ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Committee Supporting Paper	**Agenda Item**	Paper X
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Various		
Meeting	Board of Directors	**Date**	26 March 2026

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

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

Guardian of Safeguarding Hours Report – The People and Organisational Development Committee was assured on the work of the Guardian of Safe Working Hours and the adherence to national requirements.

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?)

People and Organisational Development Committee held 18 February 2026 and Quality Committee held 18 March 2026

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE and CONSIDER the appended reports for information

Alignment to strategic objectives (indicate those that the paper supports)	
SO2: Create equity of access, employment, and experience to address differences in outcome	X
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)	
People and teams plan	X
Quality and safety plan	X

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

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
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
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X

Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
External and partnership risks			
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
SDR2, SDR4							
System / Place impact (advise which ICB or place that this matter relates to)							
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

Guardian of Safe Working Hours (GoSWH)'s Report on Resident Doctors

01 October 2025 to 31 January 2026

Dr Babur Yusufi
Guardian of Safe Working Hours

February 2026

RDaSH nurturing the power in our communities

EXECUTIVE SUMMARY

This report covers a period of four months; from 1 October 2025 to 31 January 2026.

In this report, Guardian of Safe Working Hours (GoSWH) provide details of trainees currently subject to TCS 2016/2019 and information on; exception reporting and current trends, GoSWH's fines and account balance, a summary of key issues discussed at recent Junior Doctors' Forum and any other relevant feedback.

Since the start of new rotation in December 2025, there are 60 Resident Doctors in the Trust, with four vacant posts. A total of 52 exceptions reports were filed: 40 from Rotherham, 7 from Doncaster and 5 from North Lincs. Most reports were about hours worked beyond the day shift, i.e. from 09:00hrs to 17:00hrs (n = 35). There were two reports of Immediate Safety Concern, and one each for Missed Educational Opportunity and hours worked beyond night shift, i.e. from 2100hrs to 09:30 (GoSWH's fine was issued for this). Most ERs were resolved appropriately and where the Clinical Supervisor/ Resident Doctor have not responded, GoSWH have authorised payments for excess hours worked.

There were no major gaps in the Rota.

Current balance in GoSWH's Fines' Account is £16,407.

Main points discussed at RDF (Resident Doctors' Forum) include the following key considerations, along with measures to improve Care Group Management's participation in RDF, exploring if SAS doctors partaking in First On-Call Rota can report on Allocate and taking measures to ensure less than full time (LTFT) residents have been paid correctly.

Key considerations coming out of this report are; (1) Managing unscheduled work towards the end of day-shift in Rotherham inpatient services, so doctors do not have to work beyond their duty hours (2) Reaching local agreements through JLNC for full implementation ER reforms (3) Assessing and mitigating impact of service changes on training posts/ resident doctors' work schedules (4) Ensuring timely disbursement of GoSWH's fines monies through joint working (5) Organising Admin support for GoSWH, at the earliest.

INTRODUCTION

The 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training England (TCS 2016) were introduced nationally on 05 October 2016. Since August 2017, the Trust has had higher, core, foundation and GPVT residents taking up TCS 2016. All residents are now subject to TCS 2016.

This report covers a period of four months; from 1 October 2025 to 31 January 2026.
In this report, Guardian of Safe Working Hours (GoSWH) provides details of trainees currently subject to TCS 2016/2019 and information on; exception reporting and current trends, GoSWH's fines and account balance, a summary of key issues discussed at recent Junior Doctors' Forum and any other feedback.

CURRENT RDASH DOCTORS IN TRAINING

There are 60 trainees (including the Hospice) working in the trust with 4 vacant posts, from the start of the new rotation in December 2025. A breakdown of their grades is as follows:

	GP	CT	F2	F1	HT ST	**Total**	Vacant
Doncaster	4	3	2	3	5	**17**	1
Rotherham	4	12	1	4	8	**29**	1
North Lincolnshire	3	1	1	4	3	**12**	3
TOTAL	**11**	**16**	**4**	**11**	**16**	**58**	**4**

The above figures do not include the Hospice Doctors: x1 GP and x1 HT ST

EXCEPTION REPORTS (ERs)

52 Exceptions were reported over the four-month period, from 1 October 2025 to 31 January 2026.

The highest number was from **Rotherham** (n = 40), followed by **Doncaster** (n = 7) and **North Lincs** (n = 5).

Details of individual Reports and their Outcomes are as follows.

Working beyond 0900hrs to 1700hrs (n = 35)

These are about working beyond daytime shift, i.e. from 09:00hrs to 17:00hrs. Most reports are from inpatient services, predominantly from General and Older Inpatient Services in Rotherham. All but 14 (12 from Rotherham and 2 from North Lincs) resulted in Payments or Time-off in Lieu (TOIL). GoSWH have reminded the Clinical Supervisors and authorised Payments in case of lack of resolution.

Month	Grade	Overtime	Outcome	Comments
ROTHERHAM (N = 31)				
OCTOBER (n = 12)	FY1	78 Mins	Payment	Reports from Older Adults' Ward
	FY1	45 Mins	Payment	
	CT2	60 Mins	?	Reports from GA Wards. ER not processed. CS/ Med HR advised.
	CT2	60 Mins		
	CT2	120 Mins	TOIL	Reports from General Adult Wards
	CT2	105 Mins	TOIL	
	FY1	40 Mins	?	Reports from GA Wards. ER not processed. CS/ Med HR advised.
	FY1	55 Mins		
	FY1	50 Mins		
	FY1	70 Mins		
	FY1	45 Mins		

	FY2	30 Mins		
NOVEMBER (n = 9)	FY1	111 Mins	Payment	Reports from Older Adults' Ward
	FY1	80 Mins	Payment	
	FY1	80 Mins	Payment	
	FY1	70 Mins	Payment	
	FY1	75 Mins	Payment	
	FY1	85 Mins	Payment	
	FY1	70 Mins	Payment	
	FY1	60 Mins	Payment	
	FY1	72 Mins	Payment	
DECEMBER (n = 8)	CT2	55 Mins	TOIL	Report from GA Wards.
	CT2	60 Mins	?	Report from GA Wards. ER not processed. CS/ Med HR advised.
	CT1	120 Mins	Payment	Reports from Community Mental Health Services
	CT1	120 Mins	Payment	
	CT1	60 Mins	Payment	
	CT1	60 Mins	Payment	
	FY1	90 Mins	?	Reports from GA Wards. ER not processed. CS/ Med HR advised.
	FY1	60 Mins	?	
JANUARY (n = 2)	FY1	60 Mins	?	Report from GA Wards. ER not processed. CS/ Med HR advised.
	FY1	30 Mins	TOIL	Reports from Older Adults' Ward
DONCASTER (n = 0)				
NIL				
NORTH LINCS (n = 4)				
OCTOBER (n = 2)	FY1	90 Mins	Payment	Report from Inpatient Service.
	FY1	120 Mins	?	Report from Inpatient Service. ER not processed. CS/ Med HR advised.
NOVEMBER (n = 1)	FY1	30 Mins	?	Report from Inpatient Service. ER not processed. CS/ Med HR advised.
DECEMBER (n = 0)	NIL			
JANUARY (n = 1)	FY1	60 Mins	Payment	Report from Inpatient Service.

More hours worked during On-Call than Work Scheduled (n = 13)

All reports are for the **First On-Call Rota**. They are for information and monitoring only, as the average numbers of hours worked during On-Call, over the entire Rota Cycle, are calculated by a 6-monthly rolling On-Call Audit. This arrangement is a part of Local Agreement governing the First On-Call.

Month	Grade	Overtime	Outcome/ Comments
ROTHERHAM (n = 6)			
OCTOBER (n = 3)	FY2	30 Mins	For information and Monitoring only. Average numbers of hours worked during On-Call is calculated from a rolling audit every 6 months
	FY2	90 Mins	
	FY2	60 Mins	
NOVEMBER (n = 2)	FY2	99 Mins	
	FY2	60 Mins	Locum Shift – For information only
DECEMBER (n = 1)	CT1	9:30 Hrs Approx.	Worked continuously without any break. Extra-contractual - reported after contractual deadline.
JANUARY (n= 0)	NIL		

DONCASTER (n = 7)			
OCTOBER (n = 0)	NIL		
NOVEMBER (n = 7)	ST2	Raised in error	
	ST2	8 Hrs	For information and Monitoring only. Average numbers of hours worked during On-Call is calculated from a rolling audit every 6 months
	ST2	6 Hrs	
	ST2	6 Hrs	
	ST2	6 Hrs	
	FY2	120 Mins	
	FY2	90 Mins	
DECEMBER (n = 0)	NIL		
JANUARY (n = 0)	NIL		
NORTH LINCS (n = 0)			
OCTOBER (n = 0)	NIL		
NOVEMBER (n = 0)			
DECEMBER (n = 0)			
JANUARY (n = 0)			

There were no reports for the **Second On-Call Rota**.

Hours worked beyond scheduled On-Call Shift (n = 1)

This report related to working beyond the scheduled shift, which is 12:30 hrs long. On this occasion the resident doctor on-call not only worked longer than the scheduled shift but also the maximum number of hours allowed in a shift i.e. 13hrs, were breached, attracting a financial penalty.

