LEARNING FROM DEATHS REVIEW 2026/27

Has your Learning from Deaths framework evolved beyond compliance?

Our refreshed review helps organisations demonstrate meaningful learning, measurable improvement and effective patient safety governance. It considers alignment with PSIRF, Medical Examiner scrutiny, Coroner processes, Prevention of Future Death reports, and patient and family involvement.

Why this matters now

Recent Learning from Deaths reports show increasingly mature governance and PSIRF-aligned learning systems, but also recurring opportunities to strengthen communication, documentation, escalation, family involvement, mortality intelligence and embedding learning across services.

What recent Learning from Deaths reports are telling us

Key trends

- Communication and handover remain persistent themes.
- Documentation, care planning and risk assessment quality continue to feature.
- Recognition of deterioration, escalation and timely senior review remain important.
- Growing focus on health inequalities, including learning disability, autism, deprivation and ethnicity.

Good practice

- Dedicated mortality groups and Board-level oversight.
- Greater triangulation through PSIRF, incidents, complaints, Medical Examiner reviews and Coroner learning.
- Use of Structured Judgement Reviews and thematic analysis to identify system factors.
- Examples of family/carer feedback being used to strengthen learning.

Areas for enhancement

- Demonstrating impact: moving from actions completed to measurable improvement.
- Embedding learning consistently across divisions, sites and pathways.
- Strengthening family involvement and Duty of Candour assurance.
- Improving mortality data quality, coding, dashboards and thematic intelligence.

What does the review cover?

Governance and oversight

Board scrutiny, accountability, assurance, risk management, trends, themes and learning.

Learning from Deaths framework

Quality, consistency and timeliness of mortality reviews, including integration of Medical Examiner findings.

PSIRF and organisational learning

System-wide learning, triangulation of intelligence and evidence that change is leading to improvement.

Coroner and PFD learning

Referrals, inquests, Regulation 28 reports, action tracking and evidence that learning is embedded.

Family engagement and Duty of Candour

Transparency, involvement of families and compliance with statutory requirements.

Mortality intelligence and inequalities

Use of data, coding, thematic intelligence and inequalities insights to target improvement.

Moving beyond compliance to demonstrable improvement

Key questions we will help you answer

- Is the organisation demonstrating meaningful learning from deaths, not just compliance with process?
- Can learning be evidenced through changes in practice, improved governance and safer care?
- Are Coroner, inquest and Prevention of Future Death themes tracked through to completion and impact?
- Are Medical Examiner findings, PSIRF insights, incidents, complaints and mortality reviews triangulated?
- Are families appropriately involved, supported and able to influence learning?
- Does the Board receive clear assurance on mortality, themes, inequalities, actions and improvement impact?

Benefits of the review

Independent maturity assessment

- Assurance on Learning from Deaths arrangements against current expectations.
- Clear focus on governance, accountability, risk, themes and improvement evidence.
- Practical recommendations prioritised by risk, impact and Board assurance value.

Sharper improvement intelligence

- Stronger integration of mortality, PSIRF, Medical Examiner, Coroner and family learning.
- Support to identify repeated themes, variation and health inequalities insights.
- Outputs suitable for Boards, Quality Committees and Audit Committees.

Emphasis for 2026/27

1 Evidence of impact

Clearer focus on whether actions have changed practice and improved safety

2 System learning

Testing how themes are triangulated across different sources of intelligence

3 Family voice

Assessing whether bereaved families are involved and learning is fed back

4 Board assurance

Strengthening the line of sight from review findings to Board oversight

Outcome

Helping organisations demonstrate that learning is embedded, intelligence is connected and improvements are making a tangible difference to patient safety.

Key themes: Learning from Deaths | PSIRF | Medical Examiner | Coroner & PFD Reports | Patient Safety | Family Engagement | Governance & Assurance

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