Norfolk and Suffolk NHS
NHS Foundation Trust

**Compliance Team – Health Records**
Kestrel House
Hellesdon Hospital
Drayton High Road
Norwich
Norfolk
NR6 5BE

Tel: 01603 421687
Fax: 01603 421411

# FOI REQUEST NUMBER 317- 2015

**Request :**

Between 1 April 2011 and 31 March 2015:

1. How many deaths were there among your service users?
2. How many of these were unexpected deaths?
3. How many were treated as a Critical Incident?
4. How many were treated as a Serious Incident Requiring Investigation?
5. For Learning Disability service users how many unexpected deaths were treated as a Critical Incident or Serious Incident Requiring Investigation?
6. For Older People Mental Health service users how many unexpected deaths were treated as a Critical Incident or Serious Incident Requiring Investigation?Figures provided from 2012 when Norfolk and Suffolk mental health trusts merged into a single organisation.

**Response:**

| | 12-13 | 13-14 | 14-15 |
|---|---|---|---|
| **Deaths reported on the Trust's incident reporting system**<br>Includes all deaths including natural causes and may include those no longer using services (See Note 2) | 142 | 134 | 213 |
| **Unexpected deaths reported as a Serious incident Requiring Investigation**<br>These are reported on identification of death occurring; unlikely cause of death known at this point. (See Note 3) | 88 | 105 | 139 |
| **Deaths reported within Learning Disability services** | 1 | 0 | 0 |
| **Deaths reported within Older People's services** | 1 | 6 | 6 |

Further notes:

1. NSFT provides services which other mental health services may not, such as drug and alcohol rehabilitation services, where service users live a high-risk lifestyle, at greater risk of unexpected / premature death.

2. NSFT applies the national framework for serious incidents requiring investigation, ie, It reports unexpected deaths for service users whose last contact with a service may be up to six months previously. 'Contact' can include a single contact with the Trust's Acute Psychiatric Hospital Liaison Service, for example, with no follow-up required. If that individual dies unexpectedly within six months and the Trust is notified (generally by the Coroner), it will be reported as a Serious Incident.

3. The Trust reports a Serious Incident at the time it is informed of the unexpected death; this will be, in the majority of cases, before the cause of death has been established and any relevance relating to a mental health condition / issue is identified or dismissed.

   At the point that a death is reporter to the Trust, an initial investigation is carried out to identify if there are immediate actions required.

   Subsequent confirmation of the cause of death may identify a death was by natural or physical cause. At all stages the potential for learning is considered.

4. NHS England's Serious Incident Framework (March 2015) confirms the principle that commissioners do not use reporting of serious incidents as a means of performance management. The principle of the system is that any incident may be reported where there is a potential for learning.

"Whilst it may be appropriate to performance-manage, or even regulate organisations on the basis of their responses to serious incidents, it is not appropriate to performance- manage or regulate organisations only on the basis of the number or type of serious incidents that they report. Doing so will only discourage reporting, dis-incentivise information sharing and inhibit learning.
"Neither is it appropriate to sanction organisations simply for reporting serious incidents or to set performance targets based on decreasing the number of serious incidents that are reported. Simply counting the number of serious incidents reported by an organisation does not tell you how safe they are and should not be used to make isolated judgements about the safety of care."