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	Various		
Meeting	Board of Directors	**Date**	28 May 2026

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

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

Safer Staffing Annual Report 25/26 and Establishment Review – The Quality Committee were assured that appropriate systems and processes are in place to ensure that RDaSH is providing safe staffing.

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 20 May 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
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
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
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	X
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	

Strategic Delivery Risks (indicate those that this paper supports)	
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.	X

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

Establishment review paper – May 2026 (Feb 26 data collection)

1. Introduction

1.1. As an NHS organisation, we (RDaSH) follow the National Quality Board (NQB) (2016) and Developing workforce safeguards (DWS) (2018) guidance. The NQB (2016) states that providers:

"*Must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively. They should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times. They must use an approach that reflects current legislation and guidance where it is available*."

1.2. The trust must ensure the following four components in their safe staffing processes:

- Evidence-based tools (where they exist)
- Professional judgement
- Outcomes
- Compare staffing with peers

1.3. A significant component to this compliance is that the trust must ensure there is an assessment of the nurse staffing numbers, and skill mix set in the annual budget (establishments). This is based on acuity and dependency data collaboratively with an evidence-based acuity tool where available. This must be reported to the board by each hospital ward twice a year, in accordance with the NQB guidance and other NHSe resources. The review must be linked to professional judgement and outcomes.

1.4. The evidence-based tools currently available for the trust are the Mental Health Optimum Staffing Tool (MHOST), which is utilised for mental health wards. The Safer Nursing Care Tool (SNCT), which is used for physical healthcare wards and finally, the community nursing safer staffing tool (CNSST), which is used for community physical health nursing. There is no tool currently available to assess crisis teams, or community-based teams that are not physical health.

1.5. The purpose of this paper is to report the outcomes of the biannual nursing workforce review, conducted in February 2026. Workforce reviews have been undertaken across all inpatient areas, with no interim measures applied. In addition to the review of inpatient services, crisis teams have now been reviewed for the second time, supporting a more established and consistent approach to workforce assessment within these services. Building on this, the next cycle of reviews will expand to include hospital liaison services and

home treatment teams, further strengthening the trust's approach to workforce planning across urgent and emergency care pathways.

2. Workforce reviews

2.1. Workforce review is a continuous process and not a one-off event. The steps can be described as part of a continuous cycle:

- Measure the acuity/dependency of patients over the recommended period using the most relevant up-to-date tool (where available).
- Review the data collected and use a professional judgement framework and associated tools to consider the results and to help flag particular issues that may affect the staffing requirement.
- Compare the calculated establishment to current staffing levels and the establishment to other similar wards/areas and consider possible reasons for any differences.
- Reflect on the recommended establishment by referring to evidence and consider implications for daily deployment.
- Justify the decision of what the establishment should be.
- Monitor any changes that affect staffing requirements and indicators that staffing may not be sufficient such as patient and staff outcomes.
- Measure again, every 6-12 months or sooner if monitoring indicates a reason for change.

2.2. This paper highlights any recommendations for amendments to establishments following the triangulated review process. For these to be transacted, they will be requested via the Trusts annual investment funds process.

2.3. Workforce Reviews - Inpatient wards - workforce reviews are informed by the twice-yearly MHOST/SNCT data collection where senior trained nurses on each ward/department collect retrospective (24 hours) acuity/dependency data for 30 days which is then validated through a peer review process. This data is then run through the appropriate software supplied with the license which then apply multipliers to inform evidence-based decision making on staffing levels and workforce requirements.

2.4. Workforce reviews – Crisis teams - The review of crisis teams was undertaken as part of the February 2026 establishment review cycle, representing a continued and more embedded approach to assessing workforce requirements within urgent and emergency mental health services.

2.5. The review incorporated available workforce metrics, demand and caseload data, alongside professional judgement, recognising the absence of a nationally validated acuity tool for these services. Following triangulation, no changes to the current establishments are recommended at this time, with

services assessed as operating within safe parameters. However, it is recognised that further maturity is required in the approach to workforce modelling across urgent care pathways. As such, the next phase of this work will expand to include a broader review of all urgent care services, including hospital liaison and home treatment teams, to ensure a more comprehensive, consistent and system-wide approach to workforce planning and assurance.

3. Headroom Review

3.1. As part of the staffing establishments, the Trust allows for an additional circa 28% funding for staff cover for annual leave, sickness and training. In comparison to other organisations, this is a generous amount, but reasonably close to the Royal College of Nursing (2025) Nursing workforce standards guidance which advises a minimum of 27%. In 2025-26, the average actual headroom used was 29.08%. An increase of the study leave percentage in 26-27 (to allow for half-day learning) and also work to effectively manage sickness and absence, will see the headroom use being back within limits.

	% Changed Since Approval	Annual Leave %	Other Leave %	Parenting %	Sickness %	Study Day %	Total %
Apr-25	66.63%	11.38%	0.97%	1.94%	8.01%	3.39%	25.68%
May-25	41.79%	12.94%	1.14%	1.87%	6.88%	2.23%	25.06%
Jun-25	37.13%	12.16%	1.38%	1.83%	7.79%	3.04%	26.20%
Jul-25	40.81%	12.40%	1.72%	2.15%	7.73%	3.30%	27.29%
Aug-25	46.09%	15.51%	1.73%	2.44%	8.80%	2.11%	30.59%
Sep-25	45.31%	14.69%	1.38%	2.39%	8.96%	3.09%	30.51%
Oct-25	44.41%	11.11%	1.63%	2.44%	9.91%	3.53%	28.61%
Nov-25	42.84%	11.33%	1.54%	2.50%	11.29%	3.17%	29.83%
Dec-25	40.11%	13.91%	1.35%	2.06%	10.49%	1.95%	29.76%
Jan-26	43.86%	12.81%	1.21%	1.79%	11.06%	3.39%	30.27%
Feb-26	48.73%	16.51%	1.46%	1.83%	10.51%	3.99%	34.31%
Mar-26	54.22%	14.11%	1.19%	2.01%	9.84%	3.64%	30.79%
Average	**45.99%**	**13.24%**	**1.39%**	**2.10%**	**9.27%**	**3.07%**	**29.08%**

4. Skill Mix review

4.1. As part of a wider assessment of workforce requirements, skill mix ratio should be reviewed and included in ward workforce reviews. This is the proportion of registered workforce, compared to the proportion of unregistered/healthcare support workers. Professional judgment and knowledge of the local context and patient care needs also inform the skill mix of staff. The below table provides the recommended skill mix, based upon speciality and national guidance, noting that there is a clear evidence

base nationally showing a correlation between a decrease in Registered Nursing numbers causing an increase in mortality.

Source	Area	Skill Mix Recommendation
MHOST	Admission/Adults Mental Health	54% Registered
MHOST	Older Adults	47% Registered
MHOST	Psychiatric Intensive Care Units	48% Registered
MHOST	Rehabilitation	53% Registered
RCN	Physical Health wards (acute wards)	65% Registered

Ward	Target skill mix	Current Skill Mix (% of Registered staff on shift)
Brodsworth	54%	40% Day shifts, 25% night shifts
Skelbrooke	48%	40% all shifts
Cusworth	54%	40% Day shifts, 25% night shifts
Windermere	47%	33% all shifts
Kingfisher	48%	33% all shifts
Osprey	54%	40% day shifts, 25% night shifts
Sandpiper	54%	40% day shifts, 25% night shifts
The Willows	47%	33% all shifts
Pheonix	53%	
Hawthorn	65%	28% early, 33% late, 50% nights
Hazel	65%	28% early, 33% late, 50% nights
Magnolia Lodge	65%	33% Early, 40% late, 50% night shifts
Amber	No Recommendation	33% Day shifts, 50% night shifts

4.1.1. On night shifts, the total number of staff in some areas reduce, so that causes some areas skill mix to decrease (where the registered number of staff decreases) or increase (where the number of unregistered staff decreases). There are some inpatient areas that have 1 Registered Mental Health rostered on a night shift.

4.1.2. Incident data is regularly reviewed, and staffing levels are reviewed on a daily basis, within our internal safer staffing processes. Whilst the skill mix for our inpatient wards is below the recommended levels, this does not take into consideration the care hours provided by qualified Nurse Associates, alongside the non-nursing workforce, such as qualified pharmacy technicians, allied health professionals and psychological professionals. Ongoing work around job planning will begin to capture our non-nursing direct clinical care time and thus contribute to care hours.

4.1.3. It is likely that following the multi-professional work, there will be a requirement to increase the proportion of registered nurses within the workforce, specifically to increase the number of RMN on night shifts and an incremental plan will be devised to achieve this, likely over 1-2 years.

5. Care Hours Per Patient Day (CHPPD) Review

CHPPD should also be considered as part of a ward nursing workforce review. This is a simple calculation which divides the number of actual nursing/midwifery (both registered and unregistered) hours available on a ward per 24-hour period by the number of patients on the ward that day. It therefore nominally represents the average number of nursing hours that are available to each patient on that ward. At the time of the reviews, the Trust actual CHPPD was 8.8, against a national average of 9.0. Whilst this is in the main positive, there are some areas that are an outlier in terms of the CHPPD, for instance Kingfishers average is high at 31.6, and Cusworth is at the lower end measuring 5.0. Further reviews and monitoring of CHPPD will be undertaken into 26-27, alongside several key safer staffing projects which include a review of S.136 suite staffing levels, and review of zonal observations.

6. Results from the February Establishment reviews

6.1. A professional judgement framework is embedded within all workforce reviews. This provides a structured and consultative approach to determining staffing requirements, drawing on the expertise of senior clinical staff to agree the appropriate number and skill mix of staff required to deliver safe and effective care within each clinical area.

6.2. This is considered as part of the nursing workforce review process alongside workforce, finance and quality indicators. In addition to acuity and dependency data (MHOST/SNCT), a range of contextual factors that influence staffing requirements are also reviewed, including:

- The layout and design of the ward, recognising that environments with multiple single rooms or poor visibility may require increased staffing capacity
- Line of sight and the requirement for enhanced observations, including 1:1 or cohort nursing
- The availability and contribution of the wider multidisciplinary team
- Patient flow and activity, including leave (S17), external appointments, internal transfers, admissions and discharges
- Support requirements to higher-risk areas, including Section 136 suites and seclusion

6.3. Following completion of the February 2026 establishment review, overall nurse staffing levels across adult acute, older adult and crisis services are assessed as sufficient to support safe and effective clinical delivery. This position is based on triangulation of professional judgement, workforce metrics, quality indicators, and acuity and dependency data (MHOST/SNCT where applicable).