Location	Month	Grade	Shift	Overtime	Outcome	GoSWH's Fine
Rotherham	November	FY2	0900-2130hrs	109 Mins	TOIL	Yes

Immediate Safety Concern (ISC) (n = 2)

There were two ISC reports.

The first one was reported days after the incident so could not be acted upon.

The second resulted in the support provided to the Resident doctor by their Clinical Supervisor.

Location	Month	Grade	Shift	Report	Outcome
Rotherham	December	CT1	21:00 - 09:30hrs	Continuous Work – No Rest Breaks	Extra-contractual; reported late.
N. Lincs	October	FY1	09:00 – 17:00hrs	Co-worker injured	Support provided by CS

Missed Education Opportunity (n = 1)

There was one report of Missed Education Opportunity, which was the result to Resident Doctors' Strike.

Location	Month	Grade	Shift	Report	Outcome
Rotherham	November	FY1	09:00 – 17:00hrs	Missed Clinical Supervision due to Doctors' Strike	No further action.

Exception Reporting Trends

1. Most reports, especially for working beyond 9AM to 5AM, are from Rotherham. It is mostly the inpatient areas in the locality are generating these reports. There is an emerging theme of the resident doctors being exposed to unscheduled work towards the end of their shift. This is specific to a couple of hot spots and has been raised with the Clinical Supervisors and Director Postgraduate Medical Education (DME).
2. Generally, the number of ERs over the four-month period remains low, averaging around 13 per month, across the three sites.
3. Most ERs have been appropriately resolved at Clinical Supervisor/ Resident Doctor level. The remaining have been acted upon by the GoSWH, to ensure that the affected doctors get paid for the extra amount of work done.

There was no rota gaps identified.

GOSWH's FINES UPDATE

The current balance in the account is £16,407.

Resident Doctors' Forum have revised their decision to use these monies to;

1. Fund Resident Doctors' Induction lunches.
2. Buy book vouchers to distribute among the resident doctors in the Trust.

All resident doctors in post from, 1 January 2026 to 31 December 2026, will benefit from this. Therefore, a part of this money will be spent in the current financial year, i.e. 2025-2026 and the rest in the next, i.e. 2026-2027. Finance department have agreed to this.

GoSWH have authorised the spend. However, implementation requires joint working between the Resident Doctors' Reps, Medical HR and Finance. Dr Melton, Senior Resident Doctor, in pursuing this from Resident Doctors side.

FEEDBACK FROM RESIDENT DOCTORS' FORUM DATED 15/0/26

1. **Disbursement of GoSWH's Fines' Money**
   Agreement as given above,

2. **Local Agreement for Hybrid First On-Call**
   It was highlighted it is in place but hasn't been signed.

While SAS doctors participate in the First On-Call rota, with them being on a different contract, requires their renumeration to be estimated, differently. However Medical Staffing would check if they can be included in Allocate for reporting purposes, only.

3. **Attendance of Representatives of Care Group SLT at JDF**
   Attendance of Representatives of Care Group SLT at the JDF, remains thin. It was agreed RDF chair would reach out to all 5 Care Groups to ensure attendance in the future.

4. **North Lincs Care Group Feedback**
   Care Group Director provided a detailed update on building work at Great Oaks and changes to Service configuration and delivery. It was said that this was unlikely to affect the work schedules and provisions for the Resident Doctors. However it was suggested to include DME (Director Postgraduate Medical Education) in the consultation and impact assessment process, for any foreseeable change.

5. **Doncaster Care Group Feedback**
   Concerns were raised about the quality of electronic handover, from the day to On-Call Shifts and vice versa.

   It was agreed for the Medical Staffing to share the e-Handover SOP with Resident doctors and ask for doctors interested in completing a Clinical Audit of the process.

6. **Rotherham Care Group Feedback.**
   Matter of examining and clerking of patients admitted out of hours was discussed and it was agreed for this to be discussed with the Clinical Supervisors and DME.

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7. **Implementation of Exception Reporting Reforms on 4 February.**
   There are still matters pending to implement these reforms fully, such as;

   a. Methodology to evidence work done during the time, claimed for Payment or TOIL.
   b. Agreement of processing of ERs long than two hours and those occurring frequently during a period.
   c. Involvement of Clinical Supervisors in implementation of TOIL and Work Schedule Reviews, given they are not directly involved in ER process and ER processing is limited to a few, within a confidentially circle.

   Further clarity about new features of Allocate is also required.

   It was acknowledged that that the preparatory time to implement these changes was limited and more work is needed, through JLNC (Joint Local Negotiating Committee) to come to local agreements.

8. **JLNC Feedback**
   £10 million of financial cuts and their effect on jobs of around one hundred members of non-medical staff, in context of impact on work of doctors in the Trust, was discussed. The importance of Impact Assessments on the Work Schedules of

Resident doctors, because of these changes was highlighted and a suggestion was made for DME to be included in these assessments.

9. **Missing Pay for Resident Doctors**
   The resident reps raised concerns about Allocate not managing the working hours for less than full time (LTFT) residents, well, in the past meaning people were being paid incorrectly. Lead employer, Sheffield Partnership University NHS Foundation Trust have been trying to contact RDaSH about it. Medical staffing advised a meeting had been set to investigate this.

KEY THEMES:

1. **Exception Reports from Rotherham Inpatient Services**
   An emerging theme from Rotherham inpatient services is one of unscheduled work presenting towards the end of day, required Resident Doctors to stay beyond the end of morning shift. Further work is required to address this.

2. **Implementation of Exception Reporting reforms**
   Further work is required through the JLNC to ensure full implementation and work is underway to arrange a meeting within two weeks,

3. **Service changes and impact on Resident Doctors**
   The Trust is in middle financial cuts and service changes, impact of which on Resident Doctors' Work Schedules and Training must be ascertained at the planning stage. Recommendation is for the DME to be involved in Impact Assessment on Training Posts, considering any such changes.

4. **Disbursement of GoSWH's Fines' Money**
   Decision on utilisation of these monies has been made and joint working between Resident Doctors' Reps, Medical HR and Finance is required to implement the spend.

5. **Admin Support for GoSWH**
   This has been an ongoing issue, for months, which despite communications and meetings with the appropriate members of SMT and mention in GoSWH's reports, remains unresolved. This has resulted in hinderance and delays in performance of various tasks related to the role. GoSWH have recently approached Chief Medical Officer and Director of People and Organisational Development with the request to provide this essential support, at the earliest.

Dr Babur Yusufi
Guardian of Safe Working Hours (GoSWH) for RDaSH

11 February 2026

Rotherham Doncaster and South Humber NHS Foundation Trust

Mortality Report

November and December 2025

Mortality Report – PLFD

(Data focus November – December 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 November and December 2025.

3 Assessment

3.1 Mortality Reporting and Management

During the months of November and December 2025, there were 112 deaths in total reported in the Trust.

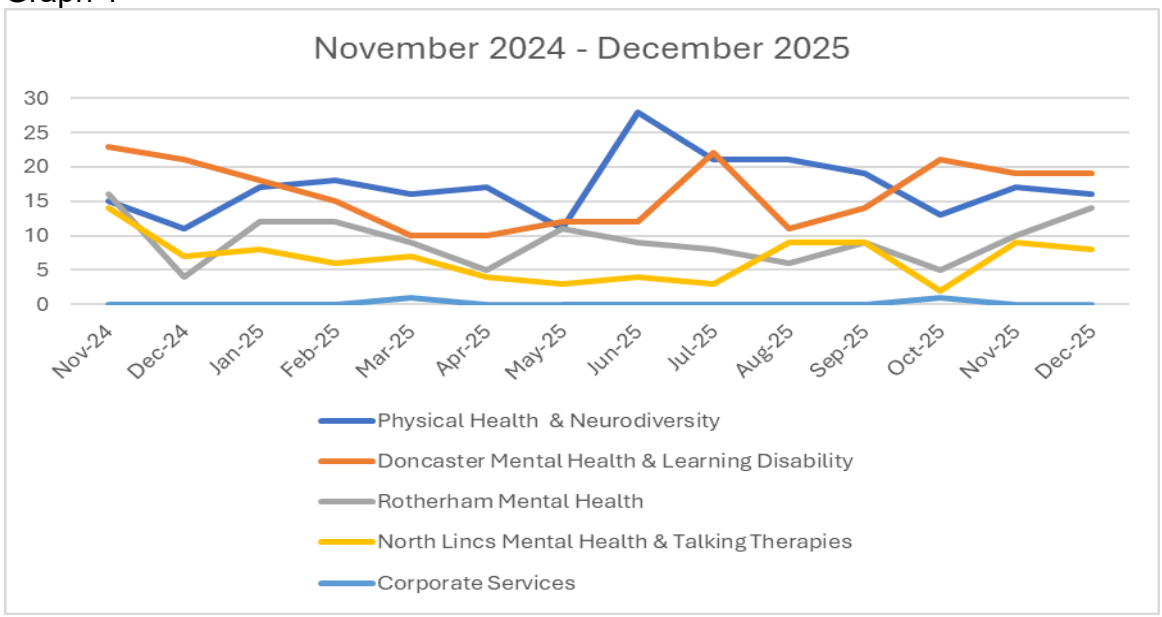
Table 1 - Status of deaths reported during November and December 2025.

