Board of Directors

February 2017

Mortality Surveillance and Learning from Incidents

1. Introduction

This is the bi-annual report to the Board of Directors on mortality surveillance and learning from incidents. This report provides an update on the work of Trust CIRCLE and progress with previously identified actions and a refresh of the previously reported mortality data to include Quarter 1 to Quarter 3 2016/17.

This report also reflects on the findings and recommendations in the Care Quality Commission's (CQC) report 'Learning, Candour and Accountability' published in December 2016 and encompasses the Trust's response to this report. The report also considers the implications of the independent thematic review of homicide investigations into the care and treatment provided to service users who committed a homicide and to a victim of homicide at Sussex Partnership NHS Foundation Trust published is October 2016.

In addition to media coverage following the publication of these two reports, there has been further recent media coverage regarding deaths in mental health services. Analysis of information from 33 trusts (including the Trust) obtained through the Freedom of Information Act by the BBC programme Panorama stated that unexpected deaths in mental health services have increased by 50% in three years. They did however recognise that there is variation in how deaths are reported across the NHS. An analysis of Trust data is included in Appendix 1, starting on page 11. This shows that the number of unexpected deaths in Local Partnerships (Mental Health) and Forensic Services (excluding Offender Health) rose from 69 in 2012/13 to 85 in 2015/16 which does not support a 50% overall increase of unexpected deaths in mental health services. There was however a spike of 104 in 2014/15.

However, in general, this data demonstrates that the number of deaths reported as an incident has fluctuated over the past five years. It is not known whether this relates to a change in reporting behaviour or whether this accurately reflects the number of deaths that required reporting as an incident.

2. CQC Report - Learning, Candour and Accountability

The review commissioned by NHS England into the investigation of deaths at Southern Healthcare NHS Foundation Trust undertaken by Mazar's was published in December 2015. Following this the Secretary of State for Health asked CQC to look at how acute, community and mental health trusts across the country investigate and learn from deaths. There was a particular focus on mental health and learning disabilities. This included all trusts submitting a Provider Information Request, visiting a sample of 12 trusts, involvement of more than 100 families and gathering information from charities, NHS professionals and other organisations.

The review identified issues over five key areas:

- Involvement of families and carers
- Identification and reporting
- Decision to review or investigate
- Reviews and investigations
- Governance and learning

Previous reports to the Board of Directors in February and August 2016 provided the Trusts response to the Mazar's report, an update on improvements that had already been made and further planned improvements. This report brings those improvements together with the findings from the CQC report. This report will cover the key five areas, from the CQC report, outlining the key findings, the Trusts current position and ongoing improvements required to strengthen the Trusts processes and oversight of mortality and learning from deaths. CQC made seven recommendations, in summary these are:

1. The Secretary of State for Health to make this a national priority, suggesting the Department of Health, in partnership with other bodies should work together to publish a full response to the report.
2. The Department of Health and other bodies should develop a single framework for learning from death.

Specifically the framework should:

3. Define what families can expect from providers following the death of a family member.
4. Provide solutions to the issues identified for people with mental health conditions or a learning disability.
5. NHS Digital and NHS Improvement should assess and facilitate the development of reliable and timely systems.
6. Health and Education England should work with the Healthcare Safety Investigation Branch (HSIB) to develop approaches to ensure staff have the capacity and capability to carry out good quality investigations.
7. Provider organisations must work together to review and improve their local approach following deaths of people receiving care from their services and provider boards should ensure national guidance is implemented.

CQC are going to strengthen their assessment of learning from deaths to cover how providers identify patients who have died and decide which reviews or investigations are needed, the quality of investigations, reports on learning from death and action taken and involvement of families.

2.1 Involvement of families and carers

In summary the key findings of the CQC report were:

- Families and carers reported a poor experience of investigations and are not consistently treated with respect, sensitivity and honesty.
- Families are not routinely told what their rights are, what will happen or how they can access support or advocacy.
- There was variable involvement in investigations and are not always informed or kept up to date causing further distress

- Families and carers are often not listened to and their involvement can be tokenistic.
- The NHS underestimates the role that families and carers can play in helping to fully understand what happened to a patient.