6.4. There is **no requirement** currently to propose adjustments the core funded WTE establishment across these services. However, as identified within this paper, the skill mix of the inpatient workforce remains below national recommendations, and there is variation in the CHPPD across the organisation. While this does not currently present an immediate requirement to change establishments, it represents a key workforce risk and priority area. A Trust-wide programme of work will therefore focus on reviewing the multi-professional workforce contribution alongside developing an incremental plan to increase the proportion of Registered Mental Health Nurses (RMNs) over time.

6.5. Data collection through MHOST and SNCT will continue to be undertaken in line with the Trust's biannual review cycle, with further data collection scheduled throughout 2026 to support ongoing assurance, trend analysis, and future workforce planning decisions.

7. Data Quality and Assurance

7.1. The review has identified variation in the accuracy and consistency of acuity and dependency data across several clinical areas. In some instances, reported acuity levels do not align with triangulated indicators, including clinical presentation, incident data, and operational oversight. Where the MHOST data seemed disproportionate to the triangulated data, professional judgement was applied to decide the recommended staffing levels. Further training will be provided to colleagues to ensure the correct application of the safer staffing tools.

8. Recommendations

8.1. There are a few actions identified within the establishment reviews that require further work:

8.2. Review of Zonal Observations Across the Organisation

- A full review will be undertaken to ensure consistent and safe deployment of zonal observation arrangements across all relevant clinical areas.
- This will involve benchmarking practice, reviewing current nursing resource allocation, and assessing the impact on care quality, safety outcomes and staff wellbeing.
- Any variation in practice or potential inefficiencies will be identified, with recommendations for standardisation and strengthened assurance.

8.3. Skill mix changes

- We need to further develop our multi-professional workforce and map how the wider workforce contributes to care hours within our inpatient areas

- Create an incremental plan, as required to increase the proportion of Registered Nurses within the establishments.

8.4. Data Quality and Assurance

- Implementation of targeted refresher training for clinical staff on the correct and consistent use of MHOST/SNCT, including clear guidance on scoring principles
- Introduction of enhanced validation and moderation processes, including peer review and independent oversight where variation is identified
- Development of clear governance expectations and accountability for data submission at ward and service level
- Ongoing triangulation of acuity data with quality, safety and workforce indicators to identify anomalies and improve confidence in outputs
- Consideration of periodic audit or spot-check processes to further strengthen data credibility

9. Conclusion

9.1. Progress, risks and mitigating actions will continue to be scrutinised through established governance arrangements, ensuring clear visibility, accountability and timely escalation where required. The trust remains committed to a proactive and evidence-based approach to workforce planning, enabling responsive adaptation to changing demand, quality priorities and regulatory requirements.

Rotherham Doncaster and South Humber NHS Foundation Trust

Mortality Report

January and February 2026

Mortality Report – PLFD

(Data focus January – February 2026)

Executive Summary:

During the period, 86 deaths were reported via the RADAR system (53 in January and 33 in February). The majority of deaths reviewed by the Mortality Operational Group (MOG) were closed following screening, with no problems in care identified. 11 required responses. Three require Structured Judgement Review (SJR) which is routine practice for patients with a learning disability and these will also be subject to LeDeR review. Most deaths were expected natural deaths, predominantly affecting people aged over 65, and largely occurring within older adult, memory, hospice, and community services across the Trust.

No concerning patterns of death or service problems have been identified. Further work is being done to allow there to be a greater understanding of presenting populations to services to contextualise some of the statistics.

This report also highlights work being done in North Lincolnshire for suicide prevention. Finally the regional LeDeR report highlights issues with constipation and diabetes in patients with a learning disability.

The report has national coronial prevention of future death reports, which identify cross cutting themes relevant to mental health services such as risk formulation, pathway integration, escalation, and clinical decision making.

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 January and February 2026.

The figures can increase due to late reporting on RADAR by services due to time scales of when the deaths occurred and subsequently reported. (Figures accurate at the time of the report).

3 Assessment

3.1 Mortality Reporting and Management

During the months of January and February 2026, there were 86 deaths in total reported in the Trust.

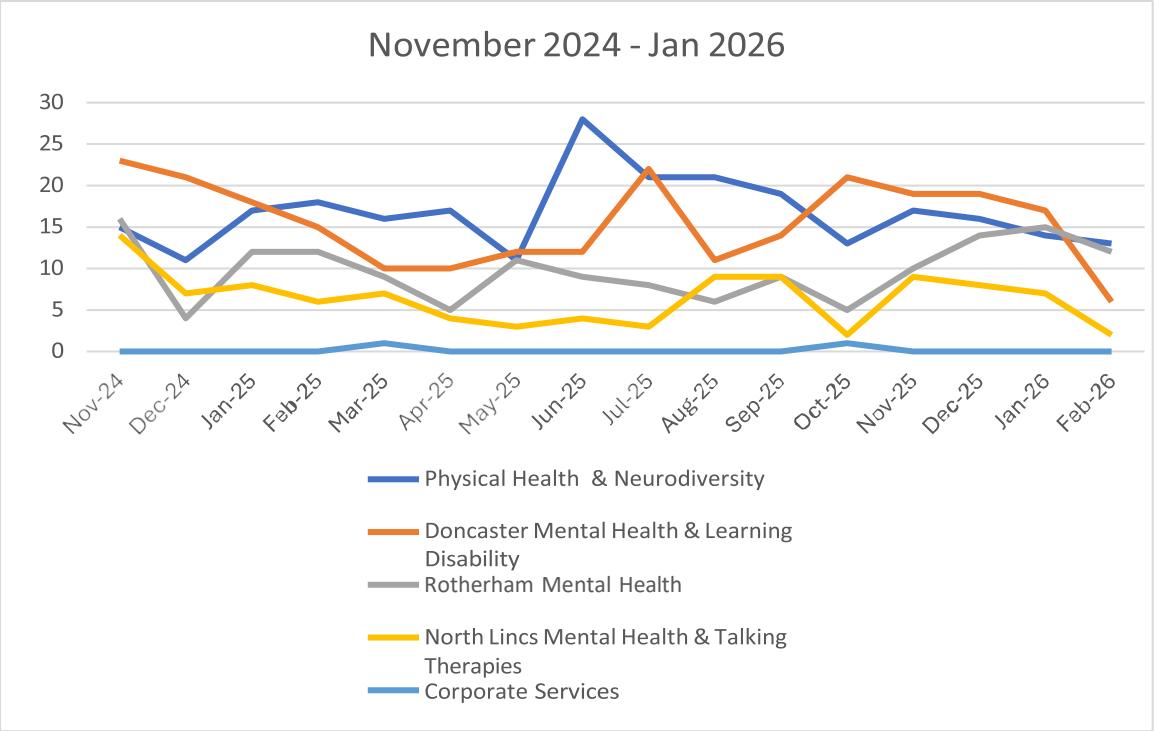
Table 1 - Status of deaths reported during January and February 2026.

Outcome of review	January	February
Reviewed by MOG and were closed as no problem in care was identified	35	27
Reviewed by MOG, however, require further information and have been returned to the author	8	2
Reviewed and requires a Structured Judgement Review (SJR)	2	1
Reviewed and required further discussion in a Learning from Patient Safety Event meeting.	0	0
Awaiting further information from the coroner on cause of death	0	0
Awaiting review by MOG	0	0

Learning Response to be done	8	3
Total	**53**	**33**

Deaths by Care Group from November 2024 – February 2026. Figures are detailed in the longitudinal data in graph 1.

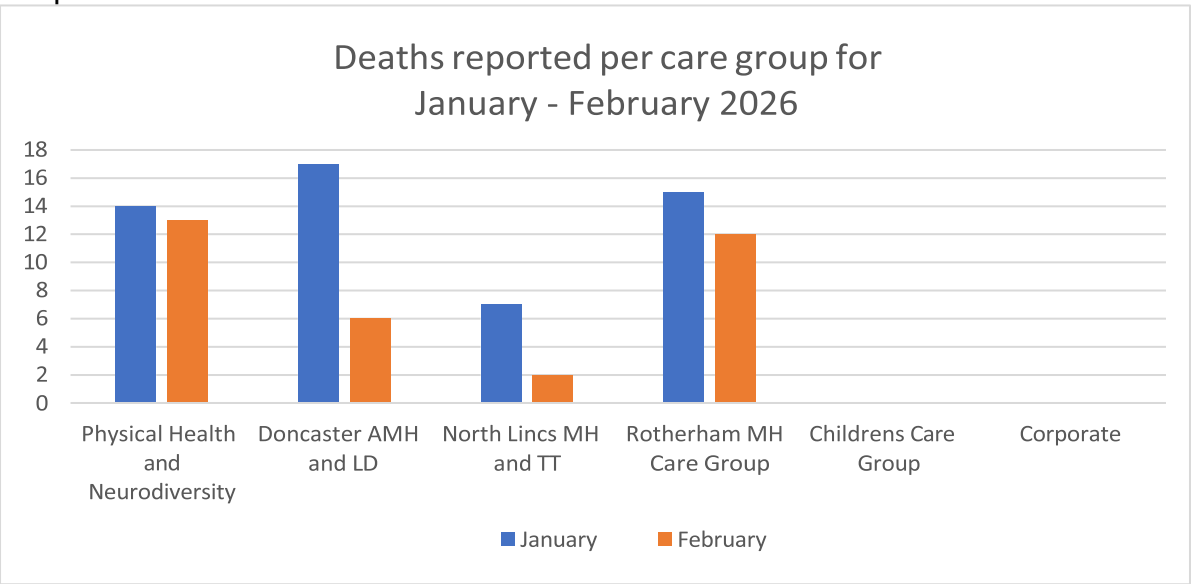
Graph 1



Deaths reported per Care Group for January and February 2026.

