage of deaths reported were female over the previous four months data.

Time frames offered by the mortality screening tool.

Graph 6



Graph 6 shows the timeframe of death as documented on the RADAR system.

The 'Not Known' category can be due to several factors such as awaiting cause of death or further information. 28.7% of the deaths reported were within this category.

58.5% of the deaths reported during July and August were expected natural deaths and within the expected time frames.
5.3% of the deaths were reported as unexpected and unnatural causes.

3.2 Structured Judgement Review Process

All deaths recorded in the Trust are reviewed by the Mortality Operational Group (MOG) via the RADAR reporting system. During the process, each death is reviewed and if any 'Red Flags' are identified the incident is escalated to either a Structured Judgement Review if the person is known to our Learning Disability Services or is tasked back to the author, care group or service for further review under the PSIRF approach options.

The escalation of the concerns is further discussed at the following LFPSE meeting along with representatives from the Patient Safety Team.

Once the learning response has been added to the RADAR form, this is again reviewed by MOG and if no further concerns are noted, the form is then closed.

The two structured judgement reviewers continue to work additional hours to address the backlog of outstanding reports.

There are 37 reviews waiting to be completed up to the end of October

2025, of which 18 are historical reviews. This figure may alter due to SJR's added following each MOG review.

Under the new PSIRF approach, care groups will have a more active role in the completion of all the different review options and therefore take the learning directly into the care teams with the opportunities to share across services.
Attendance by the two SJR / Coroner and Mortality staff at the LFPSE meeting provides further opportunity to share the learning from inquests and for the information to be shared wider across other forums throughout the Trust.

Table 2 –
The table below indicates the monthly reviews of each death which was reported during September and October 2025 on the Radar system.

Month	September	October
Total number of deaths reported	52	42
Total No of deaths reported by Care Group		
Donc AMH & LD	14	21
Physical Health and Neurodiversity	19	13
Rotherham AMH	9	5
North Lincs & Talking Therapies	9	2
Children's services	0	0
Corporate Services	0	1
Cause group		
Expected natural death	31	24
Expected natural death, earlier than expected timeframe	1	
Expected unnatural death	0	
Not known	11	16
Unexpected natural death	5	1
Unexpected Unnatural death	4	1
Gender		
Male	24	18
Female	28	24
Age Group		
<18	0	0
18- 24	0	1
25-34	0	2
35-44	5	4
45-64	11	12
>65	36	24
MOG data		

Incident appraisal screening tool only	**45**	**34**
Await further information and returned by MOG to the author	**3**	**2**
SJR Inc for LeDer report	**0**	**3**
Escalated to Patient Safety Team	**1**	**0**
Await info from coroner re Cause of Death	**1**	**0**
Await review by MOG	**0**	**0**
Learning response to be done	**2**	**3**

3.3 LeDer reports & Structured Judgement Reviews

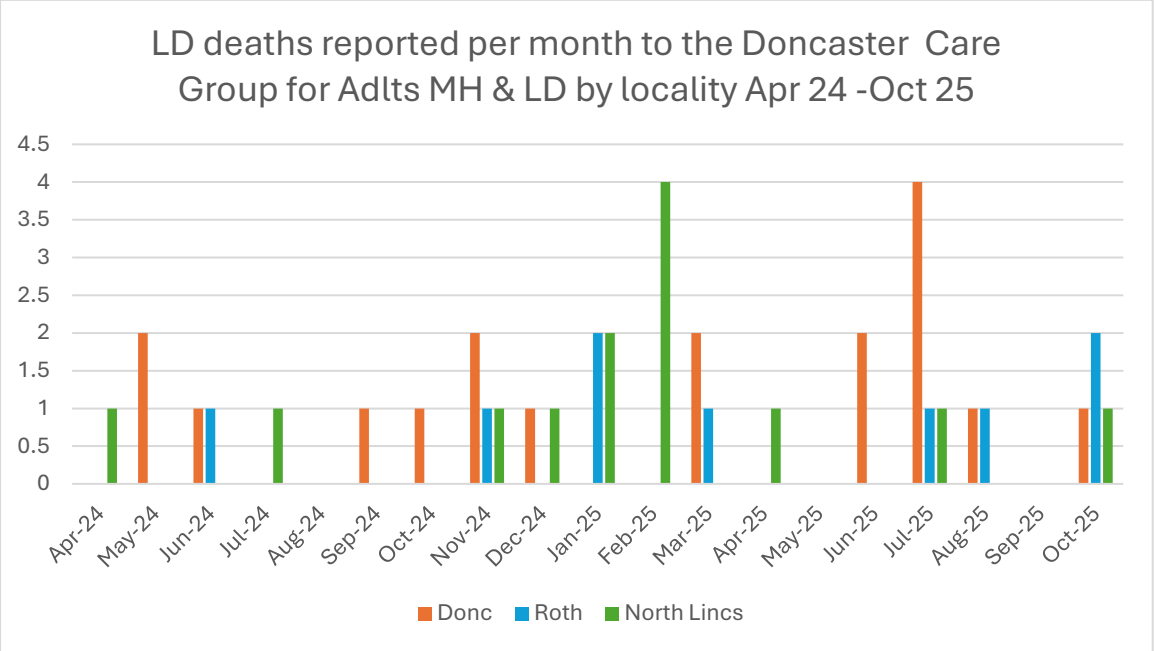
Current Trust policy states that for all deaths where it is known the deceased person had a learning disability the incident will be escalated to an SJR. As well as an SJR, a LeDeR review is also automatically completed.