Outcome of review	November	December
Reviewed by MOG and were closed as no problem in care was identified	45	46
Reviewed by MOG, however, require further information and have been returned to the author	3	7
Reviewed and requires a Structured Judgement Review (SJR)	4	1
Reviewed and required further discussion in a Learning from Patient Safety Event meeting.	0	1
Awaiting further information from the coroner on cause of death	0	0
Awaiting review by MOG	0	0
Learning Response to be	3	2

done		
Total	**55**	**57**

Deaths by Care Group from November 2024 – December 2025. Figures are detailed in the longitudinal data in graph 1.

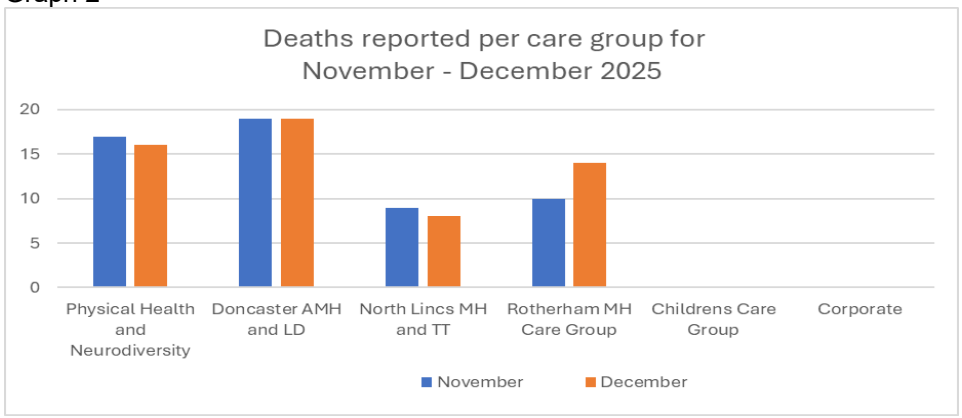
Graph 1



Deaths reported per Care Group for November and December 2025. The graph below shows detail in the number of deaths as reported via the RADAR mortality forms.

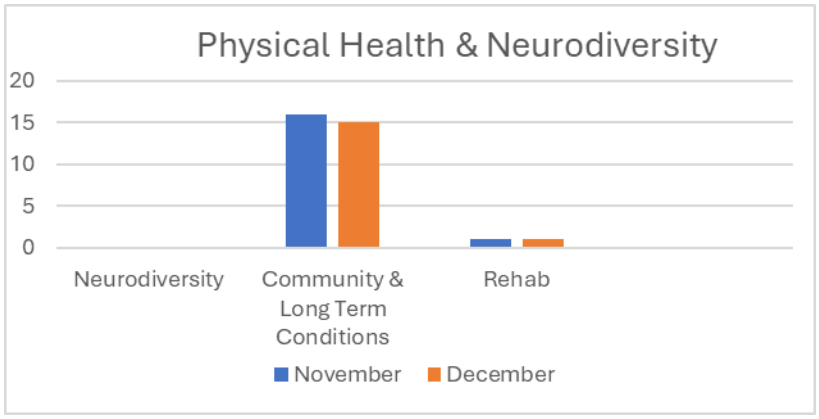
The data highlighted that Doncaster Mental Health and Learning Disability services reported the highest number of deaths during November and December.

Graph 2



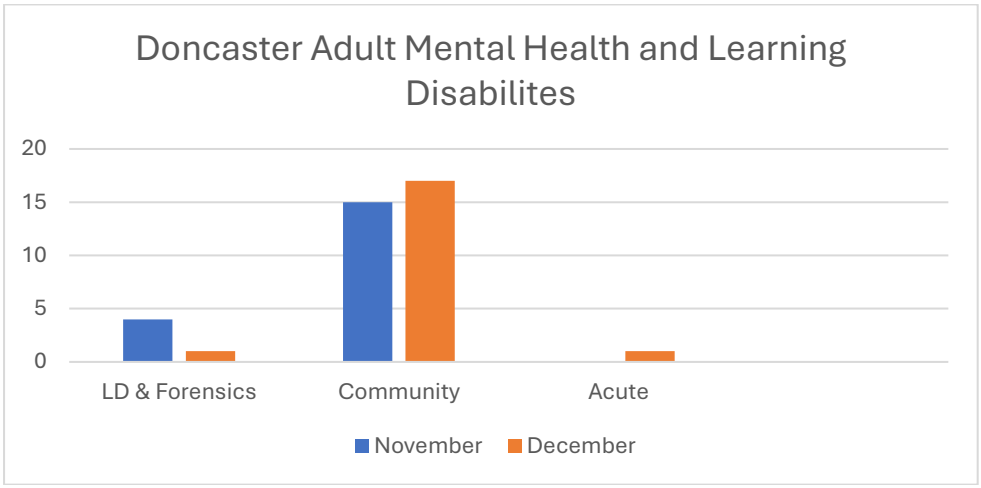
The information below detailed in graphs 2a – 2d offers the numbers of deaths reported per individual care groups within the Trust.

2a



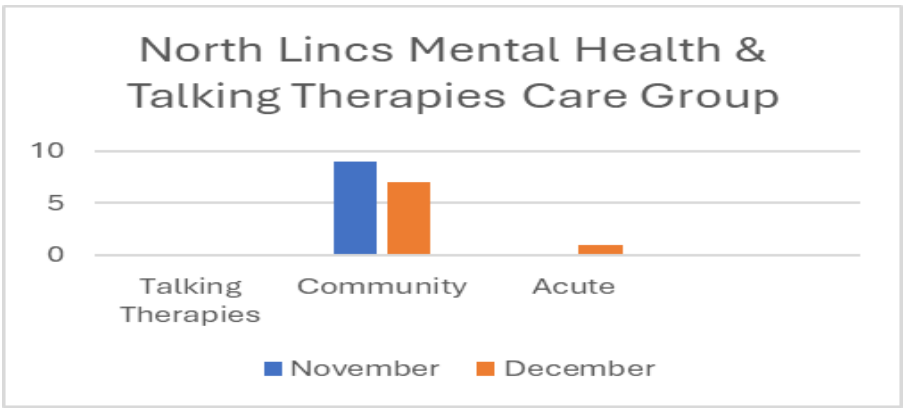
During November and December 30, or 91% deaths were reported from the hospice.

2b



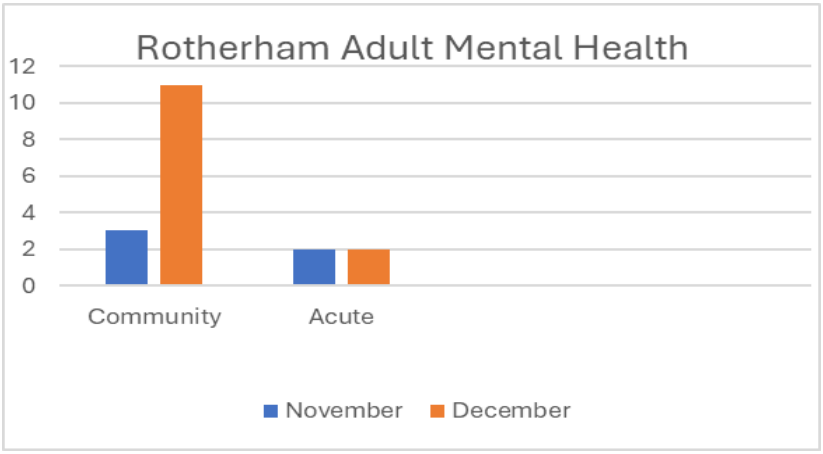
The highest number of deaths reported during November and December were from the Doncaster Adult Mental Health and Learning Disabilities care group. Further graphs in this report will offer information in more detail as to specific services the person was known to at the time of death.
Five deaths were reported from the Learning Disability Servies.

2c



There were 17 deaths reported by the North Lincolnshire care group during November and December with 41% being from Memory and Diagnostic community service.

2d



An increase was noted in the deaths reported by Rotherham mental health services during November and December 24 in total compared with 13 reported during September and October.

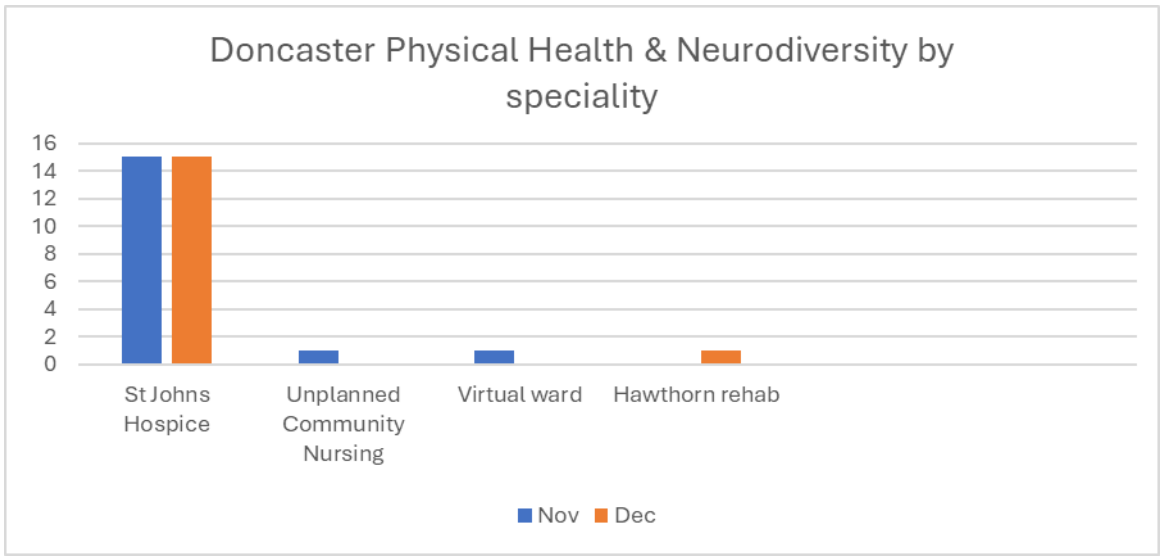
Highest reported remains the older person's services.

