Freedom of Information Act 2000 disclosure log entry

Reference

22-23131

Date sent

23/08/22

Subject

Unexpected Deaths of Service Users 2018 to date

Details of enquiry

1. The number of unexpected deaths at the trust's mental health units (inpatients – both informal or formal (sectioned) patient). Please breakdown (a-e below) by year (2018, 2019, 2020, 2021 and 2022 so far) and if possible how many of each yearly total were under the age of 65.
    a) The total number of unexpected deaths
    b) The number of the unexpected deaths that progressed to a Serious Incident investigation
    c) The number of unexpected deaths that were referred to a coroner
    d) The number of unexpected deaths that was classed as suicide
    e) The number of unexpected deaths that were not confirmed as suicide but were due to self-inflicted harm which led to the patient's death

2. The number of unexpected deaths of mental health/service users who were outpatients. Please breakdown (a-e below) by year (2018, 2019, 2020, 2021 and 2022 so far) and if possible how many of each yearly total were under the age of 65.
    a) The total number of unexpected deaths
    b) The number that progressed to a Serious Incident investigation
    c) The number of unexpected deaths that were referred (whether by the trust of by another organisation) to a coroner
    d) The number of unexpected deaths that was classed as suicide
    e) The number of unexpected deaths that were not confirmed as suicides but were due to self-inflicted harm which led to the patient's death

3. The total number of unexpected deaths of mental health patients who were discharged from the Trust's services 3 months or less before their death? Please breakdown (a-e below) by year (2018, 2019, 2020, 2021 and 2022 so far) and if possible how many of each yearly total were under the age of 65
    a) The total number of unexpected deaths
    b) The number that progressed to a Serious Incident investigation
    c) The number of unexpected deaths that were referred (whether by the trust of by another organisation) to a coroner
    d) The number of unexpected deaths that was classed as suicide
        a. The number of unexpected deaths that were not confirmed as suicides but were due to self-inflicted harm which led to the patient's death

Response sent

1. The number of unexpected deaths at the trust's mental health units (inpatients – both informal or formal (sectioned) patient). Please breakdown (a-e below) by year (2018, 2019, 2020, 2021 and 2022 so far) and if possible how many of each yearly total were under the age of 65.

Not applicable. The Tavistock and Portman NHS Foundation Trust is a specialist mental health Trust which provides outpatient and mainly psychological services. We do not provide any acute services or inpatient patient care and cannot answer this question.

2. The number of unexpected deaths of mental health/service users who were outpatients. Please breakdown (a-e below) by year (2018, 2019, 2020, 2021 and 2022 so far) and if possible how many of each yearly total were under the age of 65.

For the reasons given below, we not hold a full set of data on patient deaths. The Trust publishes limited information on deaths data notified to us on its website, where it can, and the links for this are also provided below.

- With regards to outpatients on the waiting list, there is no requirement to notify the Trust of a reason when an individual withdraws from the waiting list, or when their clinician withdraws their referral to the Trust.
- With regards to current outpatients, there is no requirement to notify the Trust of a reason when an individual ceases to attend appointments.
- In addition, the Trust may be retrospectively contacted by coroner courts and we have no control about when that may occur.
- Summaries of serious incidents of this nature can be found in our quarterly board reports, which can be found on this page: *https://tavistockandportman.nhs.uk/about-us/governance/board-of-directors/meetings/* For example on page 37 of the board papers from January 2022: *https://tavistockandportman.nhs.uk/documents/2407/Board_papers_-_January_2022.pdf*

The Trust has considered the detailed nature of the death data requested, covering deaths, and considers that this level of disclosure, when combined with other information that is or may become available in the public domain, could lead of identification of individuals and cause distress to the individual, and/or their family, friends and wider community.

The Trust has received updated guidance on the release of data, and now adheres closely to the Common Law Duty of Confidence and the 100-year rule, following guidance from the Office of National Statistics (ONS) on disclosure controls to protect confidentiality within death statistics. This means, going forward, that the Trust will not, in future, break down data around mortality reviews by individual service.

You may be interested to note that where a coroner's inquest is held, linked to a Prevention of future deaths report (Regulation 28 Report to Prevent Future Deaths), the name of the deceased is published by the coroner and placed into the public domain.

In summary: for the reasons given above, we are unable to supply the level of detail for data that you have requested. Past mortality review data is available on our website, as indicated above, and future mortality reviews (that protect patients from identification) will be published in the same location once the data is validated.

I hope that you are satisfied with this response. If you are dissatisfied you can ask us to carry out an internal review of our handling of your request. You can request a review by emailing us at FOI@tavi-port.nhs.uk. Your review will be carried out by a senior officer within the Trust. If you remain dissatisfied following completion of our internal review, you have a right to complain to the Information Commissioner's Office (ICO) at

https://ico.org.uk/make-a-complaint/official-information-concerns-report/official-information-concern/ or visit https://ico.org.uk/global/privacy-notice/how-you-can-contact-us/

3. The total number of unexpected deaths of mental health patients who were discharged from the Trust's services 3 months or less before their death? Please breakdown (a-e below) by year (2018, 2019, 2020, 2021 and 2022 so far) and if possible how many of each yearly total were under the age of 65

   Our previous response to Q3 above also applies to this question.