The 'Learning from Lives and Deaths, LeDeR' process reviews the care of individuals who have died and are known to have a learning disability or autism.
The latest LeDeR report was published in September 2025. It reviewed the deaths of 3,556 people in 2023 of people with learning disability and or autism. It found that the percentage of avoidable deaths for people under 75 years of age had fallen from 46% in 2021 to 39% in 2023. However, this was still double the percentage of avoidable deaths in the general population.

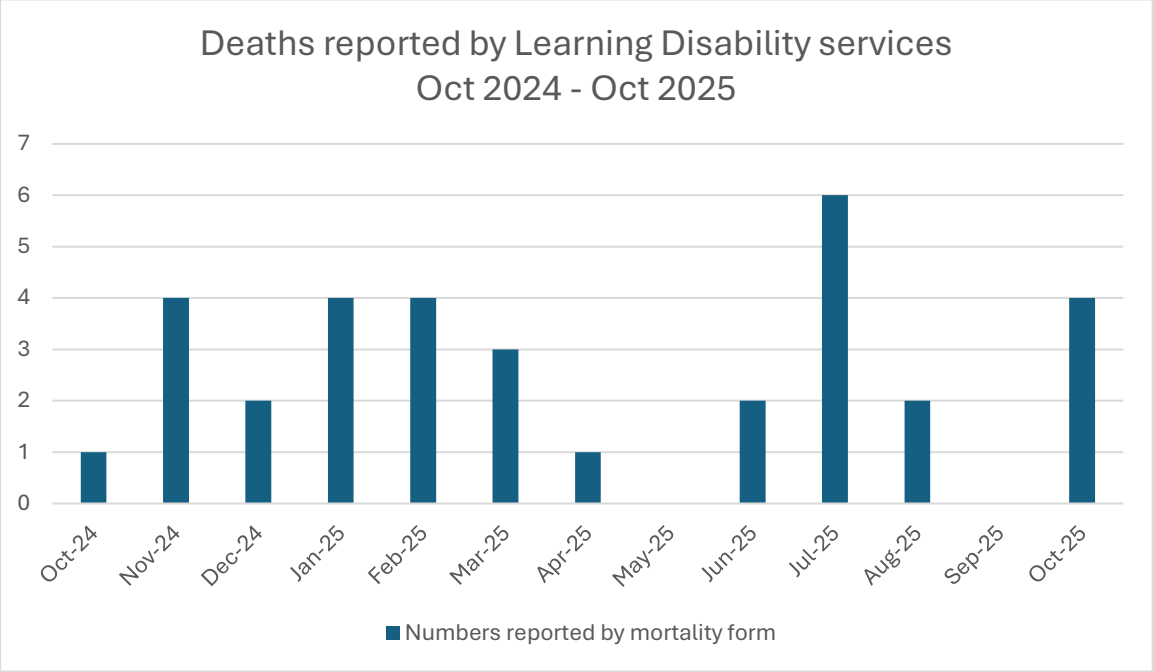
Graph 7 below shows the numbers of deaths of people with a Learning Disability which has been reported on the mortality reporting systems, both Ulysses and Radar between April 2024 – October 2025.

The graph shows that 40 deaths have been reported during this time from April 2024 – October 2025 using the reporting systems in place at the time.