3 Deaths per Directorate November and December 2025

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

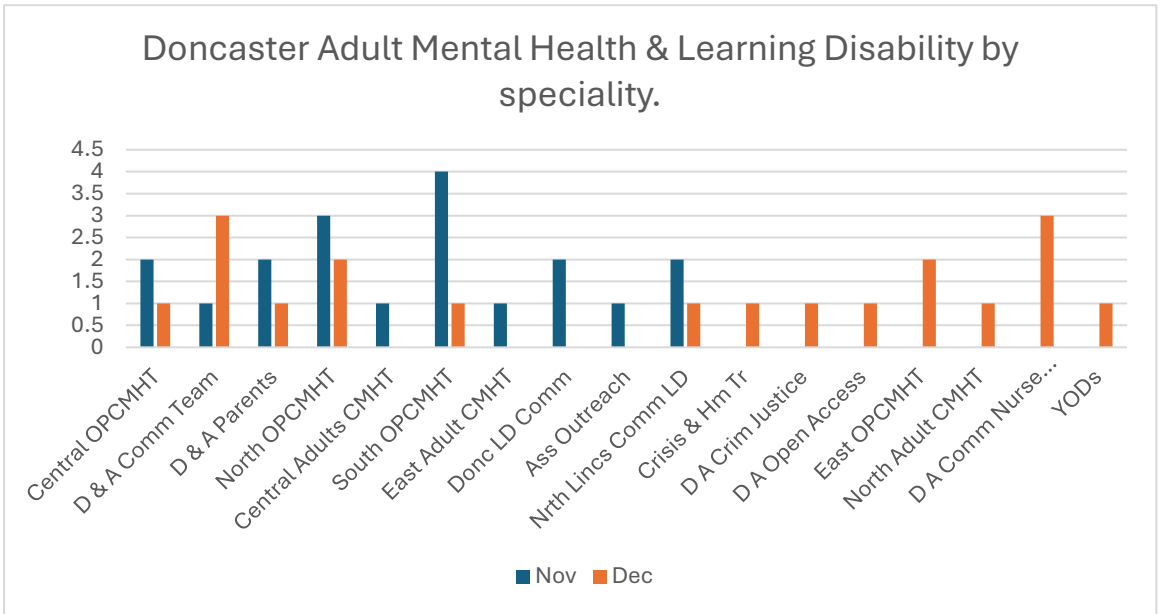
Doncaster Physical Health & Neurodiversity by specialty.

3a



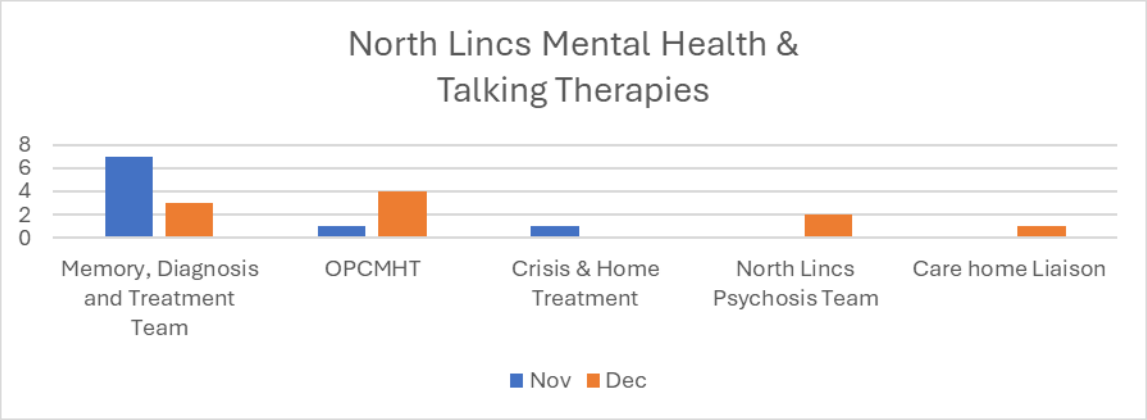
3b Doncaster Adult Mental Health & Learning Disabilities by specialty

3b



3c North Lincs Mental Health and Talking Therapies

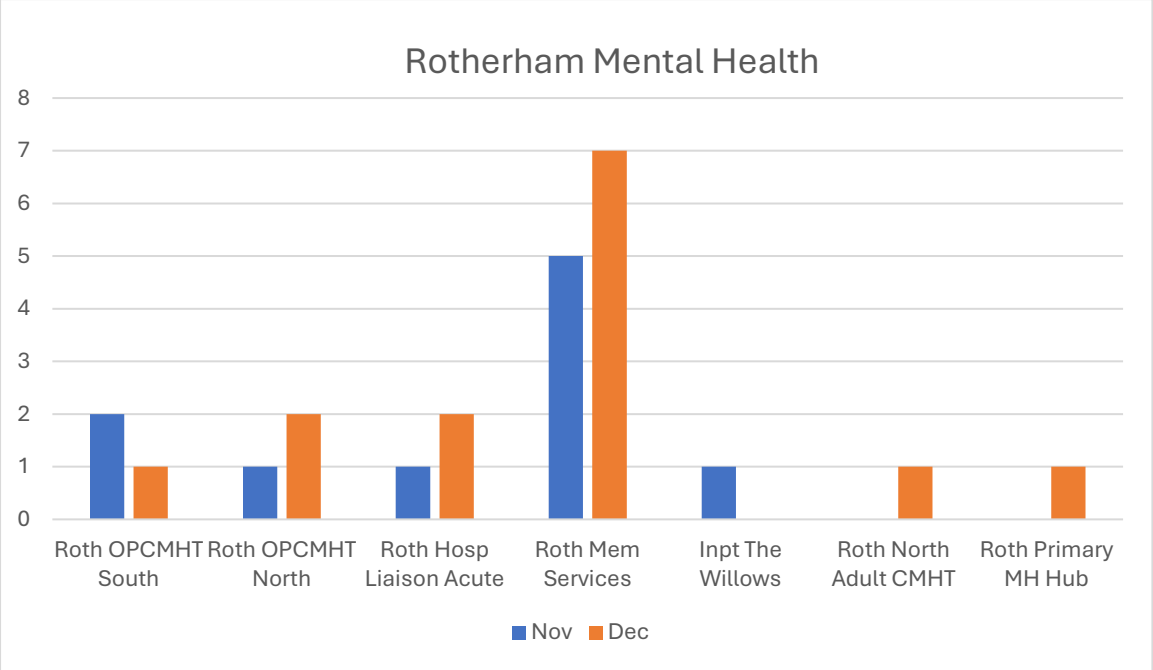
3c



The services for Older Adults services report the highest number of deaths.

