Independent review of issues contributing to preventable death of Connor Sparrowhawk

Connor Sparrowhawk died in a learning disabilities inpatient assessment and treatment unit on 4 July 2013. An investigation into Connor's death found that his death was preventable. This means that things could have been done which would mean he would not have died.


Southern Health NHS
NHS Foundation Trust

Independent investigation into the death of Connor Sparrowhawk

An easy read summary of the report, conclusions and key findings

The independent investigation

VERITA

Executive summary

You can read an Easy Read version of the investigation into Connor's death here: http://www.southernhealth.nhs.uk/news/archive/2014/report-into-death-sparrowhawk/

Southern Health NHS
NHS Foundation Trust

The unit was in Oxfordshire and run by Southern Health NHS Foundation Trust. It has now closed.

NHS England

NHS England and the Oxfordshire Safeguarding Adults Board were concerned about the safety of learning disability services provided by Southern Health NHS Foundation Trust in Oxfordshire.

Oxfordshire Safeguarding Adults Board help and protect vulnerable adults. These adults need support from care services to keep their independence and remain safe.

NHS England and Oxfordshire Safeguarding Adults Board paid for another independent review.

What the review must do

NHS England and Oxfordshire Safeguarding Adults Board wanted the review to look other things that may have led to Connor's death. Things like checking the right services were in place. They also checked how the health money was spent. And whether Southern Health NHS Foundation Trust were managing learning disability services properly.

It is important that the review is shared so other services can be improved.

How the review was done

A company called Verita did the review.

Verita talked to a lot of people about the care and services at Southern Health NHS Foundation Trust.

Verita looked at a lot of documents. These included Southern Health NHS Foundation Trust plans and reviews of their services. Verita checked what information was being reported to their Board. The Board are a group of people that manage everything that Southern Health NHS Foundation Trust does.

Summary of the review by Verita

An organisation called Ridgeway Services (or sometimes also called Oxfordshire Learning Disability NHS Trust) used to run the Short Term Assessment and Treatment Unit in Oxfordshire. On 1 November 2012 Southern Health NHS Foundation Trust took it over.

What Verita found in their review is explained on the next 2 pages.

1

Vertia did not find any evidence that the commissioners contributed to the poor care Connor received. Commissioners plan and buy health services for local communities.

2

The way that Southern Health NHS Foundation Trust took over the Ridgeway services was not very good because:

- Two learning disability experts from Southern Health NHS Foundation Trust staff left. They were directors and some people thought they would lead the service well. The Board at Southern Health Foundation Trust were slow to replace them.

- They did not focus on ways to support staff in a small learning disability service that were joining a big mental health and community organisation, which was based a long distance away from Oxfordshire.

- They did not review the worries about the local management

- Local managers were also dealing with more issues in the other Ridgeway services.

However there is no evidence that this contributed to the poor care Connor received.

3

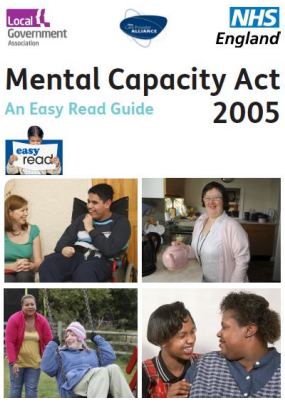
The clinical staff did not carry out procedures and processes that were their responsibility. The staff did not work together and follow guidelines for the care of people with epilepsy.

This is explained in the Overall Conclusion section of this Easy Read document: http://www.southernhealth.nhs.uk/news/archive/2014/report-into-death-sparrowhawk/

Recommendations from Verita

That commissioners should make sure service user views are taken into account.

That Southern Health NHS Foundation Trust should update their Mental Capacity Act and Deprivation of Liberty Safeguards policies.



The Mental Capacity Act is a law for acting and making decisions on behalf of adults who lack the capacity to make some decisions for themselves.

The Deprivation of Liberty Safeguards is part of the Mental Capacity Act. It makes sure that people in care homes, hospitals and supported living are looked after in a way that does not restrict their freedom.