Graph 7

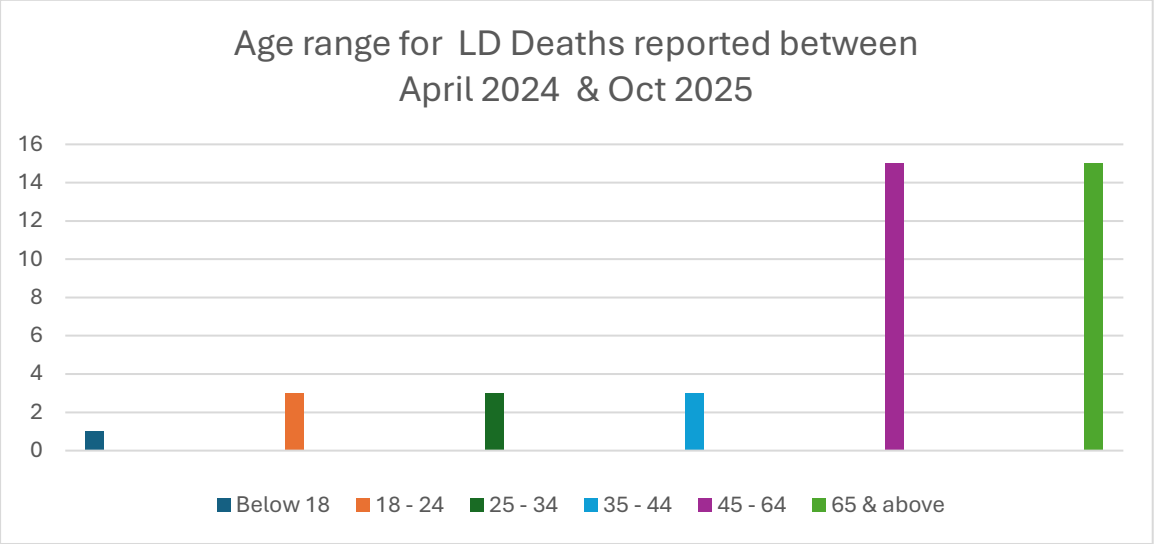


Graph 8

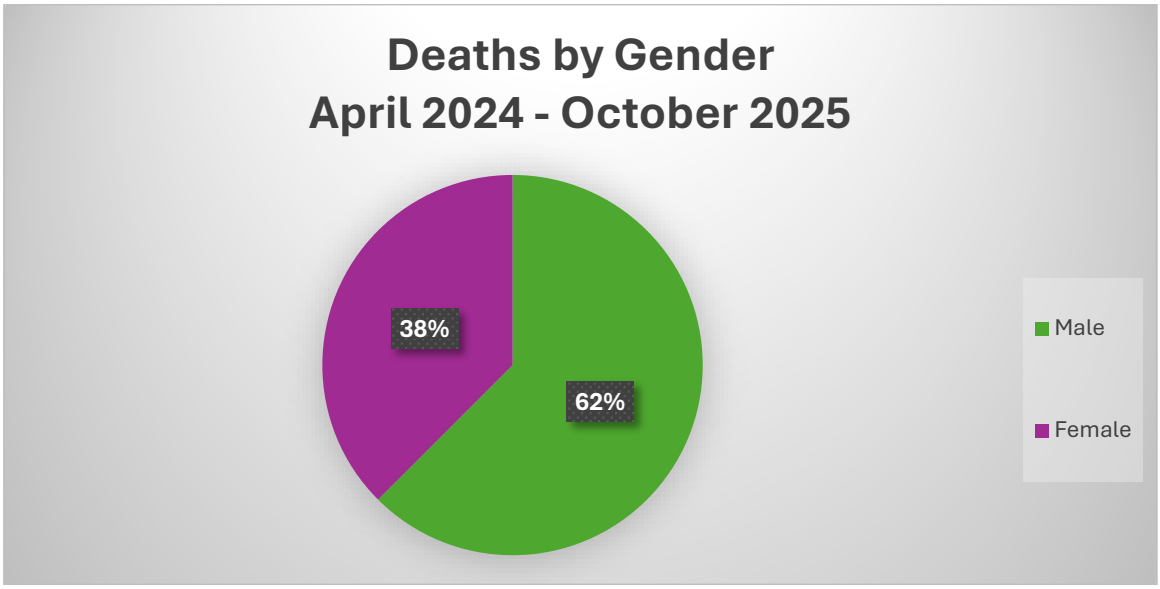


Graph 8 details deaths reported over a twelve-month period Oct 2024 - Oct 2025.

Graph 9

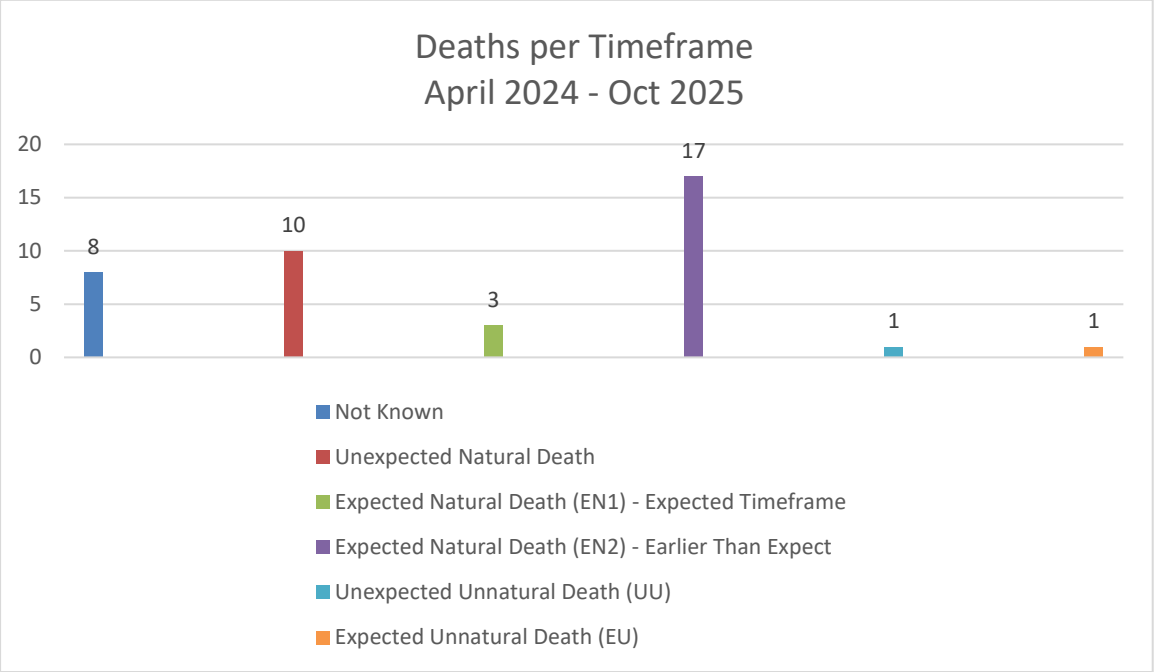


Graph 10



Graphs 9 and 10 offers detail of deaths relating to age and gender reported using the Ulysses and RADAR mortality reporting system from April 2024 – Oct 2025.