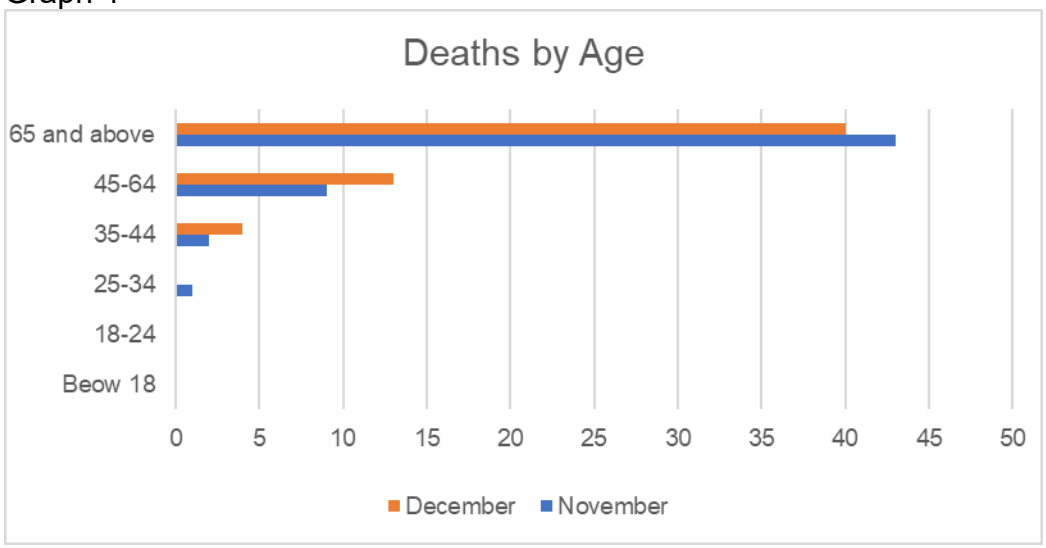
3d Rotherham Mental Health Care Group

3d



Graph 4 Deaths reported by age: November – December 2025

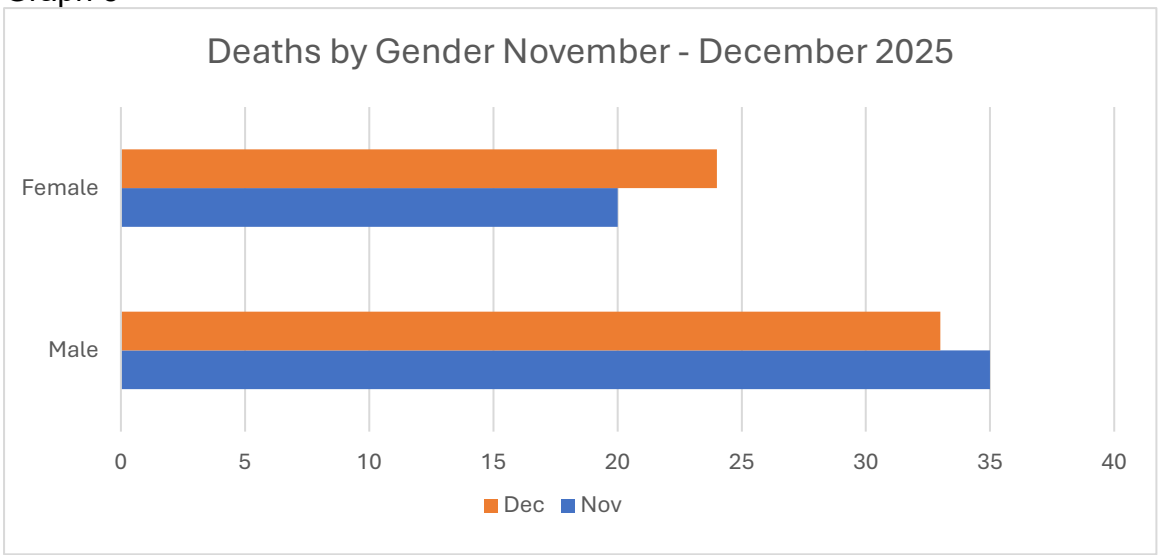
Graph 4



It was noted that during November and December of the 112 deaths reported, 42, 38% of people were 80 or above years of age, including two people who were 100 years old.

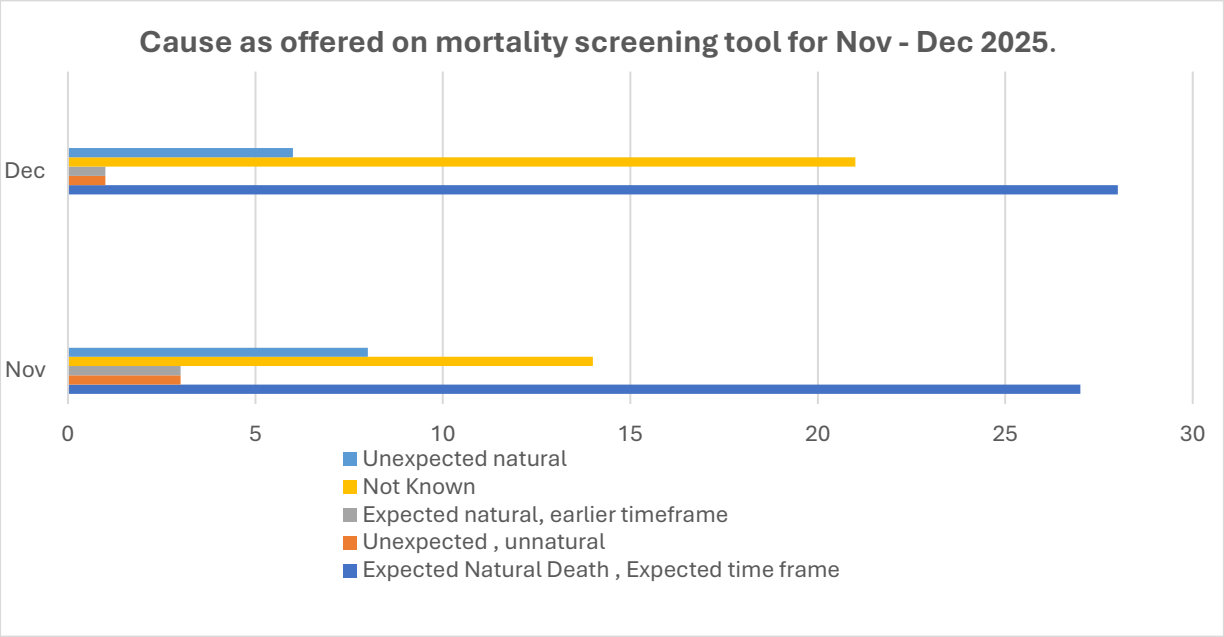
Graph 5 Deaths by Gender

Graph 5



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

Graph 6



3.2 Structured Judgement Review process.

The Mortality Operational Group (MOG) reviews all deaths recorded via the RADAR reporting system. Any deaths that MOG identify as a “Red Flag” is escalated to either a Structured Judgement Review if the person is known to have a Learning Disability, or is tasked back via RADAR to the author, care group or service for a further review under the PSIRF approach options.

Should MOG request further detail to be added to the form, this is also tasked back to the author and once completed a further review takes place. If MOG are satisfied with no further concerns noted, the form will then be closed.

A member of the Patient Safety Team attends the weekly MOG and together discuss and decide if further escalation to the LFPSE is required. Any escalation to the LFPSE meeting will be discussed and action agreed. This allows for the opportunity for further learning and shared outcome responses.

The two SJR / Coroner and Mortality staff continued to work additional hours to address the backlog of historical reports.

No reports are waiting to be completed from the old Ulysess reporting system. There are 104 forms from the previous system to close in MOG.

Up to the end of December 2025, there were 19 SJR's to be completed on RADAR.

The table below indicates the monthly reviews of each death which was reported during November and December 2025 on the RADAR system.

Month	November	December
Total number of deaths reported	55	57
Total No of deaths reported by Care Group		
Donc AMH & LD	19	19
Physical Health and Neurodiversity	17	16
Rotherham AMH	10	14
North Lincs & Talking Therapies	9	8
Children's services	0	0
Corporate Services	0	0
Cause group		
Expected natural death, expected timeframe	27	28
Expected natural death, earlier than expected timeframe	3	1
Expected unnatural death		
Not known	14	21
Unexpected natural death	8	6
Unexpected Unnatural death	3	1
Gender		
Male	35	33
Female	20	24
Age Group		
<18	0	0
18- 24	0	0
25-34	1	0
35-44	2	4
45-64	9	13
>65	43	40
MOG data		
Incident appraisal screening tool only	45	46
Await further information and returned by MOG to the author	3	7
SJR Inc for LeDer report	4	1
Escalated to Patient Safety Team	0	1

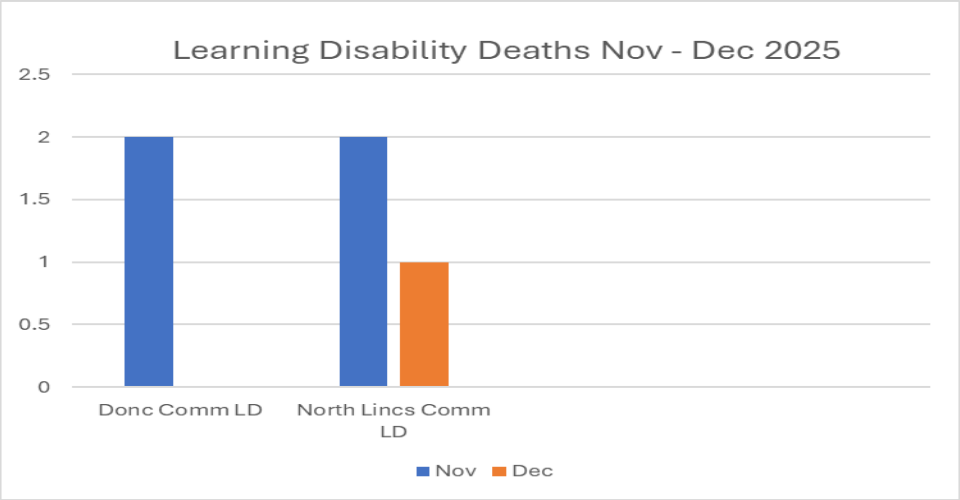
Await info from coroner re Cause of Death	**0**	**0**
Await review by MOG	**0**	**0**
Learning response to be done	**3**	**2**

3.3 LeDeR reports & Structured Judgements Reviews

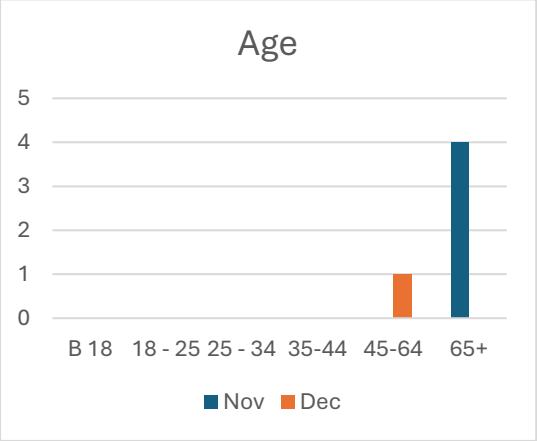
During November and December 2025 five deaths from the Learning Disability services were recorded on RADAR. These will be subject to a LeDeR review as well as an SJR.

