

FOI Request Response information

FOI request reference:	2016/028
Date request received:	02/02/2016
Date request responded to:	01/03/2016
Category:	Incidents
Tags:	Unexpected deaths, patients, untoward incidents

Request Detail:

Info re: Number of unexpected deaths 2013. 2014 and 2015

Re: Handling of patient deaths by Lancashire Care NHS Foundation Trust

Thank you for your helpful response to my data request on this matter.

I should clarify that questions (3) (5) and (6) of my original request related to *all* trust deaths and not just the deaths that the trust notified to CQC.

Please could I have therefore have data for each of calendar years 2013, 2014 and 2015, in relation to all trust deaths, as follows:

- 1) How many of the deaths were considered by the trust to be unexpected?
- 2) How many of the unexpected deaths did the trust investigated internally?
- 3) How many of the unexpected deaths were subject to external investigation?

Response Detail:

The Trust response to your recent FOI request is as follows:

Please could I have therefore have data for each of calendar years 2013, 2014 and 2015, in relation to all trust deaths, as follows:

The Trust is a combined mental health and community health Trust. All mental health service user deaths are reported on our internal incident reporting and management system regardless of the cause (including natural cause deaths). Community health service user deaths are reported where the Trust is the main provider of care.

The increase in reporting for the years of 2014 and 2015 is primarily due to a change in reporting within the Memory Assessment Service (MAS) and the significant expansion of that service (428 deaths over the three year period). It is important to note the MAS service undertakes annual outpatient appointments for memory assessment of predominately older people and no reported death

in this service has been determined as attributable to the service (i.e. all are natural causes or not connected to the service).

2015 - 849

2014 - 602

2013 - 250

All incidents occurring within the Trust are subject to a local investigation by the manager of the service, completed within 7 days of the incident occurring or 3 days for serious incidents. The Trust has a weekly Serious Incident Review Panel, chaired by the Medical Director, which reviews each reported death and determines whether the incident meets the national definition of serious incident and if so the required level of further investigation. A further level of investigation would be undertaken using root cause analysis methodology. All serious incidents are reported on the national STEIS system administered by NHS England which notifies our commissioners and NHS England of the serious incident occurring. We then submit a completed investigation report to our commissioners within 60 working days. Commissioners close the incident on the STEIS system only when they are assured that a robust investigation report and action plan has been undertaken and submitted to them.

- 1) How many of the deaths were considered by the trust to be unexpected?

We are unable to provide this data as this information is not a searchable part of the incident record and would require a manual check of each individual record which would be outside of the time/cost allowance of the FOI Act. We can confirm that all deaths (regardless of being expected or otherwise) are recorded on our incident reporting and management system and reviewed by the weekly Serious Incident Review Panel. The Trust is a combined mental health and community health Trust. All mental health service user deaths are reported on our internal incident reporting and management system regardless of the cause (including natural cause deaths). Community health service user deaths are reported where the Trust is the main provider of care. As a result, a service user death that is not expected by the Trust does not necessarily indicate it has a connection to Trust services (i.e. a patient under community mental health services who dies from a heart attack).

- 2) How many of the unexpected deaths did the trust investigated internally?

As above, whilst we cannot easily separate “unexpected deaths” from “expected deaths” we can confirm that all deaths are recorded on our incident reporting and management system and reviewed by the weekly Serious Incident Review Panel. The Trust is a combined mental health and community health Trust. All mental health service user deaths are reported on our internal

incident reporting and management system regardless of the cause (including natural cause deaths). Community health service user deaths are reported where the Trust is the main provider of care. The Trust has a weekly Serious Incident Review Panel, chaired by the Medical Director, which reviews each reported death and determines whether the incident meets the national definition of serious incident and if so the required level of further investigation. The Trust complies with the Serious Incident Framework for the NHS, which is published by NHS England. This framework can be accessed at: <https://www.england.nhs.uk/patientsafety/serious-incident/>.

3) How many of the unexpected deaths were subject to external investigation?

The following external (or part external) investigations were undertaken:

2015 - The Trust appointed an independent and external lead for one investigation.

The Trust participated in one joint investigation with East Lancashire Hospitals NHS Trust – the investigation was led by an independent and external person.

2014 - The Trust participated in one joint investigation with East Lancashire Hospitals NHS Trust – the investigation was led by an independent and external person.

2013 - The Trust appointed an independent and external person to jointly lead an investigation alongside a Trust employee.

In addition, during the period requested, three independent homicide investigations were carried out by NHS England (however they related to incidents occurring prior to the years requested). The reports from these investigations are published on our web site at

<https://www.lancashirecare.nhs.uk/Independent-Investigations>.