Graph 11



Graph 11 offers detail of the timescales of deaths reported April 2024 - October 2025.

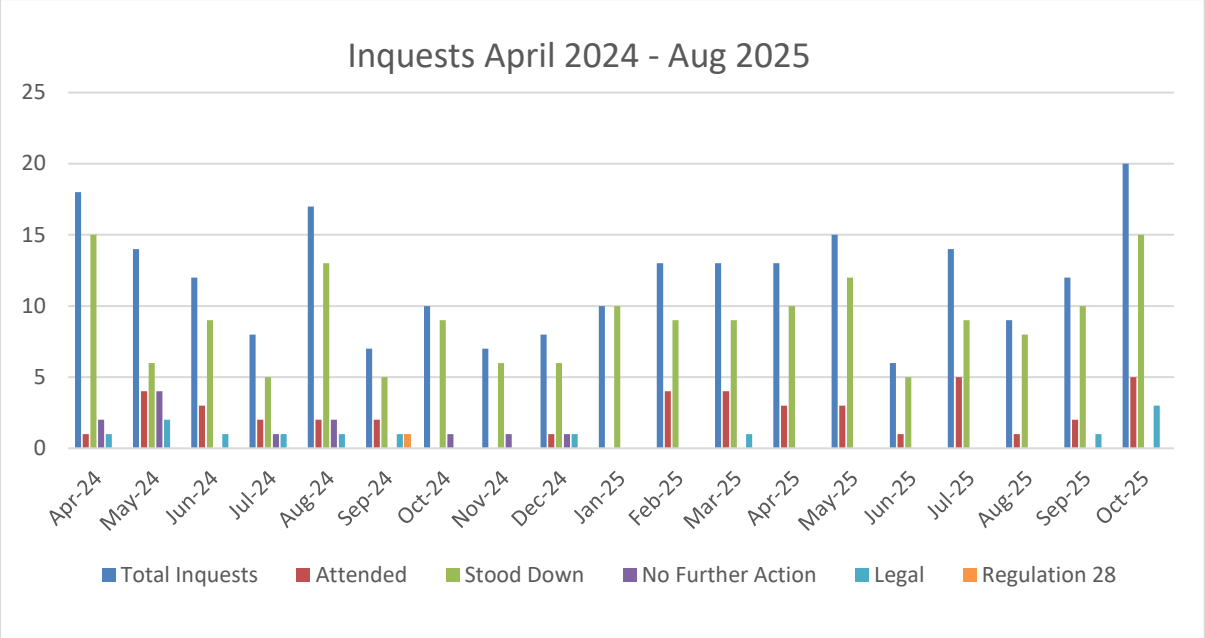
An expected unnatural death refers to where the cause of death is not from natural disease progression but still anticipated given the circumstances. This can involve where the death was expected but the manner is not entirely due to the natural disease progression. For example, resulting from an accident, overdose, or suicide. This is even when the individual was diagnosed with an existing illness.

4. Learning from Deaths

4.1 Coronial Inquest

Graph 12 This graph offers detail regarding the number of inquests from April 2024 – Oct 2025

Graph 12



During September and October 2025, thirty-two inquests were held which involved the Trust providing statements to assist the coroner.

The coroner stood witnesses down on twenty-five occasions for the scheduled inquests. The coroner was satisfied with the reports submitted without any further questions and therefore statements were read as evidence under Rule 23 of the Coroner's Inquest Rules 2013.

The coroner's liaison team received forty enquiries in total during September and October.

During September and October 2025, the Structured Judgement Reviewers / Coroner & Mortality Support staff attended court for seven inquests involving the Trust.

Legal representatives were in attendance for the Trust once in September and on three occasions during October.

Coroners' conclusion of the seven inquests attended.
Suicide recorded on 2 occasions
Drug or Alcohol related Death recorded on 1 occasion
Narrative conclusions on 4 occasions

During October, a three weeklong inquest with a jury was held in Nottingham. The Trust were summoned to attend the inquest and had two witnesses called to provide live evidence to the coroner and jury.

A legal representative was in attendance on agreed particular days of the inquest for the Trust.

A staff member from the Coroners Liaison Team attended on additional key dates and at the request of the coroner.

The conclusion of the inquest found that the deceased died whilst detained under Section 3 of the Mental Health Act from a pulmonary thromboembolism whilst in the care of the Nottingham Healthcare NHS Foundation Trust.