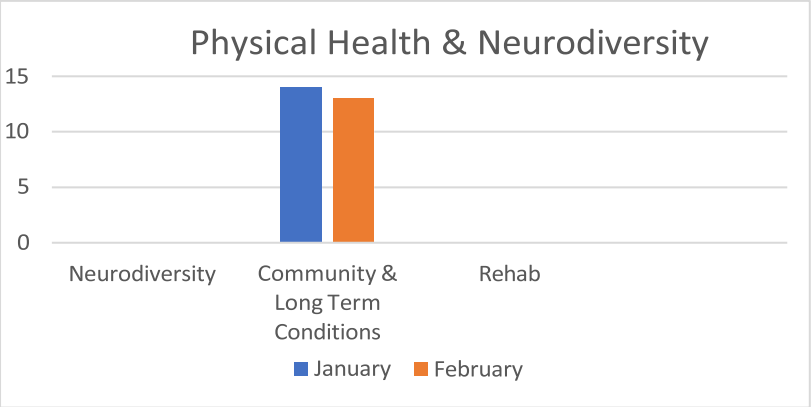
The graph below (graph 2) shows detail in the number of deaths as reported via the RADAR mortality forms.

Graph 2



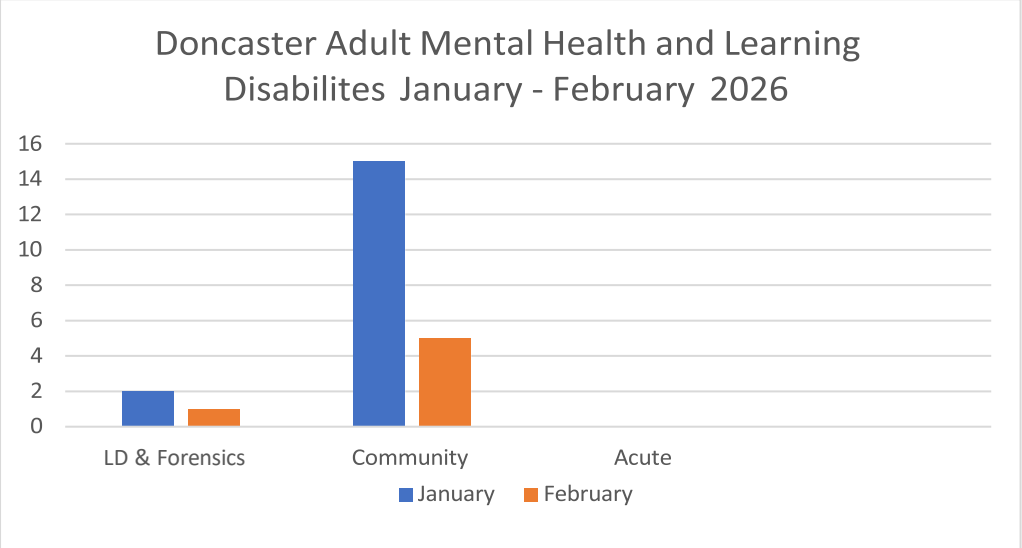
The information detailed in the following graphs, 2a – 2d offers the numbers of deaths reported per individual care groups within the Trust.

2a



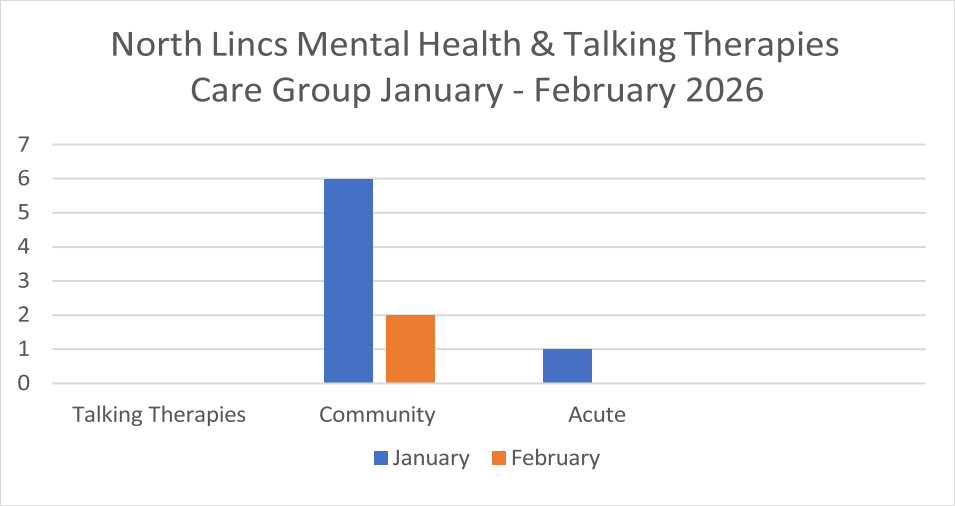
(Graph 2a) During January and February the highest numbers of deaths reported by the Physical Health and Neurodiversity care group were from the community and long-term conditions services. The highest percentage as expected recorded from the hospice service

2b



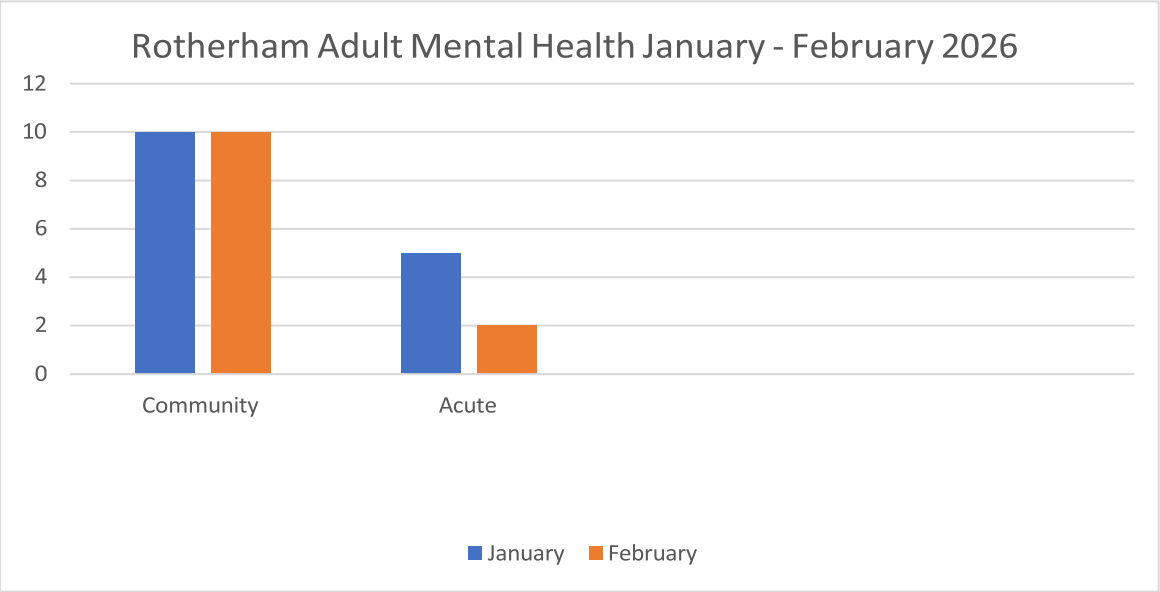
(Graph 2b) The highest number of deaths reported during January and February were from the community mental health teams. Further graphs in this report will offer information in more detail as to specific services the person was known to at the time of death.
There were 3 reported deaths from the Learning Disability services during the months of January and February with one recorded from each locality area.

2c



(Graph 2c) There were 9 deaths reported by the North Lincolnshire care group during January and February with 55% of the deaths being under the care of the Memory and Diagnostic community service.

2d



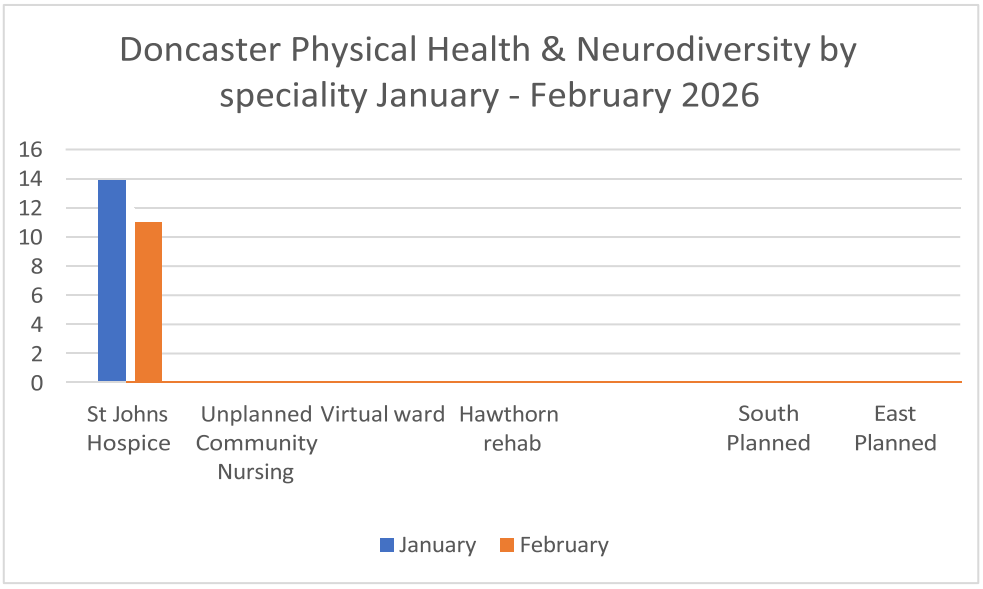
(Graph 2d) During January and February 27 deaths were recorded in total compared with 24 during November and December 2025.
These figures have spiked since September and October 2025 when 13 deaths were recorded.

3 Deaths per Directorate January and February 2026

3.1 Graphs 3a -3d show the number of deaths reported by specialties across the Trust for January and February 2026. The graphs detail specific teams within the Trust who recorded deaths using the RADAR reporting system.