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.

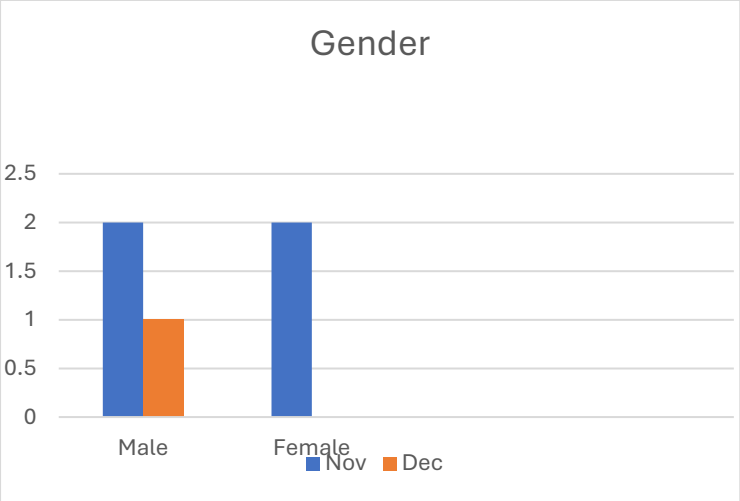
Graph 7



Graph 8



Graph 9



Graph 8 and graph 9 detail age range and gender for LD Deaths reported for November and December 2025

No further updates were available from LD services with regards to this report.

4 Learning from Deaths

The Chief Coroner for England and Wales is the most senior coroner, and they are appointed by the Lord Chief Justice of England and Wales in consultation with the Lord Chancellor. The past four appointed Chief Coroners were Crown Court judges at the time of their appointments.

Following an inquest, a coroner may issue a Regulation 28 Prevention of Future Deaths report to a person, organisation, local authority, government department or agency where it is believed that action should be taken to prevent future deaths.

The recipient of the report has a statutory duty to respond with 56 days. Only a small proportion of inquests result in a PFD being issued.

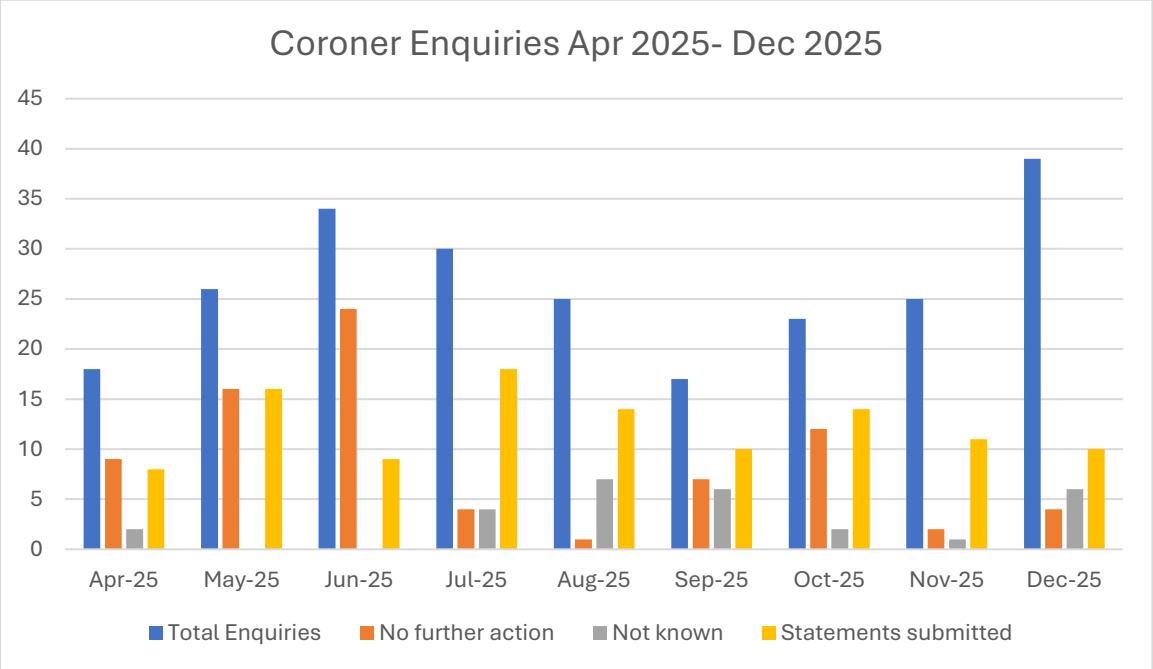
PFDs provide valuable insight and opportunity for learning for the NHS and these along with other information received by NHS England help improve services.

Detailed within appendix 1 of this report are three examples of recent PFD's which have been issued to or involving health authorities during November and December 2025 to organisations where it has been identified by the coroner there is a risk of future deaths if action is not considered or taken to prevent similar situations. The first two cases involved the deceased being known to our Trust. The PFDs were not issued to our organisation.

4.1 Coronial Inquests

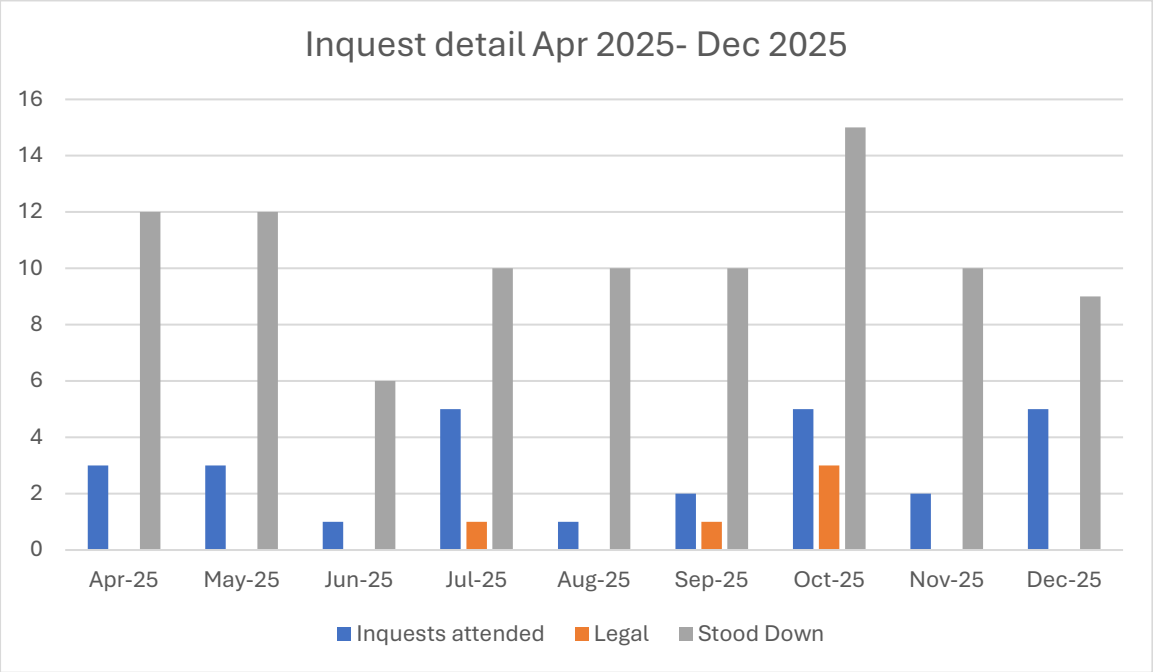
The graphs detailed below offer information in respect of the number of enquiries and inquests from a number of jurisdictions which have involved the Trust, dating from April 2025 – December 2025.