The deceased was admitted to an inpatient bed in Doncaster in December 2023. This was an out of area bed, the deceased being from Nottingham. Repatriation took place in April 2024.
The Trust accepted that communication with the patient, the patient's family and the receiving authority was poor.
As part of the submissions to the coroner, the Trust provided evidence both verbally and written to the court as to how lessons had been learnt and the steps now in place to prevent and mitigate this in the future.

After hearing the evidence, the jury all agreed that communication between RDaSH to the family regarding the repatriation was poor. The coroner accepted the learning provided by the Trust.

Other concerns raised during the inquest led to the coroner issuing a Prevention of Future Deaths, Regulation 28 reports to the two Nottinghamshire Healthcare Authorities, Mental Health Trust and to the Acute hospital. The coroner was not satisfied the measures which had been put in place by the two authorities since the death were adequate enough to prevent future deaths occurring.

Of the inquests attended during September and October it was evident from the information provided and the conclusion offered by the coroner key themes of concern emerged.

These included the following areas –

- A lack of communication between internal and external agencies.
- A lack of thorough documentation in care records
- Lack of communication with families and carers especially with regards to safety planning
- Safety plans were mentioned in the care records as "discussed;" however, no evidence was documented regarding specific detail of what these were or who they had been either discussed or agreed with.

- Acceptable learning responses following PSII reports with proactive and timely actions in place to demonstrate learning had taken place and embedded into practice.

The role of the coroner

The coroner's inquest court is a fact-finding inquiry and held in a public court where the coroner has four specific questions to be answered. –

Who has died?
When did they die?
Where did they die?
And
How did they die?

The last question is usually the focus of the inquest.

The coroner has a duty to investigate a death where –

- The cause is unknown
- Death occurred in custody or state detention, this includes deaths in prison or police custody and for people detained under the Mental Health Act
- Where the person has had a violent death and this includes self-harm
- Where the death is unnatural
- Where there has been a complication of medical treatment
- Where the death was more than minimally contributed by the shortcomings in the medical procedure.

Following the evidence presented to the coroner and the jury, if one is present, the coroner will provide a conclusion to the court. These can be made as the following short form conclusion of the inquest -

- Natural causes
- Accident
- Misadventure
- Suicide
- Alcohol / drug related
- Road Traffic Collision
- Stillbirth
- Unlawful killing
- Open

The coroner can also provide a narrative conclusion which offers further statement addressing the issues central to the cause of death.

Regulation 28
During the months of September and October the Trust received no Prevention of Future Deaths (PFD) from the coroner for inquests involving the organisation.

Regulation 28's issued to authorities and organisations are published by the chief coroner.

Attached in the appendices of this report are examples of Regulations 28's issued to authorities and organisations during September and October 2025 where mental health services have been involved.

To note: Key areas of concern are included and share similarities in learning from recent inquests concerning RDaSH.

Appendix 1

Jurisdiction	**Brief circumstances**	**Concerns for PFD**	**Issued to**
Nottingham and Nottinghamshire	Female 22 years died from a pulmonary thromboembolism whilst detained under Sec 3 of the MHA 1983. Originally from Nottingham and known to Nottingham health care. Admitted to Doncaster in patient bed in December 2023, repatriated to Nottingham April 2024. Known history of complex mental health concerns.	Lack of joint agency policy/cross-sector working between physical and mental health trusts in relation to the insertion of foreign bodies I heard evidence that it would have been beneficial in X's case for there to have been an MDT between X's psychiatric team (NHCT) and her physical health team (Orthopaedics and Anaesthesia at SFH). The reason that this would have been of assistance is due to the complexity of cases where there are physical and mental health considerations in play for decisions around the management of a foreign body.	Nottingham Healthcare NHS Foundation Trust. Sherwood Forest Hospitals NHS Foundation Trust. Department for Health and Social Care.

		There is no embedded mechanism for arranging MDT meetings, or indeed for any liaison or contact between these teams, in such cases. Similarly, there is no policy or procedure which prompts clinicians from either team to consider an MDT in these cases or, at the very least, picking up the phone for a consult. If this had happened in X's case, it seems likely that the outcome in relation to the management of the foreign body would have been different. X's psychiatric team were keen for removal and were satisfied that they could implement a robust policy to avoid re-insertion, which was one of the main concerns of the Orthopaedic team. In my opinion there is a risk that future deaths could occur unless action is taken in relation to this issue.	