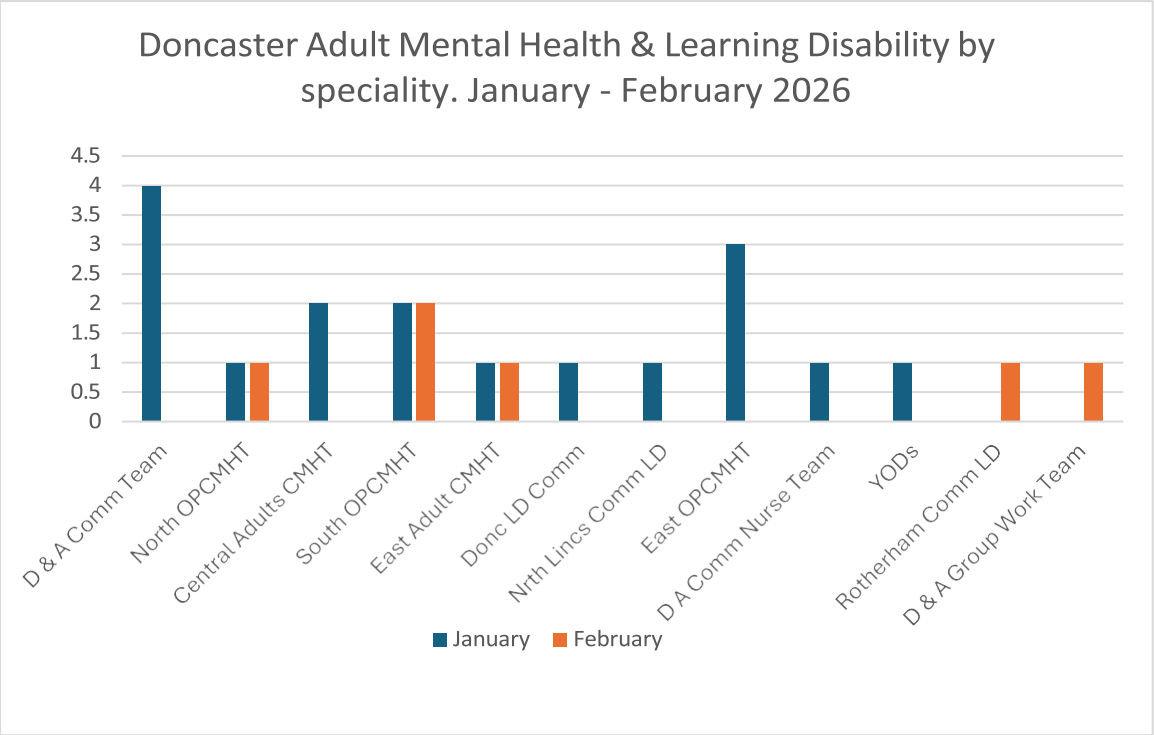
Doncaster Physical Health & Neurodiversity by specialty.

3a



Doncaster Adult Mental Health & Learning Disabilities by specialty

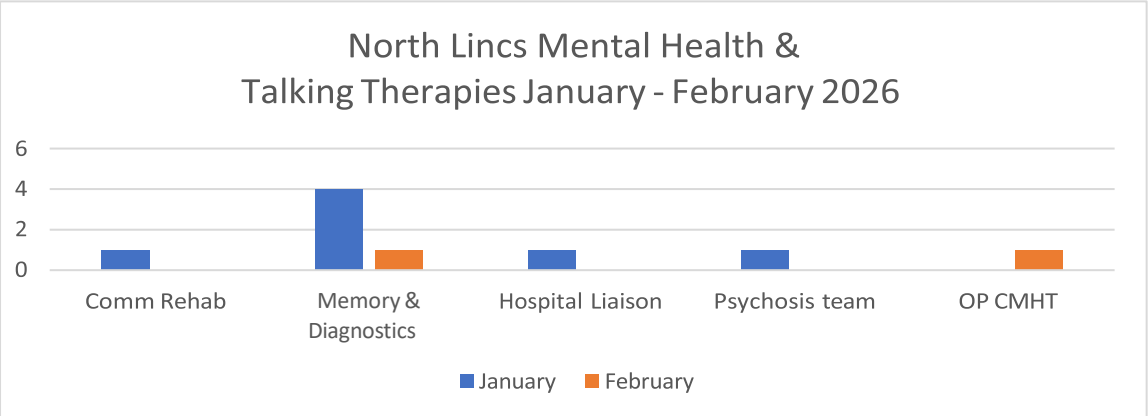
3b



The highest numbers recorded for Doncaster Mental Health and Learning disability services remain from the Older adult teams with 46% of total deaths recorded for Jan – Feb 2026.
26% of deaths were recorded from the Drug and Alcohol services .
Mental health community adult teams recorded 17% and Learning disability services 13% with one death recorded from each locality area, Doncaster, Rotherham, and North Lincolnshire.

North Lincs Mental Health and Talking Therapies

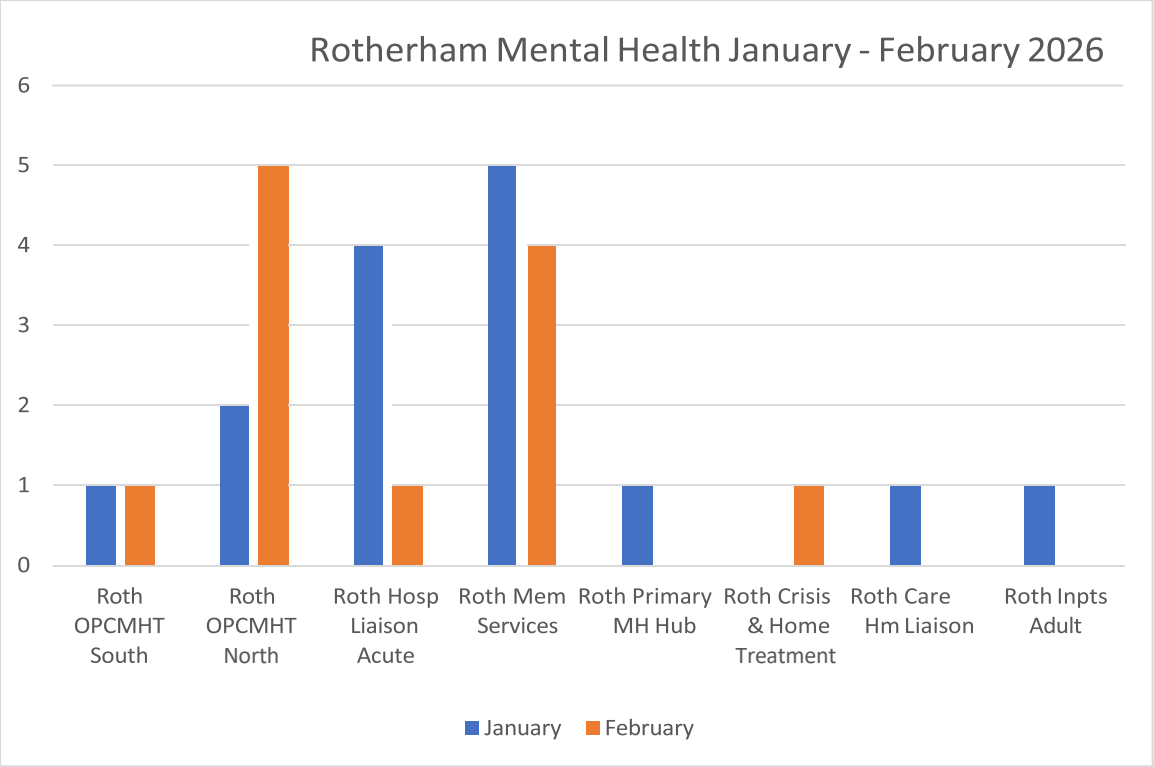
3c



Services for Older Adults report the highest number of deaths during January and February with 67% of deaths recorded.

Rotherham Mental Health Care Group

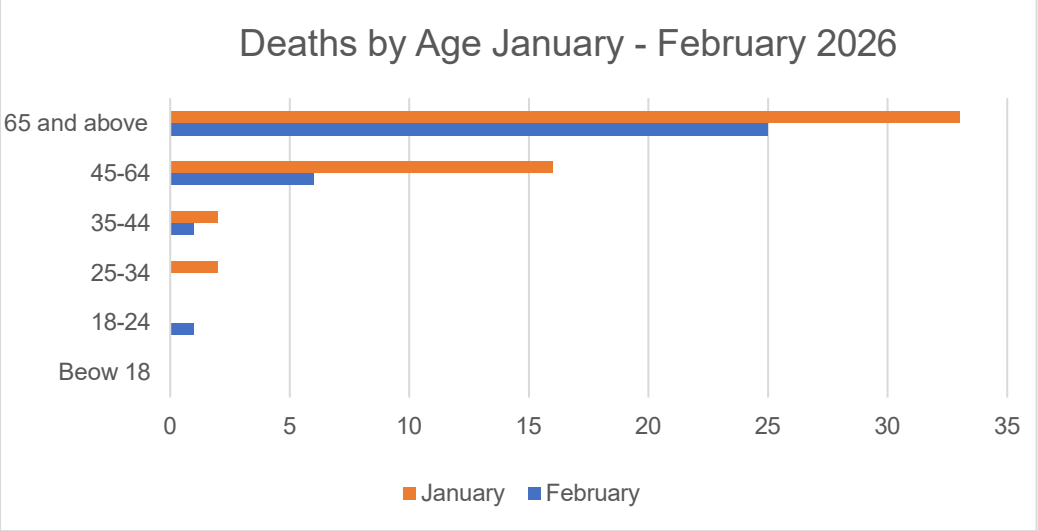
3d



Highest reported numbers remain to be from the older adults' services and with 47% of those deaths from September 2025 to February 2026 being recorded from the memory services.