Trust Position

The Trust has some good practice and processes for involving families in investigations however it has previously been recognised that this and the application of the Duty of Candour is variable. How the Trust initially communicates with families following a death is extremely important and sets the tone for the on-going relationship through any investigation. Specific areas for improvement are:

- Consistent application of the Duty of Candour. A complete review of this is underway and revised guidance for staff will be distributed by the end of February. The revised policy will be signed off by Trust CIRCLE at its March meeting which will also include strengthened monitoring arrangements.
- The Trust information leaflets which are given to families following a death will be reviewed to clearly outline our commitment to them and how they can be involved.
- Work with the Involvement Team to explore how the Trust can receive feedback from families following deaths and their experience of being involved in investigations.

Compliance with the requirements of the Duty of Candour has improved since the introduction of a weekly Serious Incident Review Group, led by the Executive Medical Director to review all new serious incidents.

2.2 Identification and reporting

In summary the key findings of the CQC report were:

- Variation and inconsistency in the way organisations become aware of the deaths of people in their care.
- Many patients who die have received care from multiple providers in the months before their death. There are no clear lines of responsibility or systems for the provider who identifies a death to inform other providers or commissioners.
- There is no consistent process or method for NHS trusts to record when recent patients die after they have been discharged from the care of the service, either from an inpatient service or from receiving services in the community.
- Electronic systems do not support the sharing of information between NHS trusts or with others who have been involved in a patient's care before their death, for example primary care.

Trust Position

Over the last year the Trust has been extracting data from the Ulysses risk management system and clinical information systems such as RiO and SystmOne. This has identified discrepancies between the systems, in part due to the national issues identified by CQC. The Trust has been working with national and regional colleagues to consider these issues and influence potential national policy. Specific areas for improvement, within the Trusts control are:

- Ensuring there is a consistent approach to recording all known deaths of service users who have mental health conditions or a learning disability on Ulysses.
- Provide clarity on what deaths within Local Partnerships (General Healthcare) should be recorded on Ulysses.
- Review what mortality information is used and how this is presented.

Previously reported data from Ulysses showing deaths reported on Ulysses has been refreshed to show Quarter 1 to Quarter 3 2016/17. This is attached as Appendix 1. Discussions are currently taking place to consider how mortality patterns within the Trust can be presented to widen understanding, use statistical process control to provide triggers to inform clinicians of unexpected variation. This will be explored further with the aim of presenting this information in a more meaningful way for the August 2017 report to the Board of Directors.

Since the last report, Trust CIRCLE has agreed revised categories for reporting deaths on Ulysses which will be applied after the death has been reviewed or investigated by a smaller group of staff to improve consistency. The Serious Incidents Requiring Investigation (SIRI) Policy has been significantly revised and incorporates the Trusts approach to reporting and investigating deaths. This policy is scheduled to be approved at Trust CIRCLE on 16th February.

2.3 Decision to review or investigate

In summary the key findings of the CQC report were:

- Healthcare staff use the Serious Incident Framework as the process to support decisions to review and/or investigate when deaths occur. However, this means investigations only happen if the care provided to the patient has led to a serious incident.
- Criteria for deciding to report as an incident and application of the framework varied across trusts.
- The absence of a single national framework that specifically supports the review and decisions needed for deaths that may need a different response to patient safety incidents is leading to variation across NHS trusts.
- There is confusion and inconsistency in the methods and definitions used across the NHS to identify and report deaths leading to decisions being taken differently across NHS trusts.
- Decision making must be informed by timely access to information by clinicians and staff, but they found difficulties in getting clinical information about the patient from others involved in delivering care.

Trust Position

As stated above the revised SIRI Policy incorporates reporting and rviewing all known deaths. This includes the introduction of a Death Investigation Decision Tree which includes the requirement to and a tool to undertake an Initial Death Review within three working days. This will guide clinicians to determine whether the death meets the criteria to report the death as a SIRI, whether the death would benefit from a review but is not a SIRI, or no review required. The decision to investigate or review will not be based on any early perceptions as to whether the death was considered to be unexpected or avoidable. These decisions can only be made after the investigation or review has been completed and therefore this has been incorporated into the revised SIRI/Death Review Policy.

The revised policy also incorporates the investigation terminology within the NHS England SI Framework where two levels of Trust internal investigations are defined:

- **Level 1 Concise Investigation** – Less complex incidents which can be managed by individuals or a small group at local level
- **Level 2 Comprehensive Investigation** – Complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable

Deaths that meet the threshold for reporting as a SIRI will be investigated at the appropriate level. Any deaths for which it has been agreed are not a SIRI but would benefit from a review will replicate the Level 1 Concise Investigation process.

