# Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust from April 2011 to March 2015

The preventable death of Connor Sparrowhawk in July 2013 led to investigations at Southern Health NHS Foundation Trust.

NHS England asked Mazars to investigate all deaths of all service users who received Mental Health or Learning Disability services at Southern Health NHS Foundation Trust.


Mazars reviewed deaths from April 2011 to March 2015. This is an easy read version of their report.

The investigation by Mazars is not a clinical case review of each service user. It is to see if there are any themes or issues that need further investigation.

It is important to investigate a death of a service user so NHS Trusts can:

- learn from any problems that need to be fixed to stop future deaths and improve services;
- find out if there are any other concerns in the care leading up to death
- to be able to provide information to the Coroner if needed;
- to be able to work with families to understand what happened and answer questions


Deaths of service users happen in different healthcare settings. This could be as an inpatient on a Mental Health or Learning Disability ward or unit or as an acute hospital inpatient or in the community.

Where the death happened could be any home or supported living or nursing home or in a different area.

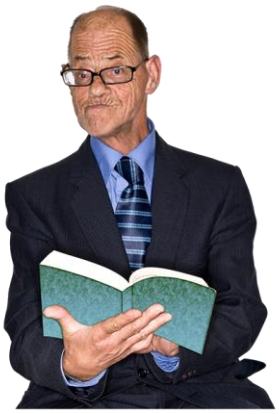
Finding out the cause of death and the need for an investigation can be difficult. This is because different healthcare settings involve different organisations. That is why it is important it is clear who should investigate the death of a service user.

People die for different reasons. Sometimes it is expected and sometimes it is not.  Not all deaths require an investigation and just because someone dies it does not mean that the care was not good.


What is important is that when someone does die unexpectedly the correct processes are in place. It also means that some deaths are investigated.

Southern Health NHS Foundation Trust had over ten thousand deaths recorded. These deaths had many different causes and were people who were using the Mental Health or Learning Disability services.

Sometimes people were using the services when they died. Others had used the services within a year before they died.



It is important that the right kind of investigation happens so:

- services can be improved
- we can find out if there had been a failure in the service
- we can learn from any mistakes
- we can share information with the families

Mazars looked at lots of reports of unexpected deaths of service users. From their review they have a list of things they found.

## What Mazars found during their investigation

Most of the ten thousand deaths recorded were expected deaths.

30 per cent of all deaths in Adult Mental Health services were investigated. About 1 per cent of deaths in Learning Disability services were investigated. Less than 1 per cent of all deaths of Older People in Mental Health services were investigated.

Southern Health NHS Foundation Trust is planning to develop a Mortality Review Group and to review every death of its service users. This will be led by the Medical Director and the Terms of Reference for this are being agreed.

Southern Health NHS Foundation Trust said in their Annual Report that learning from deaths is very important to them.

**Leadership at Southern Health NHS Foundation Trust**

There was not enough focus or time spent on carefully reporting and investigating unexpected deaths of Mental Health and Learning Disability service users.

The Board at Southern Health NHS Foundation Trust knew that the quality of the reporting of deaths was not good.

## Management of investigations

It was not clear to Southern Health NHS Foundation Trust what death should be investigated.

There was no clear process of reporting of deaths or the investigations.

Southern Health NHS Foundation Trust could not show how they had learnt from deaths.

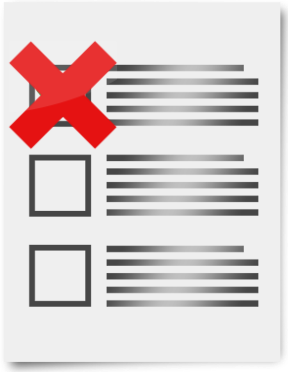

## The role of commissioners

Commissioners plan and buy health services for local communities.

The review and investigation of deaths is usually left to the NHS Trust to do.

Commissioners become involved when the NHS Trust say it is a serious incident.

Commissioners have a role in asking for better information on deaths. They could also use that to make improvements.



The commissioners did try to make sure that the reports from Southern Health NHS Foundation Trust were improved. They also told Southern Health NHS Foundation Trust the reports were not good enough.

Over four years the quality of the reports were accepted by commissioners. It also took a long time to receive the reports.

## What deaths were investigated?

Some deaths were more likely to be investigated than others.

A Mental Health death which was a suicide was more likely to be investigated than a death of someone with a Learning Disability. More deaths of people with Learning Disabilities or Older People with Mental Health illness should have been investigated.


It took Southern Health NHS Foundation Trust a long time to investigate a death. When an investigation did happen the quality of these investigations was not good.

## Learning from deaths

Southern Health NHS Foundation Trust could not show how they had learnt from deaths.

Learning from deaths can lead to improvements in patient care. It also helps families and commissioners have the right information.

## Family and carer involvement in investigations

The involvement of families and carers was not very good. Some of the investigations did not involve the family.

There was confusion in Southern Health NHS Foundation Trust about who should provide support to families.

Families should be listened to and involved in the investigation if they would like to.  This makes sure that their voices are heard. It makes sure that families have answers. It makes sure that families know exactly what happened.

## Advocacy

There has not been enough advocacy for service users across Adult Mental Health or Older People Mental Health and Learning Disability services.

By advocacy we mean independent representation and transparency.

Transparency means sharing the information you have.

## Sharing information

Southern Health NHS Foundation Trust has information on deaths that could be shared for research and review.

When information is shared it helps understand local services and what needs to improve.

Commissioners also need better information relating to Mental Health and Learning Disability service users. This will help them make decisions and to improve services.

Southern Health NHS Foundation Trust provided a lot of information for this review. But improvements are needed on how the information is presented. This will help them understand deaths better.

Mazars have made some recommendations for Southern Health and commissioners and NHS England

## Recommendations from Mazars

### Southern Health NHS Foundation Trust

The Board needs to improve their review and reporting of unexpected deaths.

Southern Health NHS Foundation Trust need to make sure that all staff understands that investigations need to be good and quick.  They also need to include families.

The Board should receive regular reports of deaths.

The 2015/16 Annual Report should include information on deaths.

Southern Health NHS Foundation Trust needs to be clear how it will investigate deaths. The Board should make sure that this happens.

Southern Health NHS Foundation Trust should have a Mental Health and Learning Disability Mortality Review Group. This group will review unexpected deaths.

Southern Health NHS Foundation Trust and commissioners and local authority should learn from unexpected deaths together.

## Commissioners recommendations

The commissioners need to make sure that incidents are reported quickly. They also need to make sure that the reports are better quality and the information in them is correct.

Commissioners should also provide support to the reviews.

## NHS England recommendations

NHS England should review information of Mental Health and Learning Disability service users deaths across the whole of England.

It is important to share what they have learnt from this with other NHS organisations.

The information that records serious incidents should be reviewed. This will make it easier to identify Mental Health and Learning Disability service user deaths.