FOI Request Response information

FOI request reference:	2016/035
Date request received:	08/02/2016
Date request responded to:	07/03/2016
Category:	Incidents
Tags:	Service users, deaths, patients, learning disability, autism, investigations,

Request Detail:

Info re SU with LD who have died

1. How many people with a learning disability or autism died while they were in your care:
2. Of these people how many deaths were not expected?
3. How many of the unexpected deaths were investigated in this time period.
4. How many deaths of people with learning disabilities or autism were reported to your Board?
5. Do you have a policy to stop people with a learning disability dying young?
6. Please tell us what things have been changed because of your investigations into deaths of people with autism or learning disabilities.

Response Detail:

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

1. How many people with a learning disability or autism died while they were in your care:
   2010 – Data not held
   2011 – Data not held
   2012 - 1
   2013 – 10
   2014 – 21
   2015 – 25

   The data above includes deaths from the Trust's learning disability service only and includes patients who have died within 6 months of discharge as well as those under the care of our services at the time of death. The increase relates to the expansion of the learning disability services. Service users with a learning disability or autism diagnosis may have died while under the care of other services but we are unable to provide this breakdown of information as the diagnosis is not a searchable part of the incident record and would require a manual correlation with the individual care record which would be outside of the time/cost allowance of the FOI Act.

2. Of these people how many deaths were not expected?

The Trust is unable to provide this information, 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. The Trust can confirm that deaths (regardless of being unexpected 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 the 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.

3. <u>How many of the unexpected deaths were investigated in this time period.</u>
   As the Trust is unable to answer question 3 in full, we cannot therefore answer this question. The Trust can say that 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. This occurs within 48 hours. 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.

4. <u>How many deaths of people with learning disabilities or autism were reported to your Board?</u>

   The Trust produces a six-monthly Serious Incident Board Report. This report details the overall levels of suicide across the Trust's services. The Trust also reports on the number of serious incidents occurring within its services to the Board and our commissioners on a monthly basis. These reports do not specifically differentiate which deaths are from patients with a learning disability or autism.

5. <u>Do you have a policy to stop people with a learning disability dying young?</u>

The Trust has a number of overarching policies, procedures and frameworks that set out our approach to the prevention and early death. An example of this would be our Suicide Prevention Framework. These policies are not specific to patients with a learning disability but cover all our services.

6. Please tell us what things have been changed because of your investigations into deaths of people with autism or learning disabilities.

   As stated above in several previous questions, the Trust is unable to extract those serious incident investigation that relate only to patients with learning disabilities or autism. However, we can confirm that each serious incident investigation report includes an action plan that has been approved by the relevant Network Director and Clinical Director. In line with the NHS England Serious Incident Framework these reports and action plans are submitted to our commissioners and NHS England. Our commissioners have serious incident panels that review our investigation reports and action plans and will only close incidents on the national STEIS system once they are assured that a robust action plan has been developed.