Unexpected Deaths

Request and Response

We are in receipt of your subsequent request for information following our response to your initial request, ref: FOI/1516/SG3519, handled under the Freedom of Information Act 2000.

1. In our earlier response we indicated to you that, whilst the Trust currently has a definition for 'expected' death, we are reviewing our 'Care of the Deceased' Policy which will include the definition for 'unexpected'. This review has been instigated by a number of key factors one of these being the publication in March 2015 of the NHS England policy document 'Serious Incident Framework'.

   This document provides for the following and will provide the basis for the Trust's definition and requirements for regulatory notification to NHS England:

   The definition below sets out the circumstances in which a serious incident must be declared…

   - *Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:*

   - *Unexpected or avoidable death[(8)] of one or more people..*

   The subsequent definition at (8) states:

   "Caused or contributed to by weakness in care/service delivery (including lapses/acts and/or omission) as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition where this was managed in accordance with best practice"

   The guidance further explains at 1.5.1 the separate requirement to notify the CQC of a 'death in custody', i.e. whilst detained.

   The CQC in its regulatory requirements for notification state at Regulation 16:

   o *Regulation 16 – "The intention of this regulation is to ensure the CQC is notified of the deaths of people who use services so that where needed CQC can take follow up action.*

   Notifications include those deaths that

   Occurred while services were being provided in the carrying on of a regulated activity, or

   Have, or may have, resulted from the carrying on of a regulated activity.

   Notifications about deaths must be sent to CQC without delay. All providers must send their notifications directly to CQC unless the provider is a health service body, local authority or provider of primary medical services and it has previously notified the NHS Commissioning Board Authority (NHS England) of the death"

   Leicestershire Partnership NHS Trust is an integrated community and mental health trust, therefore in meeting its regulatory responsibilities, services would notify under the CQC's Regulation 16, all deaths in custody i.e. that occurred whilst the patient was subject to detention under the Mental Health Act. All those deaths reported to the CQC where the patient is detained are also, as a matter of course, reported to the Coroner. However, as a health service provider, deaths that fall outside of this regulation would not be notified to the CQC but to NHS England in accordance with the policy document quoted above.

   In response to your specific request, the detail provided to you in the previous response would meet the requirements of Regulation 16 and, as previously stated, would be subject to both internal and external investigation.

2. Please advise in relation to <u>all</u> trust deaths in each of years 2013, 2014 and 2015:

   i) How many of all the trust's deaths met the NHS England/ NRLS definition of "unexpected"

OUR RESPONSE: All of the unexpected death incidents below originally met the NHS England / NRLS definition of "unexpected" at the time of reporting the incident, however some of the deaths were later confirmed as 'natural cause deaths' 'no harm caused by LPT*' following receipt of further information.

ii) How many of the unexpected deaths were internally investigated by the trust?

OUR RESPONSE:
2012/13 = 20

- 7 of the 20 deaths reported met the criteria for an internal investigation and were investigated
- 7 of the 20 deaths reported were confirmed ‘natural cause’ deaths
- 6 of the 20 deaths reported did not meet the criteria for an internal investigation

2013/14 = 48

- 12 of the 48 deaths reported met the criteria for an internal investigation and were investigated
- 19 of the 48 deaths reported were confirmed ‘natural cause’ deaths
- 17 of the 48 deaths reported did not meet the criteria for an internal investigation

2014/15 = 63

- 20 of the 63 deaths reported met the criteria for an internal investigation and were investigated
- 27 of the 63 deaths reported were confirmed ‘natural cause’ deaths
- 16 of the 63 deaths reported did not meet the criteria for an internal investigation

01/04/2015 – 31/12/2015 = 69

- 11 of the 69 deaths reported met the criteria for an internal investigation and were investigated
- 19 of the 69 deaths reported were confirmed as ‘natural cause’ deaths.
- 36 of the 69 deaths reported did not meet the criteria for an internal investigation.
- 2 of the 69 deaths reported were ‘palliative care’ deaths.
- 1 of the 69 deaths was a death of a baby and the CDOP* process was followed in this case.

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

OUR RESPONSE: No unexpected deaths have been subject to an external investigation.

KEY: * CDOP – Child Death Overview Panel.
* LPT – Leicestershire Partnership NHS Trust