Deaths reported by age: January – February 2026

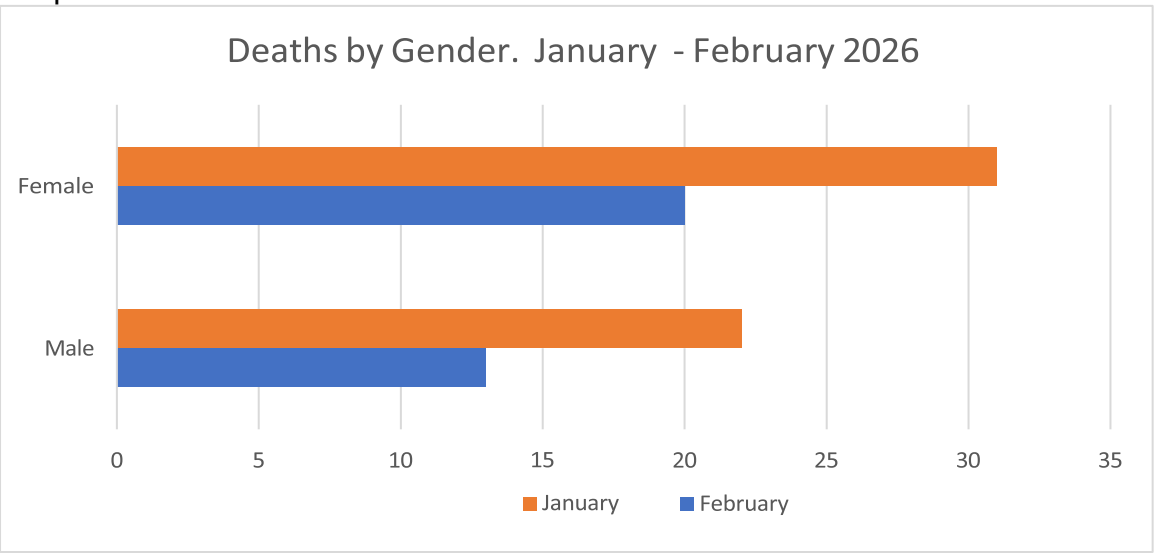
Graph 4



It was noted that during January and February 2026, 67% of the deaths were people over the age of 65 and 26% of people between the ages of 45-64.

Deaths by Gender

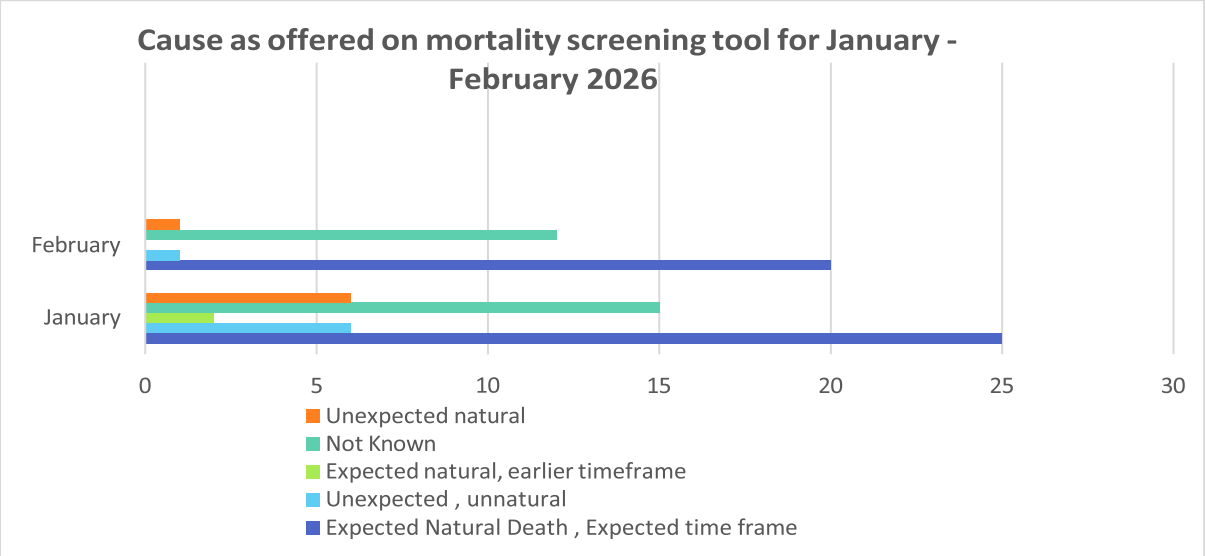
Graph 5



Noted that during January and February data , figures for female deaths recorded were significantly higher than male deaths.
Numbers showed that 51 were female compared to 35 males .
Females were under the care of the hospice in Doncaster or known to the older adult care teams or memory services across the three localities.

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. During which any that have identified as a "Red Flag" the incident 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.

Once 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 is required at the LFPSE meeting. If so, a decision will then be made at the LFPSE and the appropriate action proposed. This process allows for the opportunity for further learning and shared outcome responses.

Up to the end of February 2026, 23 SJR's are to be completed on RADAR.

Table 2 The table below indicates the detail of the monthly reviews of each death which was reported during January and February 2026 on the RADAR system.

Month	January	February
Total number of deaths reported	53	33
Total No of deaths reported by Care Group		
Donc AMH & LD	17	6
Physical Health and Neurodiversity	15	13
Rotherham AMH	14	12
North Lincs & Talking Therapies	7	2
Children's services	0	0
Corporate Services	0	0
Cause group		
Expected natural death, expected timeframe	24	19
Expected natural death, earlier than expected timeframe	2	0
Expected unnatural death	0	0
Not known	15	12
Unexpected natural death	6	1

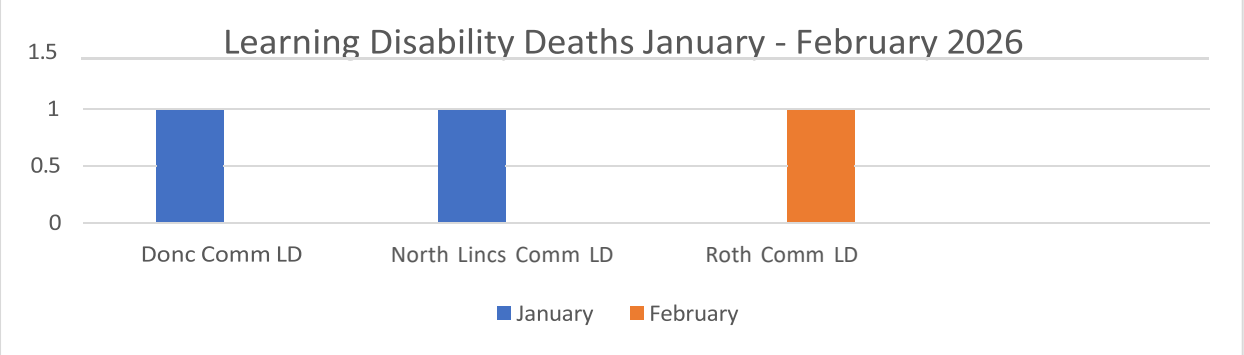
Unexpected Unnatural death	**6**	**1**
Gender		
Male	**22**	**13**
Female	**31**	**20**
Age Group		
<18	**0**	**0**
18- 24	**0**	**1**
25-34	**2**	**0**
35-44	**2**	**1**
45-64	**16**	**6**
>65	**33**	**25**
MOG data		
Incident appraisal screening tool only	**35**	**27**
Await further information and returned by MOG to the author	**8**	**2**
SJR Inc for LeDer report	**2**	**1**
Escalated to Patient Safety Team	**0**	**0**
Await info from coroner re Cause of Death	**0**	**0**
Await review by MOG	**0**	**0**
Learning response to be done	**8**	**3**

3.3 LeDeR reports & Structured Judgements Reviews

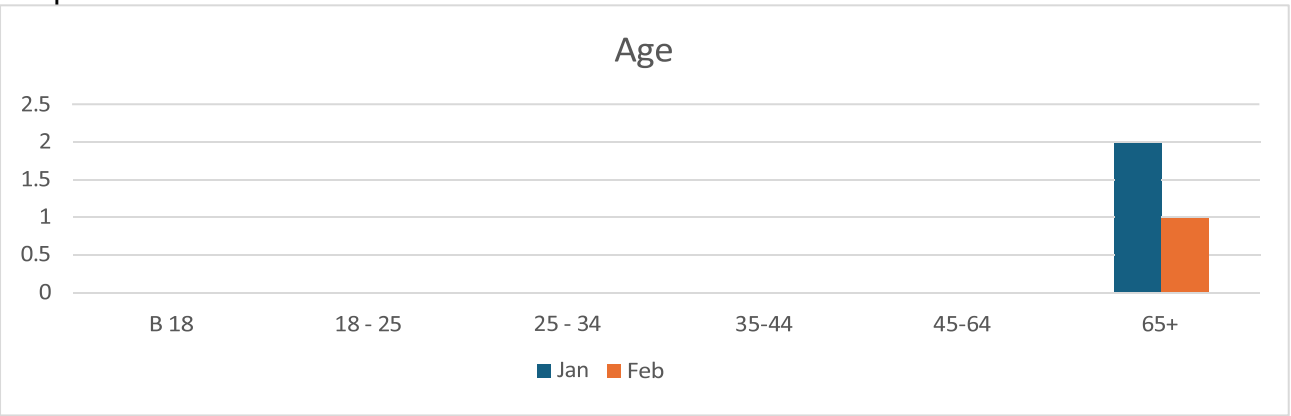
During January and December 2026, 3 deaths from the Learning Disability services were recorded on RADAR.

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.

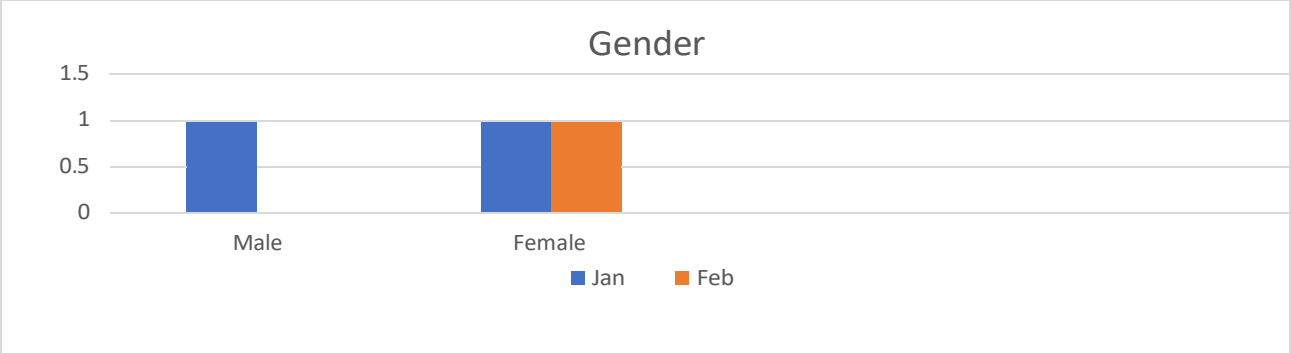
Graph 7



Graph 8



Graph 9



Graphs 7, 8 and 9 detail locality, age range and gender for LD Deaths reported for January and February 2026

Based on the South Yorkshire Leder summary for Q3 the key points are mentioned below –

- 66% of Leder reports were completed within 6 months of the KPI target

- Across South Yorkshire there were 35 reviews completed in total with 19 initial reviews and 16 focused reviews

- The key themes around the deaths were diabetes and constipation
    - Diabetes - People with a learning disability have a higher prevalence of developing diabetes and with the onset being recognised in younger people. The ICB are providing some targeted training for care homes and carers along with RDaSH staff having access to this training.
    - Constipation – This remains one of the highest causes of death in people with LD and remains a common theme throughout reviews. The ICB are planning to launch an awareness programme and toolkit with further information being provided in future reports.

