FOI 2122196- Deaths

NHS Calderdale CCG's response to your request can be found below.

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.

   NHS Calderdale CCG.

2. How many patients that your 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?

   0 patients are recorded as having died 'unexpectedly' post June 2021. Pre June 2021 there was a different LeDeR platform and NHS England owns this database. If you need to contact the National Team please use the following email address: england.lederprogramme@nhs.net.

   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?

As identified within NHS England Policy, LeDeR reviews are undertaken for all people who have died and who had a learning disability or autism and not in response to a death being 'unexpected'. The goal of LeDeR reviews is to improve care and reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received.

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.

   We are not aware of any independent investigation that is underway and NHS Calderdale CCG has not commissioned any. Serious incident investigations are undertaken by the Trust Providers not the CCG. Any information shared with NHS Calderdale CCG is non patient identifiable as set out in the serious incident framework.

   This question will need redirecting to all learning disability providers.

5. How many of the unexpected deaths were concluded as a suspected suicide or suicide?

   NHS Calderdale CCG does not hold this information. For additional information this question will need redirecting to the Coroner's office.

6. How many of the unexpected deaths were concluded as neglect?

   None recorded.

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 – i.e. Key Findings).

As identified above there are no reports recording unexpected deaths. LeDeR reviews are completed on all learning disability deaths, none of these are published.
Additional requests need to be directed to the NHS England.

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?

   NHS Calderdale CCG does not hold this information, this question will need redirecting to the Coroner's office.