Graph 10



During November and December, the Trust received 64 enquiries from the coroners

Graph 11

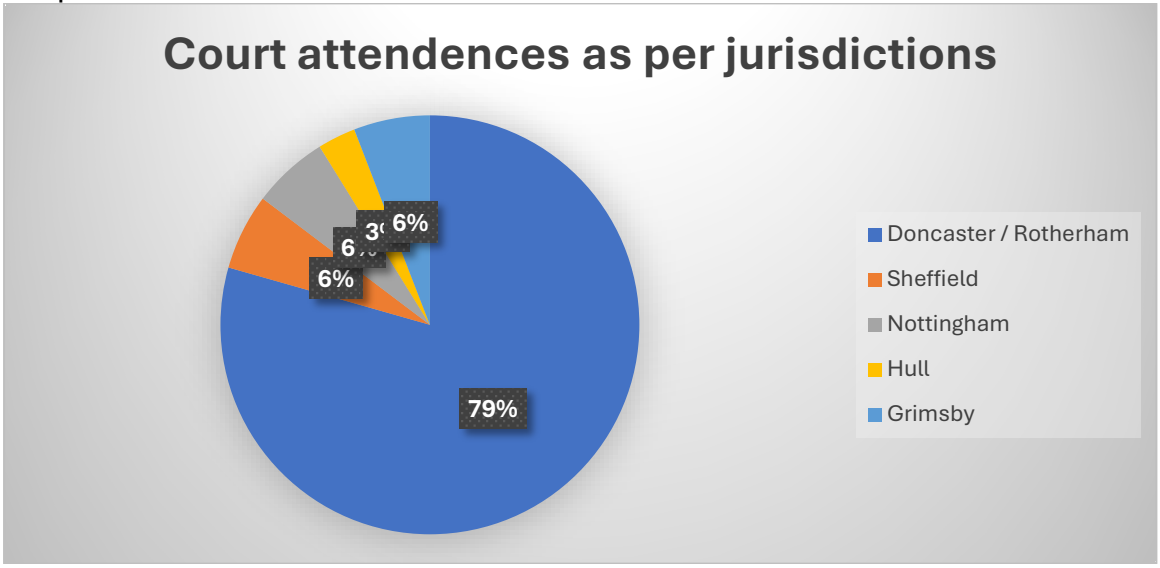


Throughout November and December, the coroner and mortality team attended 7 inquests.

On 19 occasions the Trust was stood down by the coroner as it was deemed the evidence provided by the Trust was read out to court under Rule 23.

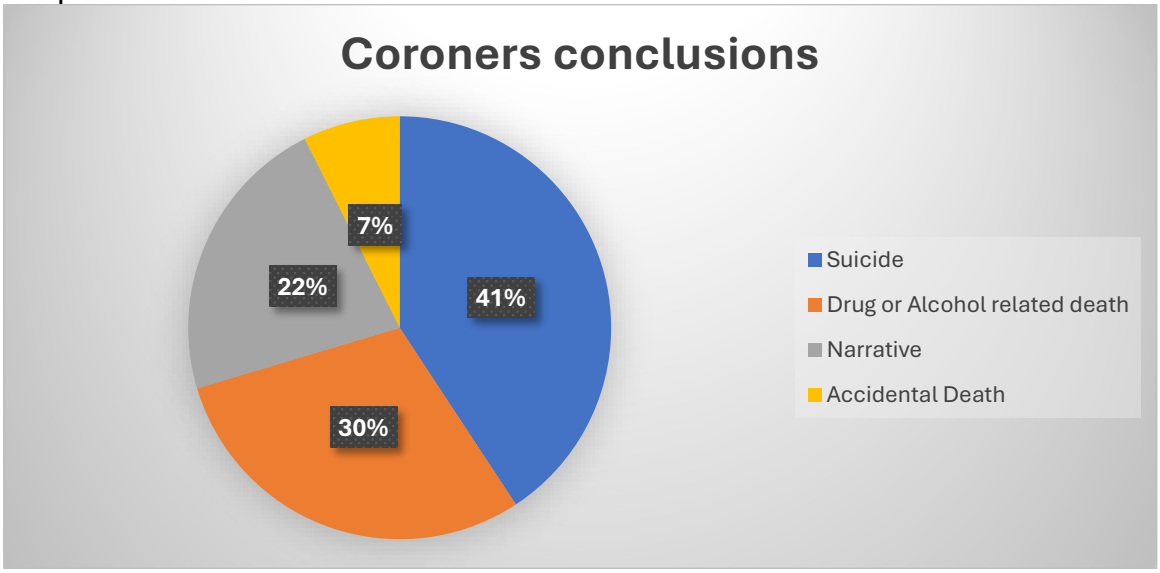
The graph below details the different jurisdictions as to where it has been requested that RDaSH attend to offer live evidence to the coroner.

Graph 12



Outcomes of the coroners' conclusions are detailed in graph 13

Graph13



Suicide Prevention

In 2024 there were 6,190 suicides registered in England and Wales (11.4 suicide deaths registered per 100,00 people) (Office of National Statistics).

All deaths by suicide are certified by a coroner and cannot be registered until an inquest has been completed. A certain level of proof is required in order for the coroner to conclude the death was by suicide, referred to as "standard of proof" and on the balance of probability.

Male suicides in England and Wales were relatively unchanged in 2024 17.6 per 100,00 people compared to 17.4 per 100,00 people in 2023.

For females it remained stable for 2023 -2024 with 5.7 registered per 100,000 people.

Yorkshire and Humber had the third highest numbers of deaths concluded as suicide registered in 2024 in England and Wales. 13.7 per 100,000 people aged 10 and over.

Lincolnshire – high rate of suicide during 2021- 2023 with 20.1 deaths per 100,00 people.

South Yorkshire – Highest rate in Doncaster 14.9 deaths per 100,000 people.

The South Yorkshire ICB has set out objectives for 2025 -2026 to develop and implement a programme of work on suicide prevention and based on the National Suicide Prevention Strategy 2023- 2028.

In 2023 the Government launched the latest suicide prevention strategy for England. The ambitions of the strategy were set to -

- reduce the suicide rate over the next five years with initial reductions observed within half this time or sooner
- to continue to improve support for people who self-harm
- to continue to improve support for people who have been bereaved by suicide.

Suicide prevention is a priority area within the South Yorkshire Integrated Care System (ICS), with joint working taking place with members of the SY ICB to address the following areas

- Using information from the Real-Time Surveillance System to collect and to develop specific actions to address vulnerable and at-risk groups in high-risk locations.
- Suicide prevention and inclusion groups
- Supporting children, young people and adults bereaved by suicide and with a focus during 2025 -2026 on peer support for young people
- Deaths at frequently used locations
- South Yorkshire Coroners Audit for 2025 -2026.

Membership of the SY NHS ICB consists of all place teams, local authorities, mental health trusts, community trusts, acute trusts, primary care, Department of Health and Social Care, Department of Work and Pensions, Network Rail, South Yorkshire Police, Yorkshire Ambulance Service, Samaritans, third sector organisations, experts by experience and universities.
Members oversee the development and implementation of a programme of work around suicide prevention plans.

A recent meeting was held with the Public Health Specialist for Mental Health, Suicide Prevention and Loneliness for the Rotherham area and the SJR / Coroner & Mortality leads, where information was shared regarding the work taking place in Rotherham.

The information detailed in this report is from the Rotherham area.

Within the Rotherham Place Plan, suicide prevention is an area of focused work and in support of the Suicide Prevention Action Plan 2025-2028 of the Health and Wellbeing Board.

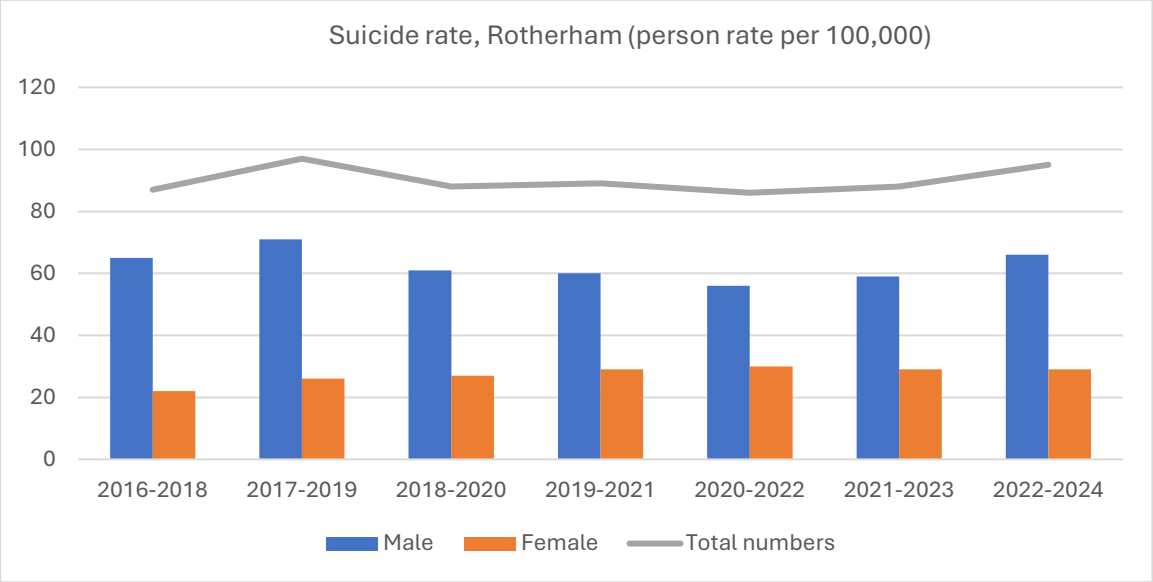
Aim 1 *Making suicide prevention everyone's responsibility*
Aim 2 *To support those bereaved, affected and exposed to suicide*
Aim 3*: Support the people of Rotherham to live in good and improving mental health throughout their lives, accessing and shaping the services*

and resources they need to be able to do so.
***Aim 4** Using data to inform delivery of suicide prevention in Rotherham*

Local statistics provided by Rotherham Public Health

As of 2024 estimated population for Rotherham was 276,595.

Graph14



It is estimated that 19% of the population aged 16 and over and 12% of the population aged 65 and over have a common mental health condition.

