Unexpected deaths

Request and Response

Please advise, in calendar years 2013, 2014 and 2015,

1) How many death notifications did the trust submit to the Care Quality Commission?
OUR RESPONSE:
2013 - 3
2014 - 5
2015 - 3

2) How many of these notifications related to patients detained under the Mental Health Act, or subject to Community Treatment Orders, at the time of death?
OUR RESPONSE: Notifications to the Care Quality Commission (CQC) are only done so under regulatory requirements when a patient is subject to detention at the time of death, all notifications by definition, therefore, are done so under these circumstances.
2013 notifications
1 - Section 2 1 - Section 3 1 – Community Treatment Order (CTO)

2014 notifications:
4 - Section 3 1 - CTO

2015 notifications:
2 - Section 3 1 - CTO

3) How many of the deaths did the trust consider to be unexpected?
OUR RESPONSE: Please see our response to Question 4.

4) What is the trust's definition of "unexpected"?
OUR RESPONSE: Unfortunately, the Trust does not currently have a definition of "unexpected" deaths**.** However, the Trust's definition of an "expected" death is where a patient's death was anticipated in the near future, the cause of death was known including those patients on end of life pathways, and there were no suspicious circumstances to suggest anything untoward occurred. All deaths that fall outside of this "expected death" definition are treated as unexpected deaths. The Trust is currently writing a "Care of the deceased" policy which will include a definition of unexpected deaths. We anticipate this policy will be published in April 2016.

5) How many of the unexpected deaths were internally investigated by the trust?
OUR RESPONSE: Outside of the definition of 'unexpected death' – where a patient dies whilst subject to detention, the Trust would undertake an internal investigation.

6) How many of the unexpected deaths were subject to external investigation?
OUR RESPONSE: In accordance with the definition outlined in point 2 above, where a death is reported to the CQC under regulatory requirements, the CQC and the Coroner have a duty to investigate.