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.

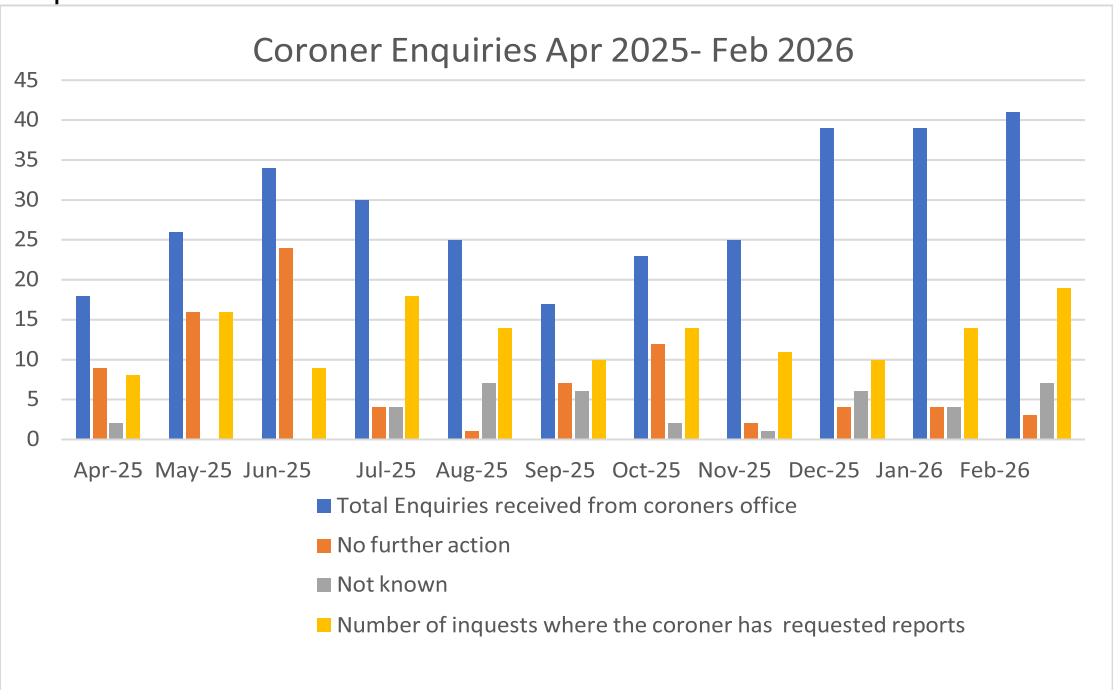
Detailed in Appendix 1 of this report are a selection of PFD concerns issued during the months of January and February 2026 to a number of organisations.

The information available in Appendix 1 provides detail of why the coroners felt it necessary to issue Prevention of Future Deaths reports to the authorities involved and or organisations to where particular attention to current care provision requires review.
These are areas of learning for our organisation and an opportunity to review our practice, policies, and procedures.

4.1 Coronial Inquests

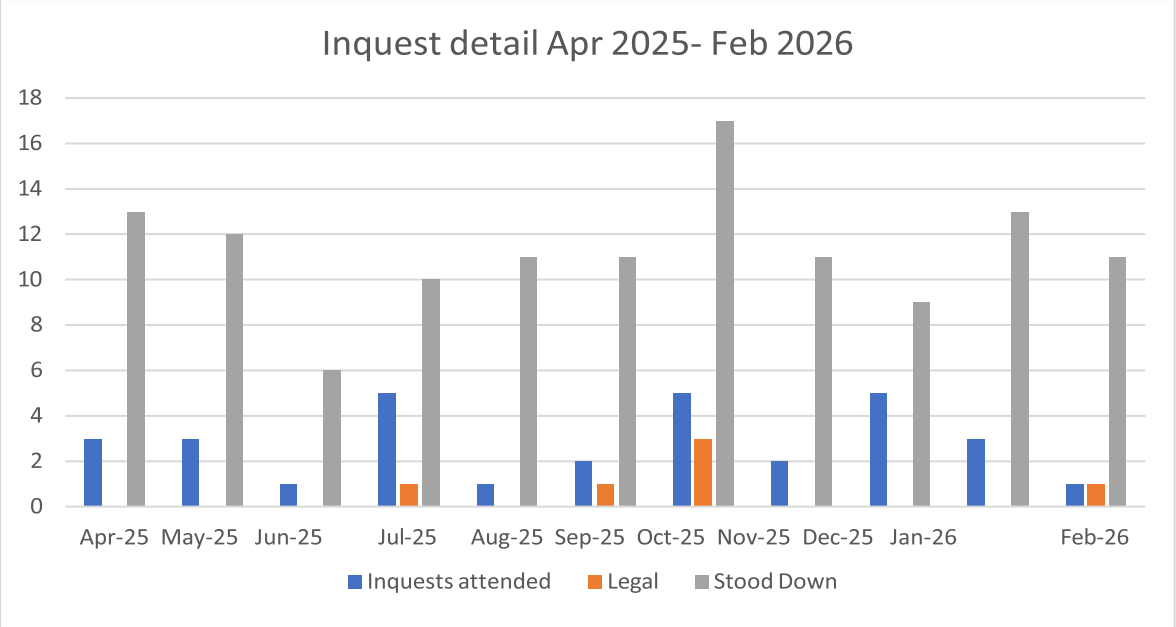
The information below details the number of enquiries and inquests from a number of jurisdictions which have involved the Trust, dating from April 2025 – February 2026.

Graph 10



During January and February, the Trust received 80 enquiries from the coroner's office and local jurisdictions.

Graph 11

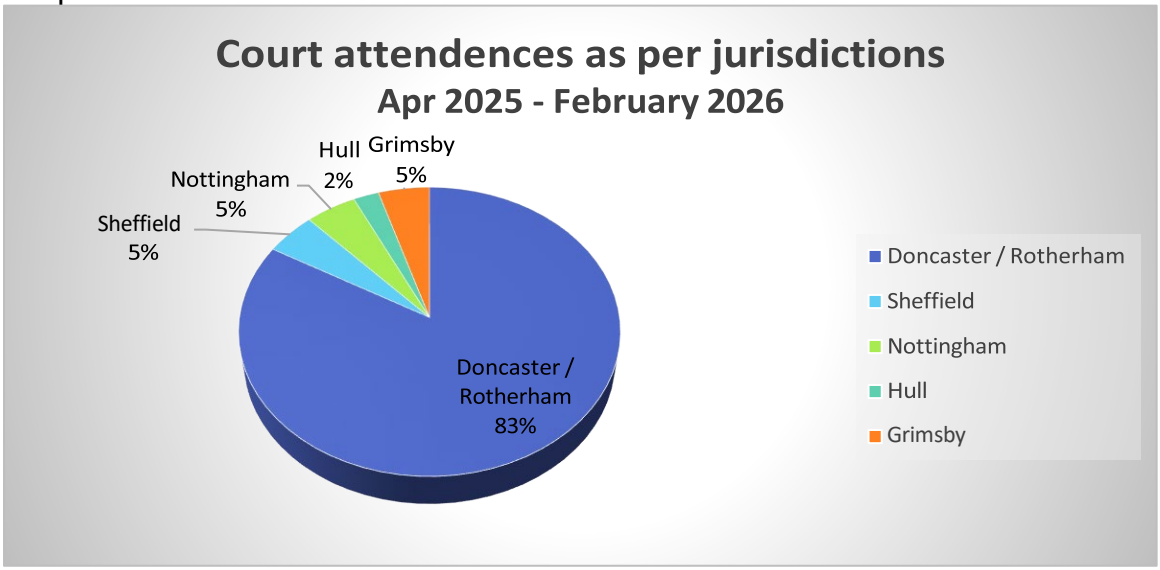


Throughout January and February, the coroner and mortality team attended 4 inquests.

The Trust was stood down by the coroner on 24 occasions as it was deemed by the coroner that the evidence provided in reports by the Trust could be 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. Doncaster / Rotherham being significantly higher.

Graph 12



4.2 Suicide Prevention

North Lincolnshire Suicide Prevention Panel

The panel meet quarterly and is chaired by Public Health with membership drawn from a number of authorities, organisations, and partner agencies to share good practice with a focus on thematic learning. The panel share emerging themes, cross cutting risks, insights, and processes.

Information collated from Real Time Surveillance for North Lincolnshire reported that in 2025 there had been 15 suspected suicides in North Lincolnshire with 13 deaths recorded as male and 2 as female.

A number of contributory factors were identified which included:

- History of mental health including PTSD, delusional disorders, depression / anxiety
- Previous attempts of suicide or self-harm
- Long term physical health conditions
- Recent bereavement
- Relationship issues
- Financial concerns
- Substance misuse

Other regional updates offered from Hull in that during 2025 there had been 27 suspected suicides recorded .

Male deaths were recorded at 74% and with 60% of cases aged between 30-50 years of age.

Contributing factors included an increase seen in unemployment ,housing insecurity, and homelessness.

There are several initiatives in progress or planned in the North Lincolnshire area in support of suicide prevention, domestic abuse awareness, and opportunities to share information as well as networking forums.

The **Better Man Campaign** launched in March 2026 with links to the information available listed below.

- The Better Man Film - https://youtu.be/jv25JglpgME
- The Better Man Trailer - https://youtu.be/KEXvXWDBVz0
- The Better Man Website - https://thebetterman.org.uk/

Declan's Law supports children who are at risk of abuse .
Declan's Law – Justice is the right thing to serve.

- Kev's campaign trailer for Declan's Law - https://youtu.be/syXcrLROybE

Appendix 1

Regulation 28 Prevention of Future Death Reports published In January 2026 – February 2026

Below is a selection of the summery reports issued to healthcare services and or organisations and have included healthcare issues during January and February 2026.