Specific areas for improvement are:

- Development of an easy to understand guidance pack for clinicians and managers to support implementation of the policy. This will include guidance on whether to conduct a Level 1 or Level 2 investigation.
- Review and revision of the current investigation templates and a new Initial Death/Incident Review Report

2.4 Reviews and investigations

In summary the key findings of the CQC report were:

- Most NHS trusts follow the Serious Incident Framework when carrying out investigations. The quality of investigations is variable and methods are applied inconsistently. This acts as a barrier to identifying the opportunities for learning, with the focus being too closely on individual errors rather than system analysis.
- Specialised training and support is not universally provided to staff completing investigations, many staff do not have protected time in which to carry out investigations. This reduces consistency in approach, even within the same services.
- There are significant issues with the timeliness of investigations and confusion about the standards and timelines stated in guidance
- A multi-agency approach to investigating is restricted by a lack of clarity on identifying the responsible organisation for leading investigations or expectations to look across pathways of care. This is a missed opportunity for identifying improvements in services and commissioning, particularly for patients with mental health or learning disability needs.

Trust Position

The Trust is currently working through the East Midlands Academic Health Science Network to develop and implement a Human Factors Analysis and Classification System (HFACS) to enhance learning from serious incidents in healthcare. This has involved working with two human factors experts along with the other providers of mental health services in the East Midlands.

The first phase included a retrospective review of 34 Trust serious incident reports following deaths in Offender Health or in contact with Crisis Teams by a human factor expert and the outcome was reported to the Board of Directors in August 2016. This

identified some common themes across the four levels of HFACS where potential errors can occur:

- **Level 4:** Overarching organisational influences (e.g. human resource management)
- **Level 3:** Supervision and operational planning (e.g. leadership of a Community Mental Health Team, organisation of local administrative procedures)
- **Level 2:** Environmental, technological and behavioural preconditions (e.g. workplace design, interface with IT systems, team co-ordination and communication)
- **Level 1:** Acts or omissions proximate in time to the event (e.g. a medication error)

The report to the Board of Directors in August identified implications for incident investigations as reports often lacked critical relevant information and inconsistencies between timelines, contributory factors identified and conclusions and recommendations. The quality of the analysis and therefore identification of causal, contributory or risk factors is dependent upon the quality of the investigation and whether HFACS has been considered.

The second phase of the project has now commenced and the Trust is being supported by a human factors expert to undertake an investigation using a human factors approach. This is not yet complete but early indications are that the structured approach to the analysis of relevant data to support the investigation and a different approach to interviewing staff has been received positively and is identifying issues that would not previously have been explored.

It is likely that the Trust will be changing its approach to serious incident investigations and a project team has been established as part of the Sign up to Safety Campaign to take this forward.

Specific areas for improvement are:

- Development of a detailed project plan for the move towards HFACS investigations, this will include training.
- Consider the resources and skill mix required to undertake data analysis, investigating using a human factors approach and classification of issues identified following completion of the investigation. These are three different skills.

2.5 Governance and learning

In summary the key findings of the CQC report were:

- There are no consistent frameworks or guidance in place across the NHS that requires boards to keep all deaths in care under review or effectively share learning with other organisations or individuals.
- Trust boards generally only receive limited information about the deaths of people using their services other than those that have been reported as serious incidents.
- When boards receive information about deaths, board members often do not interrogate or challenge the data effectively. Most board members have no specific training in this issue or time that is dedicated to focus on it.

- Where investigations have taken place, there are no consistent systems in place to make sure recommendations are acted on or learning is being shared with others who could support the improvements needed.
- Robust mechanisms to disseminate learning from investigations or benchmarking beyond a single trust do not exist. This means that mistakes may be repeated.