		2. VTE risk assessment and associated policy and training at NHCT During the course of X's inquest, I heard evidence which concerns me that there is a lack of clarity in relation to the current local VTE policy. I was provided with version of the policy that I have assured was current at the outset of the inquest. All witnesses who were directly asked about this policy recognised it as the current policy in its terms. On 22 October 2025, I was sent late disclosure of the correct updated policy which was ratified in April 2025 (available to view from May 2025), some 6 months before the inquest hearing began. The updated policy was materially different in its terms on the frequency and circumstances in which VTE risk assessments should be undertaken. This gives rise to a number of specific concerns: A) The staff do not have a proper working	

		knowledge of the current local VTE policy. B) The knock-on concern from this is that the training around the VTE policy is not robust in its content or is otherwise not being properly engaged with by staff. C) The current policy has been weakened in its terms, in particular at paragraph 1.6 where the requirement for an updated assessment of risk on at least a weekly basis has been removed. I understand from the evidence that, notwithstanding the wording changes to the policy, prompts are given on VTE risk assessment at the weekly MDTs. I am concerned that the policy is not reflective of the encouraged practice on the Wards. I am also concerned that, whilst this happens on Fir Ward, it is important that guidance is consistent across all wards within the Trust. The common document across the wards is the local policy and therefore I am concerned about the	

		clarity and robustness of its terms. In my opinion there is a risk that future deaths could occur unless action is taken in relation to this issue. 3. The disbanding of the Personality Disorder I am told that as of mid-October 2025, the Personality Disorder Hub at NHCT has been disbanded. Neither the witness who worked within the disbanded service, nor the policy witness for NHCT was able to give me any particulars as to the arrangement of the new service, beyond a general statement that it was being absorbed into the LMHTs. I was told by the witness who had worked within the PDH that his understanding for his LMHT was that there would be a personality disorder service which would consist of him, as that was his specialist interest. Given the current inquiry into Mental Health	

		Services in Nottinghamshire, and particularly the care of those patients with personality disorders within the service, I am concerned about the lack of clarity within the Trust as to the current position and level of service available to patients with personality disorders. I am concerned that an absence of a specialised and central service dealing with personality disorder patients, with care provided by specialists in personality disorder, causes a risk of future death. 4. The policy and procedures around the management of insertion of foreign objects for SFH Hub at NHCT I have had sight of the newly ratified local policy for management of insertion of foreign objects at SFH. I am concerned that its content is lacking in specificity, the language used is vague and open to interpretation, and it	

		does not provide clear advice for medical professionals accessing it for guidance. It is not a robust policy in its terms. Further, I am concerned that it does not make any reference to consultation of mental health services, whether local or acute, at all. Given that the policy recognises that in the majority of cases where management of insertion of foreign objects the patient has a mental health condition, I find this particularly concerning. Based on the evidence that I have heard, I am also concerned that there is no effective communication of the policy and guidance to Trust staff on this issue. 5. Staffing on mental health wards I have been told by numerous witnesses to this inquest that the staffing levels on Fir Ward both at the time of X's admission, and now,	

		are insufficient. The result of that, I am told, is that the wards cannot run safely and patient care and safety negatively impacted. Staff simply do not have time to complete essential tasks on the ward (like physical observations, completing care plans and risk assessments etc.) or give the patients the 1:1 time they require. I saw a genuine concern and regret on the faces of the hardworking healthcare professionals who gave evidence in my court of the course of this inquest, some were brought to tears. The job is relentless, and they do not feel supported by virtue of a lack of staff numbers and experience. I am told that this remains the case notwithstanding that the minimum staffing levels as governed by the Department of Health and Social Care are being met. This is an issue of grave concern. It suggests that the minimum levels of staff are too low, the staff pool is not sufficiently	

		experienced across the board, that the wards are not functioning safely and that patients are at risk of death as a result.	
Birmingham and Solihull	Male , long history of paranoid schizophrenia. Past suicidal thoughts and attempts on life. Inpatient under Section 37 .On hourly obs. Despite accepting of prescribed medications continued to experience persistent voices. On the particular day not out of characters noted , mood settled, taken usual unsupervised leave and staff had raised no concerns. Seen in dining room 17:05 Then seen on cctv in garden towards roof. Alarm raised by resident 17:10. Staff witnessed	Unprotected fire escape at the rear of the building which could be easily accessed from the garden which gave easy access to the roof. No risk environmental assessment completed . Inadequate railing at top of the staircase. . No guidelines setting out what protections are required for fire escapes in rehabilitation settings. The lack of guidelines presents a risk of future deaths , action to be taken.	Care Quality Commission NHS England Birmingham and Solihull Integrated Services

	male lying face down in driveway. Staff provided immediate first aid. .Ambulance called 17:15 Pronounced deceased at 19:11. Cause of fall not determined. Inappropriate for the Trust to rely solely on individual risk assessments when considering who could use the garden unsupervised. Failure in the generic risk assessment methodology.		
City of London	Deceased died as a direct result of own deliberate act. State of mind adversely affected by acute symptoms of diagnosed mental illness which had probably resulted from a period of noncompliance with medications prescribed to	1. The Deceased presented to the South London and Maudsley NHS Foundation Trust's psychiatric liaison team which was operating within the Accident and Emergency Department of King's College Hospital, with a referral letter from his General Practitioner which sought possible	Medical Director of the South London and Maudsley NHS

	manage symptoms. Sent to A&E by GP with referral letter requesting an assessment of their mental state, possible admission, and medication review. Seen by mental health liaison team and was decided their presentation resulted principally from social circumstances rather than mental illness and discharged back to care of GP. The assessment did not take into account a reported plan to end their life by jumping from abridge if no clinical treatment or support offered. The death more than minimally contributed to by receiving no	admission and medication review. The Deceased was known to the Trust, and he had been the subject of a safeguarding referral and a self-referral shortly before his attendance at the hospital. From the information available to the psychiatric liaison team, it was apparent that: (i) The Deceased had a chronic and persisting mental health condition which was usually controlled by medication but which, when not controlled, could give rise to suicidal ideation; he had previously been helped by periods of detention / voluntary admission to hospital, (ii) By May 2024, there was evidence that he was suffering an acute deterioration in his mental health which he subsequently reported was because he had not been properly compliant with his prescribed	

