Southern Health NHS Foundation Trust criticised in independent review of deaths

In December 2015, the '*Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015'* was published. The review arose from the preventable death of Connor Sparrowhawk, who was under the care of Southern Health NHS Foundation Trust when he died in 2013.

The review looked at deaths occurring between April 2011 and March 2015, where the deceased had been receiving care from the relevant trust. The stated aim of the review was "*to establish the extent of unexpected deaths in Mental Health and Learning Disability services provided by the Trust and to identify any themes, patterns or issues that may need further investigation…*"

The trust informed those carrying out the review that it provided mental health and learning disability services to approximately 45,000 people each year. This would include such services across all age groups, whether they were provided at home, in the community or in a hospital or social care unit.

The review analysed 540 reports of deaths which occurred between April 2011 and March 2015 and found (amongst other things) that:

- "*there was a lack of leadership, focus and sufficient time spent in the Trust on carefully reporting and investigating unexpected deaths of Mental Health and Learning Disability service users*";
- 30% of all deaths in Adult Mental Health services were investigated as a Critical Incident Review (CIR) or a Serious Incident Requiring Investigation (SIRI) but less than 1% of deaths in Learning Disability services were investigated as such;
- when looking at unexpected deaths, 60% of Adult Mental Health services deaths were investigated as CIRs or SIRIs by the trust, whereas only 4% of unexpected deaths occurring within Learning Disability services and 13% in Older People's Mental Health services were investigated as such;
- timeliness of investigations was stated to be "*a major concern*", with it taking an average of ten months to close a SIRI relating to deaths; and
- 64% of investigations did not involve the family of the deceased.

Those carrying out the review concluded that "*too few deaths were investigated in Learning Disability and Older People Mental Health services*" and that there had been insufficient transparency around investigations into deaths. Where investigations did occur, the review found that they were "*of overall poor quality*". The review also found examples of "*poor leadership*" within the trust, as concerned investigations into deaths.

This review highlights the discrepancies that can arise as a result of the discretion which is afforded to NHS trusts in deciding how and whether to investigate deaths. The Chief

Executive of Southern Health NHS Foundation Trust has stated that "*reports such as this challenge not only Southern Health, but the wider health and social care system, and society as a whole, to reflect on the way we support, include, and value people with learning disabilities and mental health needs*"[1].

Lucy Wilton
Senior associate
+44 (0)20 394 6406
Lucy.Wilton@russell-cooke.co.uk

www.russell-cooke.co.uk

[1] http://www.southernhealth.nhs.uk/news/statement-from-southern-health-17-12-2015-independent-review/