The prevalence of depression in Rotherham increased between 2013 and 2022 from 9.9% to 17.3%, remaining above the England average of 13.2%.

1.5 out of every 100 individuals were newly diagnosed with depression in 2023

18% of secondary school students reported feeling lonely most of the time or always within the last twelve months. Girls being twice as likely to report persistent loneliness compared to boys.

In Rotherham neighborhoods, up to 42% of the population aged 65 and above live alone.

A number of activities have been introduced over the quarters of 2025 - 2026. These have included the following –

- Hosting suicide prevention steering group meetings
- Continuing with task and finish groups focusing on Real Time Surveillance, bereavement and neurodiversity
- Develop service specification from Children and Young People peer

support bereavement report
- Develop and deliver level 1 suicide prevention in LGBTQ + communities training
- Consider the impact of deaths at high-risk locations and set up a new task and finish group as required
- Delivery of ECHO training (Suicide prevention awareness in older adults)
- Deliver an annual suicidal memorial service
- Annual review of steering group, progress and outcomes
- Complete South Yorkshire coroners audit.

Progress and achievements from previous action plans to date –

- SPOT and Speak suicide prevention courses delivered by Papyrus January -March 2024 with 223 people trained.
- Internal courses on suicide prevention for teams within partner organisations
- Taxi drivers encouraged to complete the zero-suicide alliance taxi driver training
- Domestic homicide and suicide prevention learning events held for partner organisations
- Suicide prevention for primary care
- Suicide prevention workshops as part of Safeguarding Awareness week and held every year since 2020
- Amparo support for children, young people and adults across South Yorkshire who have been bereaved, affected or exposed to suicide
- 4 Survivors of Bereavement by suicide (SOBS) Groups now operating across South Yorkshire
- Since 2021 there have been four memorial events for families and friends in South Yorkshire who have been bereaved by suicide.

Whilst the Rotherham suicide prevention plan is led by Public Health, all partners contribute towards the delivery of actions. RDaSH representation is present at the Rotherham Suicide Prevention and Self-help Group and at the Suicide Operational Group. Representation is the Safer Neighbourhood practitioner.

The Rotherham Strategic Suicide Prevention Group is attended by the Interim Deputy Care Group Director for the Rotherham Care Group.

A number of projects have been introduced in Rotherham to help and better understand the concerns around suicide and how interventions may support in the reduction of cases.

For further detail please refer to appendix 2 of this report.

Appendices

Appendix 1

Case 1- Prevention of Future Deaths Regulation 28 issued by the South Yorkshire Coroner to South Yorkshire Police

Inquest heard by South Yorkshire West coroner who determined the conclusion of suicide at this inquest.

Background and concerns raised by the coroner.

In November 2025, an inquest was heard in Sheffield where a gentleman had been assessed by mental health services in Sheffield 10th Aug 2023 after expressing suicidal thoughts. He was assessed , discharged from the team after being referred to the alcohol care services and GP primary mental health team.

Several appointments and attempts to contact him were made by services including Sheffield Health and Social Care. These concerns were raised with South Yorkshire Police. Appointments were made for him however he failed to attend. A missing person's report was created on the 17th August 2023.

SYP were unable to contact the gentleman and contacted both his friend and his brother.

On 19th Aug his brother contacted SYP to inform them the gentleman was at a hotel in Sheffield. On the 20th, August the police were called to the hotel as he was threatening to harm himself. A section 136 was utilised by the police whereby the police were able to take him to a place of safety for a mental health assessment.

SHSC were informed of this by the police, and they conveyed him to the 136 suite at Swallownest Court Rotherham due to Sheffield having no availability to assess.

The handover to SNC by the SYP did not have any next of kin details. The gentleman's brother was informed that he had been taken to the 136 suite, however received no further updates from SYP.

A MHA assessment took place which determined he did not require any admission or referral to secondary services. No next of kin information was available and therefore no communication was made during or after the assessment. The outcome of the assessment was not communicated to SHSC or to SYP.

The gentleman was provided with a taxi to take him to Sheffield train station as he stated he was going to stay with his brother.
Once at the station the gentleman found the station manager and requested that his laptop be handed to the police as he stated he was being followed by a gang from Germany.

British Transport Police spoke with the gentleman, and they carried out a check using the police national computer where it was identified that he was known to mental health services and that he had in the past expressed ideas around suicide.

No information was detailed re recent missing person status, recent 136 detention or next of kin and BTP emailed SYP control to check if they had any details. The response informed that he believed he was being followed by gangs and that he had been reported as missing, but this was now closed.

No attempts were made to contact mental health services for further information. He was asked if he felt suicidal to which he responded no, and the officer had no reason to disbelieve him and allowed him to get onto the train.

SHSC made attempts to contact SNC for the outcome of the assessment due to their continuing concerns.

The gentleman took his own life on the train and was found by the train conductor and despite being attended to was pronounced deceased at the scene.

The coroner issued Prevention of Future Deaths to the Chief Constable SYP as concerns were raised around the police not passing on NOK details to the 136 suite. The police did not contact the NOK to offer details on the 136 suite.

It was not clear if a full handover had taken place between the police due to shift change. Information was missing on PNC check and did not flag up recent concerns. RDaSH were asked to provide statements in relation to this inquest. The coroner /mortality team attended the Pre Inquest Hearing and received further instruction from the coroner. Additional information was provided to the coroner including details relating to the 136 suite and Section 12 approved Doctors. The coroner after review of the additional information made the decision for RDaSH to be stood down from the inquest being satisfied with what had been provided.

Within this inquest conclusion the importance of detailed written clear documentation and professional curiosity was again highlighted.

Case 2 - Inquest heard in December by the South Yorkshire East Assistant Coroner at Doncaster coroner's court . The conclusion made by the coroner was that the death be registered as an alcohol, drug related death.

The evidence heard did not assure the coroner that similar deaths may occur and a Prevention of Future Deaths issued to the South Yorkshire ICB.

Background.

A 29-year-old gentleman had registered with a new GP six weeks prior to his death. The practice recognised that a medication review was required due to the number of prescribed medications for pain management.

It appeared that the previous GPs had continued to prescribe and add medications to the prescription therefore allowing the opportunity to access medications to which the gentleman was addicted.

Following the toxicology results it was identified that a number of the drugs were prescription medications and that the prescribing had not been adequately monitored by primary care.

Concerns

The concerns from the coroner were that primary care services did not identify the potential addiction and drug seeking behaviours or review of medications and if they were required.

A response from the ICB was provided to the coroner in January 2026.

Case 3 – This inquest was heard by the Senior Coroner South Yorkshire East During the course of the investigation, inquiries revealed matters giving rise to concern and the risk of future deaths.

Conclusion of the inquest was suicide.

A Prevention of Future Deaths issued to Sheffield Health Partnership, University Foundation Trust.

Background
The gentleman had developed mental health symptoms in April 2024 essentially depressive and psychotic episodes. He engaged with both GP and several mental health services to attempt to manage his symptoms.

He remained fixated on symptoms linked to serious medical complaints and appeared at no time to accept that the physical symptomology of which he complained was linked to his mental health challenges.

The gentleman received various levels of management which included medication, one being Olanzapine. This medication was abruptly stopped due to the belief that this was responsible for deranged liver function tests but there were inadequate follow up arrangements thereafter.

Concerns

Antipsychotic medication abruptly ceased and the management plan of daily monitoring was not followed.

This created a risk of relapse in terms of psychotic symptoms associated with the deterioration in mental health.

Risks of relapse when any medication is abruptly stopped must be fully monitored.

The absence of full assessments and monitoring exposes patients to risk of a serious deterioration in mental health.

Appendix 2

Vista Project

April 2025 saw the launch of the Vista project aimed at people aged 18 plus. This is a pilot project to support people who have attempted suicide due to a life event. It offers short-term interventions for people and where both mental health and physical health needs in relation to the suicide attempt have reviewed. Funded by Rotherham Public Health, the project offers a combination of both emotional resilience coaching and practical support. Referrals are made via RDaSH, Crisis and Hospital Liaison Teams.

Amparo

This service was established in 2015 and is free to anyone who has been affected by suicide. It is the largest suicide bereavement support service in the UK.

Amparo offers emotional and practical support and liaison workers can also offer help with a range of matters such as liaising with the police and coroners, helping with media enquiries, preparing for attending inquests and help in finding other support services.

It is not a counselling service and once a referral has been received, contact will be made within 12 hours. Support via contact will be within 24 hours and with the aim of a liaison worker to have co-created with the beneficiary a support plan within seven days.

The service offers support to anyone recently or historically affected by suicide. This may be a next of kin, immediate family member, friends, colleagues, peers and may also be the finder or witness to the deceased.

Support is also offered to organisations and can be tailored to meet the necessary identified needs.

Papyrus

The Papyrus charity was founded in 1977 by a group of bereaved parents who shared their core beliefs that suicide is preventable and families with lived experience of suicide can offer valuable contributions to the wider conversation around suicide prevention.

The national charity is a service specifically for young people and has offices throughout England, Scotland Wales and Northern Ireland. As the leading youth charity in suicide prevention the service offers a 24-hour

helpline where trained staff advisors in suicide prevention and young people are available to offer support seven days a week. Papyrus works with communities across the UK in the promotion and awareness of suicide prevention in children and young people.