	treatment or support from mental health services following their assessment by a mental health liaison team in the emergency department.	medication for a number of weeks, and (iii) The Deceased recognised the deterioration in his mental health, that he was suffering specific suicidal ideation. relating to jumping from London Bridge, and that he needed help from mental health services, including by voluntary admission to hospital; he sought help by making a self- referral to the Trust via the Single Point of Access service and by attending his GP and the hospital. 2. When the Deceased attended the hospital, the Accident and Emergency team's triage notes included express reference to his specific suicide plan and attached the GP's letter of referral. The Deceased was then assessed by a psychiatric liaison nurse who concluded that his presentation was as a result of psycho-social	

		stressors rather than mental illness; and was not concerned about the risk of suicide because he had no plan or intent; and so, referred the Deceased to the homelessness team and discharged him back to the care of his GP. The nurse did not take any steps to review the Deceased's medication or consider admission, or escalate these matters to a doctor, nor did they involve the Crisis or Home Treatment teams for follow up / immediate safeguarding. Despite there being a recognised risk to self and to others, both of which the Deceased himself said he could not control, there is no evidence of any risk assessment documentation being completed. 3. The Deceased was subsequently seen in the Accident and Emergency Department by a Social Worker from the homelessness team. The Deceased insisted that he was not	

		homeless and that he had attended the hospital for help with his mental health, without which he would jump from London Bridge. The Social Worker immediately passed this information to members of the psychiatric liaison team who he found, together, in their office. Subsequently, whilst still in the department, the Deceased became agitated and abusive, which behaviour was a recognised aspect of his behaviour when he was unwell. It seems he later left the department and/or was escorted out as he was being abusive; the records show that at least one member of the psychiatric liaison team was aware of this development but took no action to prevent the Deceased from leaving or to encourage him to stay in order to re-assess him, nor to alert the Crisis and/or Home Treatment teams, the GP, or the Deceased's family as to the situation.	

		4. Following the report of the Deceased's death, South London and Maudsley NHS Foundation Trust's own review highlighted various concerns about the operation of its Single Point of Access service but neither that review, nor the evidence provided to the inquest from the Consultant Psychiatrist who was responsible for the psychiatric liaison team in King's College Hospital, identified any concerns about the management of the Deceased by the psychiatric liaison team on the 4th July 2024. This may suggest that there were systemic as well as operational factors which led to the Deceased not receiving the help and support, he needed on the 4th July 2024.	
West Sussex Brighton and Hove	This death concerned a 25-yr old young women. Deterioration in mental health. Taken substance as impulsive act	Issued before the Inquest had concluded as it had already become apparent that there was a real lack of British Sign Language Interpreters (BSLs) able to help support Deaf	Cabinet Office, 1 Horse Guards Road, London, SW1A 2HQ | Secretary of State for Health and Social Care, 39 Victoria St London

	and may have made a deliberate decision to take her own life .However failure by MH services to manage her risk by failing to review her care plan following a suicide attempt the previous year. Failing to put into place safeguarding measures following advice that she had accessed pro suicide websites and had disclosed that she had purchased chemicals to use in suicide. Failing to have a face-to-face appointment to assess risk. This being on the background of systemic longstanding and well documented challenges in the provision of MH for deaf patients with particular emphasis on the national shortage of BSL interpreters and the difficulty	patients in the community who were being treated with mental health difficulties. This was putting this cohort of individuals at risk. The overall lack of British Sign Language Interpreters was also evidenced directly by the Court in that this Inquest has had to be delayed/adjourned for two months due to there being no available Interpreters to interpreter for two deaf/mute witnesses over the two-week period of the Inquest. A joint response to this report from Department of Health and Social Care and NHS England has been received. Having heard further evidence in this matter, once the Inquest resumed, I felt compelled to issue a further report. My concerns are Matter for the Cabinet Office (Equalities. The Disability Unit/BSL Advisory Board. Sponsoring the Procurement Act 2023. AND the Minister of State (Minister for Social	SW1H 0EU | Minister of State, Minister for Social Security and Disability, Department for Work and Pensions, Caxton House, Tothill Street, London SW1H 9NA | Minister of State for Education, Department of Education, Orchard House, 20 Great Smith St, London SW1P 3BT

	this presents for patients to be able to communicate their distress when their mental health is deteriorating or they are in crisis. The deceased suffered complex PTSD and mixed EUPD, anxiety and dependant traits. Able to lip read however required a BSL interpreter to assist her MH practitioners in providing support. These were not always available, and assessments would go ahead without an interpreter present	Security and Disability) The Chief Executive of the NRCPD provided evidence that the Procurement Act offers NHS bodies and Integrated Care Boards (ICBs) the opportunity to collaborate with organisations like NRCPD to develop contracts that improve the delivery of BSL interpreting services. At present, contracts for interpreting services are often awarded to larger agencies, where BSL interpreting forms only a small part of broader contracts primarily focused on spoken languages, rather than being handled by agencies specialising in BSL. Evidence also highlighted the absence of statutory regulation for BSL interpreters. The NRCPD Chief Executive emphasised that establishing a statutory regulator would help professionalise and elevate the status of BSL interpreters, which in turn would promote the role and increase the number of specialists available to support deaf mental health patients.	