Trust Position

The Trust strengthened its governance and oversight of deaths through the establishment of Trust CIRCLE in November 2015. This has been further strengthened by the introduction of a weekly Serious Incident Review Group in November 2016, led by the Executive Medical Director which reviews all new serious incidents including deaths. Trust CIRCLE encompassed the role of a Mortality Surveillance Group, however to create capacity to undertake in depth reviews of mortality data and review the outcome of the application of HFACS to investigations a separate Mortality Surveillance Group reporting to Trust CIRCLE is being established. The Trust has also identified a lead Non-Executive Director (NED) for this area as required nationally, this is Patrick Callaghan who is also the Chair of the Quality Committee. The lead Executive Director and NED are attending a national conference in March, the outcome of which may also identify further required improvements ensure Trust processes are aligned with the national direction of travel.

Previous reports to the Board of Directors has included deaths reported as incidents and also included the number of deaths reported on clinical information systems, e.g. RiO and SystmOne. This report only includes incidents as what data and how to present it is being reconsidered as defined in section 2.2 above.

It is anticipated that adopting a human factors approach to the investigations as described in section 2.4 above will improve the quality, provide a more systematic analysis of issues and enable the Trust to focus on the right improvements.

Specific areas for improvement are:

- Consider what data on deaths should be reported to the Mortality Surveillance Group, Trust CIRCLE, Quality Committee and Board of Directors.
- Continue to implement the HFACS model and develop a database of the outcomes of the analysis to identify strongly causal, contributory, risk factors and good practice – this will enable the Trust to understand why people die.
- Consider how the outcomes of HFACS analysis will be shared and fed into the development of the Trusts quality priorities for improvement for 2017/18/
- Development of a learning log which will clearly define issues identified (linked to HFACS), track implementation of cross-organisational learning and provide evidence of sustainability of actions. This will strengthen processes for the Board of Directors to receive assurance on the effectiveness of improvements to improve quality and reduce harm.
- Continue, through Trust CIRCLE to strengthen the Trusts response to alerts following patient safety incidents that originate from the National Reporting and Learning System.
- Undertake a further retrospective analysis of previous investigation reports that were completed following homicides or in-patient deaths.

- Consider how learning from complaints and additional learning following the completion of a claim can be developed to be consist with processes being developed as part of the human factors project

The Trust will be including mortality data, improvements to mortality surveillance already made and ongoing improvements required in the 2016/17 Quality Report.

3. Homicide Review

A thematic review of homicides was published by Sussex Partnership NHS Foundation Trust and NHS England in October 2016. This presented an independent review of the reports of 11 investigations into the care and treatment provided by the Trust to ten service users who became involved in homicides between 2007 and 2015. The review identified useful learning across these cases, which is presented briefly below and includes where possible the equivalent data for Nottinghamshire Healthcare to allow benchmarking. There was not sufficient time to examine the data on evidence of completion of action plans but this is being considered separately through Trust Circle.

Homicide covers the offences of murder, manslaughter and infanticide. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2015) states that in recent years around one patient homicide on average occurs annually for every million of the general population. This allows a crude calculation of the potential number of patient homicides for the Trust.

Sussex Partnership NHS Foundation Trust covers a population of 1.6 million. According to NCISH's analysis, this would equate to eight homicides committed by someone known to mental health services over the five-year period covered by the thematic review (as is the case). Nottinghamshire Healthcare NHS Foundation Trust covers a population of approximately 1.1 million, from the same analysis that would suggest approximately 5 homicides in the equivalent period (as is the case).

Sussex Partnership	**Nottinghamshire Healthcare**
10 serious incidents (two reports related to one serious incident): • 9 serious incidents (10 reports) are homicides • 1service user was the victim of a homicide • 8 of the homicide investigations were independent (relating to seven homicides) • 2 of the homicide investigations were internal.	5 serious incidents • 4 homicides and 1 attempted homicide • 2 of the homicide investigations were external • 2 homicide investigations and the attempted homicide investigation were internal

The review considered identified "recurring" themes. Themes were defined as 'recurring' if they were identified in at least two investigation reports. The themes that we identified using this definition were as follows.

Sussex Partnership	Nottinghamshire Healthcare
• Escalating users to a proper level of expertise. Several of the reports showed that there could be delays either between GP referral and initial assessment by the Trust; or between initial assessment by the Trust and access to more specialist assessment (for example, forensic services). • Risk assessment and risk management. In seven out of the nine cases of homicide, there was criticism of the risk assessment process and/or the design of the risk management plan. In several cases, the process was seen as inadequate or the risk posed was not recognised or was seriously underestimated. • Knowledge and use of the Mental Health Act. On several occasions in the investigation reports, Trust staff did not know the full extent of their legal powers when working with service users. • Systemic or professional problems identified. Several investigations reported that staff did not conform to local policies and/or national guidelines	• Risk assessment and management. In two of the five cases risk assessment and management were criticised and a lack of proactive approach to risk commented on. • Delays in utilising the Mental Health Act or failure to consider it's use were identified in two reports • Pressure of workloads leading to poor team working practices and difficulties with medical cover It should be noted that these issues arose in the same two cases where care had been longer term with the mental health services. Three cases were primarily drug and alcohol services and there were very few issues raised re trust care which was seen as good.

