# Investigation of Patient Deaths at TPNHSFT

- The Trust has used Quality Portal , a digital patient safety reporting tool since mid 2018
- QP is not compliant with requirements of Patient Safety Incident Response Framework (PSIRF) and needs to be replaced as soon as possible. Project for replacement led by IMT
- Currently, all deaths that the Trust comes to know about should be logged on QP. A decision is made at Incident Panel as to the type of investigation that should follow
- A Mortality review form is completed if the death appears to be from natural causes
- A Concise Review report is requested if the death appears to be from unnatural causes/if the patient has recently been seen at the Trust.
- Depending on the circumstances of the patient's death a Serious Incident investigation may be commissioned.

# GIDS Audit of Deaths

- Time period : Mid 2019-end 2022
- [redacted]files reviewed
- Age range [redacted]years
- [redacted]young people AFAB [redacted] AMAB, 1 young person – unclear)
- [redacted] died of natural causes
- [redacted] cases closed between 2-5 years. Deaths became know via reconciliation with NHS Spine and in one case through request for a report
- [redacted]open, active cases - of whom [redacted] died in an in patient adolescent unit
- Of remaining [redacted] cases – [redacted] young people were on the GIDS waiting list. [redacted] in process of being referred to adult gender service [redacted] been referred to adult gender services and referral accepted.

# Key Findings 1

- Age at Death
  - [redacted] young people 15- 18 years,
  - [redacted] young people 18 -22 years
- In [redacted] cases death is known/highly likely to be from unnatural causes.
- In [redacted] cases method known to be either ligature/hanging or jumping from height/jumping onto train track.

# Key Findings 2

Extensive co-morbidity in this group of young people.

- Significant history of risk/self harm/suicidality.
- Significant psychiatric co-morbidity
- Trauma
- Family disruption
- Previous involvement with CSC
- Care leaver/in care
- Suicides in geographical area
- In patient admission ( [redacted])

# Transfer of care from GIDS to Adult Gender Services

- At the time of the original audit concern that for aged group 17+ there may not be a process of transition rather there was a move from one waiting list to another.
- It is possible that a cohort of young people are being particularly disadvantaged by still being on a waiting list age 17 years plus.
- Oct 2019 concerns raised by a CAMHS (to GIDS via email) that there is no support for young people in terms of transition to adult specialist gender services.

# Recommendations

1. Findings of this audit have been shared ( discussed) with NHS E/ICB but this should now be formalised.
2. “Red flags” identified in this audit should be shared in relation to the waiting list which has recently (22 March 2023) been transferred from TPNHSFT to Arden and GEM CSU.
3. Share findings with CAMH Services , GPs via RCGP and Adult Gender Services
4. An audit in the Adult Gender Service of deaths in the 18–24-year age group should be undertaken including looking back at earlier histories particularly if previously known to GIDS.
5. Learning from Serious Incident Reports and Child Safeguarding Practice Reviews must be shared internally with GIDS and GIC clinicians.
6. Develop research partnership for this area of work.