		Since the Cabinet Office holds responsibility for disabilities, I raise these concerns regarding the national shortage of BSL interpreters and the lack of regulation in this area. 2. Department of Health and Social Care Evidence indicates that clinicians who are fluent in British Sign Language (BSL) provide a significantly better experience for deaf patients compared to non-BSL- speaking clinicians relying solely on interpreters. The NHS England response to the earlier Prevention of Future Deaths (PFD) report outlined the role of Integrated Care Boards (ICBs) in commissioning interpreting services for NHS Trusts. However, there is a clear shortage of BSL-proficient clinicians, and insufficient efforts are being made to recruit and retain these professionals. This gap is failing to meet the needs of deaf individuals. 3. Matter for the Department of Education. Evidence was heard that the lack of	

		BSL interpreters was in part due to the lack of availability of BSL qualifications and training.	
North Yorkshire and York	Deterioration of deceased MH disorder with an increase in incidents of suicidal ideation , threats, and actual self-harm as well as episodes of binge drinking. Suicidal ideation exhibited a preoccupation with going to the river . Body recovered from river Derwent October 2024.	Assessed on three separate occasions between mid-May 2024 and the end of August 2024 by members of the Crisis and Acute Hospitals Liaison Teams. It was clear during all three assessments that her episodes of binge drinking, and impulsive acts of self-harm were the result of unresolved childhood trauma. Despite that, secondary mental health services considered there was no role for them in offering support or a treatment pathway to her. The safety plans agreed following these assessments were therefore limited and offered her no additional support beyond that which she was already accessing through the Horizons service. The assessment documents contained no discussion of treatment pathways for addressing trauma which might be accessed through the	Tees Esk & Wear Valley NHS Foundation Trust

		Community Mental Health Team, and no indication that such pathways had been offered or rejected by her. Instead, it was suggested at the second assessment that she may wish to refer herself to a named private psychotherapy service at some point in the future. There was no rationale included in the second assessment for naming this service, and no explanation of what it might provide or why this could not be offered on the NHS via the CMHT. When she indicated at her third assessment that she had left a message with this private provider and received no response from them, the third safety plan simply suggested she try again. Mental Health services were aware at the time of the second and third assessments that a number of agencies were involved with her, but no multi-agency meeting or approach was suggested or called by them to consider the	

		most appropriate support .	
Essex	Death of 20-year-old male. Directly contributed to y the non-availability of an inpatient bed in a mental health assessment unit. Very high level of risk of suicide had been determined by formal mental health act assessment to require an immediate period of assessment and treatment as inpatient with a recognition in terms that his risk of suicide was such that he could not be kept safe in the community . Spent six days at home awaiting a bed before taking his own life by ligature.	(a) A highly vulnerable 20-year-old man, with a history of anxiety, depression and impulsive previous suicide attempts made two further serious attempts to take his own life and inflicted an extensive wound to his arm Those suicide attempts were frustrated by his mother. The subsequent formal MHA assessment determined .... to be such a high risk of suicide that an immediate period of assessment and treatment as a (voluntary) in-patient on an MHAU was required as his high risk of suicide could not be safely managed in the community. (b) No such bed was available over the six days between the MHA assessment and .... suicide with still no indication, at the time of his death, as to if or when a bed would be	The National Medical Director, NHS England: and Secretary of State at the Department for Health and Social Care:

		available. By default, and not withstanding point (a) above, the HTT, absent an in-patient bed, became responsible for his care in the community. (c) In his evidence, it was further expressly recognised by the HTT psychiatrist who saw .... on the 31st May that his "very, very high risk" of suicide at that time could not be managed safely in the community by the HTT and, further, that ..... was "untreatable" in the community. (d) Nonetheless, and notwithstanding the unanimous clinical view, the non- availability of an EPUT MHAU in-patient bed meant that the HTT were required to attempt to mitigate this unmanageable level of risk in the community, something that the HTT was, as had been anticipated, unable to do. (e) The evidence confirmed that a lack of	

		available in-patient beds for high- risk mental health patients who, as was acknowledged at the time, cannot be managed safely in the community, is a chronic and on-going situation in Essex and, the inquest was told, nationally. (f) ..... took his own life by deploying a ligature on the sixth day awaiting the necessary, required in-patient bed. Had an in-patient bed been made available, he would probably not have died. .... death was avoidable. (g) Absent the provision of available mental health in-patient beds for very high-risk patients that formal Mental Health Act assessments have clinically determined cannot be managed safely in the community, then further avoidable deaths by suicide amongst this cohort of vulnerable patients appears inevitable	