Report information	Details
1) **Date Published:** 24.02.2026 **Coroner:** Elizabeth Wheeler **Date of report** 20.02.2026 **Ref**: 20026-0103 **Area:** Greater Manchester **Response requested from:** Greater Manchester Medicines Management Group **Category:** Alcohol drugs and medication related deaths	**Circumstances** On 3 February 2025 Mr Crabtree was prescribed methotrexate for ongoing rheumatoid issues. This was clinically indicated and the risks were explained. He developed idiosyncratic side effects to the methotrexate – namely, the rapid development of pancytopenia.(A person has fewer Red ,White and Platelet blood cells) He was admitted to Macclesfield Hospital on 18 February 2025 as a result of the symptoms of methotrexate induced pancytopenia and was treated for these. Despite treatment, due to his compromised immune system, he developed pneumonia and died on 1 March 2025 **Concerns** 1. The dose regime referred to in the "Shared Care Guideline for Oral Methotrexate in Rheumatological Conditions in Adults" does not reflect current practice and the initial dose recommended is a sub-therapeutic dose. 2. The "Shared Care Guideline for Oral Methotrexate in Rheumatological Conditions in Adults" was produced in September 2017. Since then, the "Pharmacy First" scheme has come into effect. The guidance therefore does not reflect the changes in the relevant responsibilities between secondary care, GPs and community pharmacists leading to ambiguity as to what type of healthcare professional a patient should consult and potentially fatal delay in ceasing methotrexate or commencing treatment for toxicity for the same. **Investigation and inquest** 04.03.2025 commenced an investigation into the death of Alan Crabtree aged 84 .The investigation concluded at the end of the inquest on 26 January 2026 The conclusion of the inquest was that of Misadventure.

2) **Date Published: 21.01.2026** **Coroner:** Ian Potter. Area coroner for Kent and Medway **Date of report 01.12.2025** **Ref 2026-0023** **Area: Kent and Medway** **Response requested from:** • Chief Executive, Kent, and Medway Mental Health NHS Trust **Category:** Alcohol drugs and medication related deaths	**Circumstances** Mark Vidler had severe depression, which presented atypically. He was under the care and treatment of Kent and Medway Mental Health NHS Trust (the Trust) between July 2024 and his death on 8 May 2025. Mark had previously been detained under the Mental Health Act 1983 (MHA) (August – September 2024, and November 2024) following serious and impulsive attempts to end his life. He was well known to 'mask' his symptoms and feelings. On 30 April 2025, Mark made a very serious attempt to end his life by hanging: the only reason the attempt was unsuccessful was due to the ligature snapping after Mark had fallen unconscious. Mark's treatment was escalated to the Home Treatment Team (HTT) due to his increased risks. Some days later, Mark requested to be discharged by the HTT. This request to be discharged was a significant risk factor that was not fully appreciated by clinicians in the HTT when they agreed to discharge Mark on 6 May 2025. Given the events of 30 April 2025 and Mark's evolving risks, his discharge from the HTT was premature. On 7 May 2025, Mark made a further serious attempt to end his life by hanging, which included leaving a final note for his family. Mark was seen by a nurse from the Mental Health Together Plus (MHT+) that day, who immediately recognised that Mark was at a real and immediate risk of death by suicide. The nurse escalated her concerns to a psychiatrist who agreed with that view and planned for Mark to be assessed urgently with a view to detaining him under the MHA. Neither the psychiatrist nor the nurse considered Mark's home was a place of safety for him. The plan was for Mark to be referred to the Trust's Rapid Response Team, who could have seen him that night for safety and risk management input, pending the MHA assessment. The referral to the Rapid Response Team was declined by the clinician and there was no valid reason for that decision. This meant Mark was not seen or reviewed by an 'out of hours' clinician on the night of 7 May 2025. This was a failure in care that more than minimally contributed to Mark's death. In the early afternoon of 8 May 2025, Mark's son entered Mark's home address due to concerns for his welfare. Sadly, he found Mark suspended by ligature and Mark's death was verified by a paramedic shortly thereafter. Mark had intended to end his life. **Concerns** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. Before setting out my concerns, it is only right that I acknowledge that I heard evidence about good aspects of care treatment provided to Mark. Further, the Trust has undertaken some work to address the risks and concerns it has identified by way of its own internal processes. The **MATTERS OF CONCERN** are as follows: (1) Some staff at the Trust were so focussed on 'process' that they lost sight of the need for patient centred care. This was accepted within the Trusts PSII report. I was insufficiently reassured that action has been taken to address this matter.

(2) The process in place for triaging and considering referrals to the Rapid Response Team is reliant, for the most part, on call handlers working through a script and there is a total lack of clarity regarding clinical decision making in this regard. The Trust acknowledged in its PSII report that there was "no evidence of senior clinical oversight of the decision making or clarity as to where the final clinical decision sits regarding accepting or declining referrals." A senior manager from the Trust told me, in evidence, that there is still work to be done to address this concern.

(3) Evidence I considered showed that some risk factors, such as the masking of symptoms, were well documented. However, the HTT clinician still appeared not to acknowledge the extent of such risks. This raises the risk of a repeat of this concern in the future.

(4) I heard evidence that the decision to discharge Mark from the HTT was made at a multi- disciplinary team (MDT) meeting prior to the HTT nurse visiting Mark on 6 May 2025. This raises the concern that the decision was pre-determined. I heard no evidence that this situation has changed.

(5) Both the nurse from MHT+ and the consultant psychiatrist gave evidence that the MHT+ were not included, as the receiving team, in the MDT decision on 6 May 2025. They considered that this would have been useful and is something that can and has happened in the past. I was told that this left Mark 'in limbo' following his discharge from HTT and I was told that this is something that has not changed since.

(6) I heard evidence that the Trust does not have care co-ordinators and the clinician felt that this could lead to similar situations arising in the future.

(7) The Collaborative Assessment and Management of Suicidality (CAMS) work undertaken by the Trust lacks "dedicated resource in place to manage or support implementation" (quote taken from Trust PSII report). I also heard that the CAMS programme cannot currently be integrated with the Trust's computerised records system, due to copyright issues. This matter was due to be resolved by June 2025; however, it remains unresolved with a current target date of June 2026. I was told that there is no system in place to safety net the use of both paper and computerised records in the meantime.

(8) I heard evidence that as a result of the referral to the Rapid Response Team being declined, Mark's mental health care technically rested with the MHT+ team, which only works until 17:00. As a result, the Approved Mental Health Practitioner service (responsible for arranging MHA assessments) would have been unable to speak to the referrer. While this was not an issue in the specific circumstances of this case, I consider that it raises risks for others in the future.

Investigation and inquest

09. May 2025 an investigation was commenced into the death of Mark Stuart VIDLER. The investigation concluded at the end of the inquest heard on 2, 3, and 19 December 2025. The conclusion of the inquest was:
Suicide, contributed to by a failure in care.
Hanging

3) **Date Published: 10.02.2026** **Coroner: Catherine McKenna** **Date of report** 04.02.2026 **Ref** 2026-0058 **Area:** Manchester North **Response requested from:** Curaleaf Clinic. London **Category:** Mental Health Related Deaths	**Circumstances** Oliver Robinson was 34 years old when his body was discovered at his home address on 24 November 2023. He died by means of self-ligature which he had tied at a time when he was experiencing acute emotional dysregulation. The Court found that his actions in tying the ligature were undertaken as a means of communicating distress rather than with an intention to end his life. The Court also found that Oliver's emotional dysregulation was caused by multiple factors and psychosocial stressors including conflicts with housing and NHS services, debt and a physical and psychological dependence on cannabis which he was obtaining through illicit sources and by way of a prescription from a private clinic. Oliver had enrolled on the UK Medical Cannabis Registry research study run by Curaleaf Clinic in April 2022 and received prescriptions for medicinal cannabis for the treatment of treatment-resistant depression between 7 May 2022 and 17 November 2023. During this time, there were periods when he could not afford to pay for the prescription of medicinal cannabis and would use illicit cannabis as a substitute. Oliver had a background history of addictive tendencies which included excessive cannabis use. He had been under the care of a Consultant Psychiatrist at the Priory Clinic between September 2019 and September 2022 who had diagnosed him with depression but was of the view that by January/February 2022 Oliver's addictive behaviours were the larger problem impacting on his mood. Oliver declined the addictions programme that was offered by the Psychiatrist at that time. Following an assessment by an NHS Consultant Psychiatrist in April 2023, Oliver was given a dual diagnosis of Recurrent Depressive Disorder and Mental and Behavioural Disorder due to Cannabinoid Dependency. Notwithstanding this context, Curaleaf clinic continued to issue prescriptions for medicinal cannabis to Oliver. **Concerns** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows: (1) The Consultant Psychiatrist who reviewed Oliver at Curaleaf specialised in Child and Adolescent Psychiatry and had no Consultant level experience in treating adult patients with Oliver's complex presentation or in the type of treatments available for adult patients with treatment-resistant depression. Treatment options had not been exhausted at the time that medicinal cannabis was prescribed. (2) Curaleaf's initial prescribing decision was based on an out-of-date GP summary care record and without the knowledge that Oliver was under the care of a Consultant Psychiatrist at the Priory. As such the prescribing decision was based on incomplete information. (3) Once Curaleaf Clinic became aware that Oliver had been reviewed by Consultant Psychiatrists at the Priory and the NHS, it did not communicate

	directly with them or seek to inform themselves of the treating Psychiatrists' views. (4) The continuation of prescriptions for medicinal cannabis acted as an obstacle to Oliver receiving appropriate psychiatric and addictions care. **Investigation and inquest** On 29 November 2023 an investigation into the death of Oliver Marc Robinson was commenced. The investigation concluded at the end of the inquest on 30 January 2026, 1 recorded a conclusion of Misadventure. **Copies of report sent to** Chief Coroner and to the following Interested Persons namely: Family of the Deceased The Priory Pennine Care NHS Foundation Trust [REDACTED] also sent a copy of this report to organisations that may find it of interest: Care Quality Commission Health Research Authority
4) **Date Published:** 12.02.2026 **Coroner:** Graeme Irvine **Date of report** 06.02.2026 **Ref** 2026-0072 **Area:** East London **Response requested from:** East London Foundation NHS Trust | Department for Health and Social Care **Category:** Suicide Mental Health	**Circumstances** Mansoor Zaman was a 27-year-old man with a history suicidality, substance misuse, and a diagnosis of Emotionally Unstable Personality Disorder ("EUPD"). Following a period of inpatient treatment at the Newham Centre for Mental Health ("NCMH") following a suicide attempt, Mr Zaman was discharged into the community. On the evening of 6th of December 2024 The City of London Police attended to Mr Zaman, sitting on the side of Southwark bridge over the River Thames. Mr Zaman indicated suicidal intent. He was detained by police under Section 136 Mental Health Act 1983 and taken to a place of safety at Homerton Hospital where he tried to abscond and was physically restrained. On the morning of Sunday 8th December 2024, Mansoor was admitted to Ruby Ward at the NCMH as an informal inpatient. At 14:33hrs Mansoor asked to be escorted outside to smoke, staff declined, he escaped through a fire exit. Staff followed him, persuaded him to return and he re-entered the ward at 15:23 hours. A duty doctor was called to assess Mansoor. The consultation was shortened as Mansoor became agitated. The Junior doctor considered that a S.5(2) Mental Health Act 1983 emergency authorisation was indicated which would allow both restraint and rapid tranquilisation of the patient but deferred completing the decision to seek telephone advice from the on-call specialist registrar. After the duty doctor assessment at 15:31, Mansoor assaulted a ward staff member. At 15:37hrs he walked towards the fire exit door and kicked it open and