In Sussex the nine independent investigation reports reviewed made a total of 48 recommendations. In Nottinghamshire there were two external reports in the time frame which made 12 recommendations, 11 of which were for the Trust.

	Sussex Partnership	Nottinghamshire Healthcare
Communication	3	2
Policy management	4	0
Practice/risk	22	4
training	4	1
Organisational learning	8	4
Contact with families	5	0
Miscellaneous	1	1
Pathway development	1	0
Total recommendations	**48**	**12**

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The thematic review identified a number of areas where Sussex Partnership should build on the improvements already taking place. These include:

- Improving the effectiveness of links between corporate governance and local governance processes
- Variable reporting of incidents in different Care Delivery Services (CDSs)
- Completion of serious incident reviews within the required timescale in just under half of cases

These themes will be considered by the Quality Committee in March to inform discussions regarding the Trusts quality priorities for 2017/18.

4. Themes and Learning from Serious Incident Investigations

The report to the Board of Directors in August included the outcome of the retrospective analysis of 34 investigation reports as part of the HFACS project referred to in section 2.4 above. The most prevalent themes emerging from that review related to:

- Clinical risks not being identified or identified risks not being acted upon or included in care planning
- Policy compliance
- Accuracy and timeliness of record keeping
- Communication with families
- Deficient coordination between teams and care coordinators
- Poor process planning
- Deficient booking and follow-up systems for patient referrals

A review of 130 serious incident reports from April to August 2016 has since been undertaken, specifically to identify issues relating to policy compliance. The most commonly occurring areas of compliance related to:

- Management of violence and aggression – in particular risk management (33 incidents)
- Care Programme Approach (17 incidents)
- Safe and secure handling of confidential information (15 incidents)
- Prevention and management of falls (14 incidents)

These themes will be considered by the Quality Committee in March to inform discussions regarding the Trusts quality priorities for 2017/18 and to agree any deep dives into specific areas.

5. Recommendations

The Board of Directors is asked to:

- Note the current mortality information in Appendix 1
- Note the progress made since August 2016 and support the ongoing improvements outlined in the report
- Note the progress made with the human factors approach to incident investigations and analysis and support the proposal to undertake further retrospective analysis of in-patient deaths and homicides
- Support the proposal to consider the emerging themes following incidents to inform the Trusts Quality Priorities for 2017/18.

Dr Julie Hankin
Executive Medical Director

Fiona Illingsworth
Associate Director Quality Governance and Performance

February 2017

APPENDIX 1 - Current Mortality Information

The data presented to the Board of Directors in August 2016 has now been refreshed to incorporate deaths reported between April and December 2016. The tables below include:

- The number of deaths recorded on Ulysses
- The number categorised as 'unexpected' which includes suspected suicide
- The number reported on STEIS as a Serious Incident Requiring Investigation (SIRI) in accordance with NHS England's Serious Incident Framework.
- The number of deaths reported to the National Reporting and Learning System (NRLS) as a 'degree of harm 5', i.e. death was attributable to the patient safety incident.

The recent BBC Panorama programme stated that unexpected deaths in mental health services went up by 50% in 3 years. Analysis of information from 33 trusts (including the Trust) obtained through the Freedom of Information Act by the BBC programme Panorama stated that unexpected deaths in mental health services have increased by 50% in three years. They did however recognise that there is variation in how deaths are reported across the NHS. The tables below show that the number of unexpected deaths in Local Partnerships (Mental Health) and Forensic Services (excluding Offender Health) rose from 69 in 2012/13 to 85 in 2015/16 which does not support a 50% overall increase. There was however a spike of 104 in 2014/15. However, in general, this data demonstrates that the number of deaths reported as an incident has fluctuated over the past five years. It is not known whether this relates to a change in reporting behaviour or whether this accurately reflects the number of deaths that required reporting as an incident.

