Our Ref: ID 2087

NHS Wirral Clinical Commissioning Group
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Tel: 0151 651 0011

Re: Freedom of Information Request - Unexpected deaths of learning disability and/or autism patients in hospitals

Thank you for your request for information made under the Freedom of Information Act 2000, which was received into this office on the 28th March 2022.

You Asked for:

The information requested is regarding the commissioning of inpatient care for those with a learning disability or autism and how many have died whilst detained in a hospital facility. This is for hospitals that are providing mental health support or specialist facilities for learning disability or autism such as an assessment and treatment unit (ATU). The death may or may not have occurred on the ward but at the time of the death the patient resided in that hospital facility.

1. The name of your organisation.
2. How many patients that your Clinical Commissioning Group (CCG) has commissioned (in or out of area) inpatient care for those with a learning disability and/or autism have unexpectedly died whilst in the care of the hospital between January 2015 and December 2021? Please list by year and whether the placement was in or out of the area. If possible, if the placement was out of area, please give the area where the patient was placed.

The following questions are relevant if there has been an unexpected death(s):

3. How many of the unexpected deaths did the CCG commission a LeDeR review for?
4. For how many of the unexpected deaths was an independent review or a serious incident investigation undertaken by you or the trust/hospital/independent provider where the patient was living? Please give details of what kind of review/investigation took place.
5. How many of the unexpected deaths were concluded as a suspected suicide or suicide?
6. How many of the unexpected deaths were concluded as neglect?
7. For each of the unexpected deaths that had a review/investigation please attach the review or investigation in the response (Patient/staff names to be redacted in order to prevent identities being revealed. Or attach as must of the review as possible - ie Key Findings)
8. How many of the unexpected deaths had an inquest and what was the conclusion of the inquest? And (if known) at the end of the inquest how many were subject to a regulation 28 (Prevent Future Death Report) by the coroner?

Our Response:

1. NHS Wirral Clinical Commissioning Group (CCG).
2. 0.

We hope this information is useful, however, if you require any further information, please do not hesitate to contact a member of the Corporate Affairs Team, (contact details at the top of this letter).

Re- Use of Information