Related Deaths	walked out. Staff did a ground and area search but could not locate him. At 16.46 on 8th December 2024, a person believed to be Mansoor was observed [REDACTED]. At 18.27 on 8th December 2024, staff at Ruby ward called police on 101 to report Mansoor missing. On 29th December 2024. The body of the deceased was recovered between Westminster bridge and Lambeth bridge. **Concerns** The **MATTERS OF CONCERN** are as follows. 1. The failure of nurses on the ward to instigate an authorisation under S.5(4) MHA 1983 when Mr Zaman returned to the ward after absconding on the afternoon of 8th December 2024. 2. The failure of nursing staff on the ward to adequately document observations and care decisions. 3. The failure of Trust staff to reappraise the level of risk presented by Mr Zaman to himself and others in light of his erratic behaviour on 8th December 2024, specifically, a. His escape from the ward by violently kicking the fire exit door. b. His aggression toward the duty doctor during assessment. c. His assault upon a member of ward staff. 4. His second escape from the ward in identical circumstances to the first. The failure of Trust staff to re-assess the frequency and quality of observations that Mr Zaman should be subject to during the afternoon of 8th December 2024. 5. The failure of the duty doctor to act decisively and impose an authorisation under S.5 (2) MHA 1983 having been presented with an agitated patient who had minutes before escaped from the ward. 6. The dilatory response of staff on the ward to report Mr Zaman as a missing person to the police, an action that did not happen for almost three hours after it was known that he had absconded. 7. The categorisation of the risk presented by Mr Zaman as of a medium level by the nurse in charge when considering action to be taken after he absconded. 8. The use of the police 101 number as opposed to the required emergency 999 number to make the report. 9. The inadequacy of the Trust patient safety framework investigation which neither sought the recollections of treating staff, nor communicated the findings of the report to the same staff. **Investigation and inquest** On 10th January 2025, this court commenced an investigation into the death of Mansoor Dawud Zaman aged 27 years. The investigation concluded at the end of the inquest on 30th January 2026. A jury returned a shortform conclusion of suicide along with a narrative that cited failure of staff on a mental health ward on 8th December 2024 as factors that probably contributed to death, these were: The failure of the nurse in charge to authorise treatment under S.5(4) Mental

	Health Act 1983. The failure of a reviewing doctor to authorise treatment under S.5(2) of the Mental Health Act 1983. The jury also determined that the following factors possibly contributed to the death: The failure to increase the frequency of observations after Mr Zaman escaped the ward and then returned earlier on 8th December 2024. The failure of staff on the ward to reappraise the level of risk presented by Mr Zaman on 8th December 2024. Mr Zaman's medical cause of death was determined as: 1a Immersion in water. **Copies sent to the Chief Coroner and to the following Interested** Persons Mr Zaman's family, the Care Quality Commission (CQC), the N ursing & Midwifery Council, the General Medical Council I have also sent it to the local Director of Public Health who may find it useful or of interest.
5) **Date Published:** 20.01.2026 **Coroner:** Paul Marks **Date of report** 01.12.2025 **Ref** 2026-0013 **Area:** East Riding and Hull **Response requested from:** NHS England **Category:** Alcohol drugs and medication related deaths Hospital Death (Clinical Procedures and medical managem	**Circumstances** Amy Grace Pugh had a complex psychiatric history comprising emotionally unstable personality disorder, post-traumatic stress disorder, attention deficit hyperactivity disorder, anxiety, and depression as well as drug and substance misuse. She had a proclivity to self-harm resulting [REDACTED] and taking overdoses of medication. She received a custodial sentence of 18 months imprisonment which she served at HMP Low Newton and was released on 27th March 2024. Whilst in prison two Assessments, Care in Custody and Teamwork (ACCT) were opened and subsequently closed. The ACCT's were opened due to self-harming behaviour whilst in custody. On her release she was inadequately supported by various agencies and the combination of this lack of support resulted in the recurrence of self-harming behaviour and a serious deterioration in her mental health, which had been stable during the latter part of her incarceration. Two hospital attendances resulted from applying a ligature to her neck and later the same day, 3rd April 2024, from a combined overdose of medication and consumption of alcohol. She required elective ventilation in the intensive care unit of Scunthorpe Hospital until the effects of alcohol and drugs had passed off. On regaining consciousness on 5th April 2024, she displayed psychotic symptoms and was detained under 5(2) of The Mental Health Act 1983. Despite this, she absconded from hospital but was returned the same day. She underwent a mental health assessment on 8th April 2024 which resulted in her informal admission to Avondale Unit in Hull. She obtained leave on 10th April 2024 to visit her twin sister in York. Whilst in the company of her sister, she appropriated her sister's drugs which comprised pregabalin, diazepam, gabapentin, codeine, and propranolol. She returned as scheduled to the Avondale Unit on 10th April and queries were raised around 21:00 hours that she might be intoxicated. She denied this. At 22:00 hours she collapsed in the garden of the facility and lost consciousness but recovered after about 2 minutes. Paramedics were called and attended, by which time she was fully conscious with essentially normal vital signs.

ent) related deaths	Out of an abundance of caution, paramedics advised that she should go to hospital to be checked, but Amy refused and the default position was that staff of the Avondale Unit would observe her overnight. Observations were conducted at 01:00 and 02:00 hours visually through a flap in the door of Amy's bedroom with neither entry into the room or physical examination being carried out. In all the circumstances, this was an inadequate means of assessing Amy. At 03:00 hours, a further observation occurred, this time with entry into Amy's room. She had no pulse, was not breathing and had fixed, dilated pupils. Despite cardiopulmonary resuscitation being carried out, there was no return of spontaneous circulation, and she was declared deceased at 04:13 hours at Hull Royal Infirmary. The aggregation of failings in this case may be considered to have more than minimally, negligibly, and trivially resulted in Amy's death. **Concerns** Following Amy's admission to Avondale Unit on 8th April 2024, clinical staff were unable to access important records pertaining to Amy's mental health from partner NHS mental health institutions and this compromised her assessment and subsequent management. **Investigation and inquest** On 23rd July 2024, I commenced an investigation into the death of Amy Grace Pugh, aged 23 years. The investigation concluded at the end of the inquest on 26th November 2025, the narrative conclusion of the inquest was:- **Amy Grace Pugh took an overdose of [REDACTED] and other drugs around midnight on 10th April 2024 which resulted in her death on the morning of 11th April 2024. Whilst it is certain she took the drugs, it is not possible to discern her intent.**
6) **Date Published:** 21.01.2026 **Coroner:** Sarah Clarke **Date of report** 14.01.2026 **Ref** 2026 0020 **Area:** Kent and Medway **Response requested from:** Kent and	**Circumstances** Stephen Taylor experienced a significant deterioration in his mental state in the week preceding his death. He was acutely distressed about work-related issues and his financial situation, expressing fear that he could lose both his job and his home. He had a significant history of mental ill health, including a serious and impulsive suicide attempt in 2013. On 19 May 2025, Mr Taylor attended his GP surgery in a state of acute distress. Medication was prescribed and a review was planned for ten days later. No immediate referral to secondary mental health services was made. Between 20 and 24 May 2025, Mr Taylor's mental state deteriorated further. His daughter repeatedly contacted health services including Talking Therapies and the Kent and Medway Urgent Mental Health Helpline, reporting escalating distress, sleep disturbance, reduced self-care, and behaviours consistent with his previous suicide attempt. On 24 May 2025, a telephone triage assessment took place. It was determined that there was no immediate risk and that a routine referral to the Older Adult Mental Health Team would be made. No urgent or in-person

Medway Mental Health Trust | Vita health Group : Kent and Medway Talking Therapies **Category:** Suicide (from 2015) | Community Health care and Emergency Services related deaths | Mental health related deaths.	assessment occurred. On 26 May 2025, Mr Taylor died after deliberately jumping from Louisa Bay Cliffs, Broadstairs, Kent. **Concerns** The MATTERS OF CONCERN are as follows: (1) Mr Taylor was in contact with multiple services during a period of escalating mental distress. Each service operated within its own framework, but there was no evidence of coordinated, real-time escalation or ownership of risk across services. (2) Clinical decision-making consistently relied on Mr Taylor's denial of immediate intent and his stated ability to keep himself safe, despite significant indicators of elevated risk, including a previous serious suicide attempt, escalating distress, severe anxiety, sleep disturbance, reduced self-care, and repeated concerns raised by a close family member. (3) Referrals to secondary mental health services were identified as necessary by more than one service but were treated as routine rather than urgent and were not actioned immediately. (4) Family-provided information indicating heightened and escalating risk did not result in same-day escalation or urgent face-to-face clinical assessment. (5) Responsibility for escalation became diffuse across multiple services, creating a foreseeable risk that no single service took ownership of urgent risk management. **Investigation and inquest** On 26th May 2025 I commenced an investigation into the death of Stephen Taylor. The investigation concluded at the end of the inquest on 5th January 2026. The conclusion of the inquest was Suicide. The medical cause of death was recorded as: 1a. Multiple Injuries.