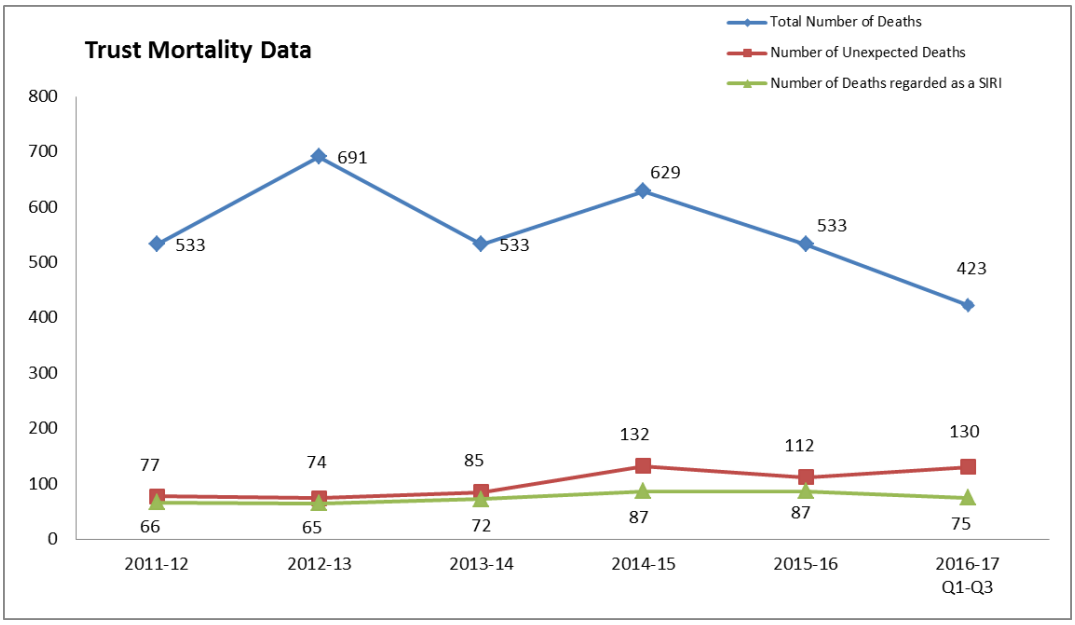
TRUST TOTAL	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17 Q1-Q3	TOTAL
Total Number of Deaths	533	691	533	629	533	423	**3342**
Number of Unexpected Deaths	77	74	85	132	112	130	**554**
Number of Deaths regarded as a SIRI	66	65	72	87	87	75	**452**
Number of Deaths Degree of Harm 5	203	41	49	75	63	52	**483**
LOCAL PARTNERSHIPS - General Healthcare	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17 Q1-Q3**	**TOTAL**
Total Number of Deaths	NA	5	11	24	18	14	**72**
Number of Unexpected Deaths	NA	2	6	13	8	10	**37**
Number of Deaths regarded as a SIRI	NA	0	0	0	2	1	**3**
Number of Deaths Degree of Harm 5	NA	0	0	0	1	1	**2**
LOCAL PARTNERSHIPS - Mental Health	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17 Q1-Q3**	**TOTAL**
Total Number of Deaths	517	672	502	578	470	379	**3118**
Number of Unexpected Deaths	66	65	68	102	76	97	**435**
Number of Deaths regarded as a SIRI	50	54	54	61	45	45	**309**
Number of Deaths Degree of Harm 5	191	41	41	63	37	31	**404**
AMH	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17 Q1-Q3**	**TOTAL**
Total Number of Deaths	57	54	55	73	59	73	**371**
Number of Unexpected Deaths	36	33	34	56	42	53	**233**
Number of Deaths regarded as a SIRI	34	29	32	45	35	37	**212**
Number of Deaths Degree of Harm 5	33	22	27	40	29	21	**172**
MHSOP	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17 Q1-Q3**	**TOTAL**
Total Number of Deaths	424	574	405	466	376	281	**2526**
Number of Unexpected Deaths	11	13	15	23	24	29	**102**
Number of Deaths regarded as a SIRI	6	9	8	8	4	5	**40**
Number of Deaths Degree of Harm 5	138	6	7	7	3	6	**167**

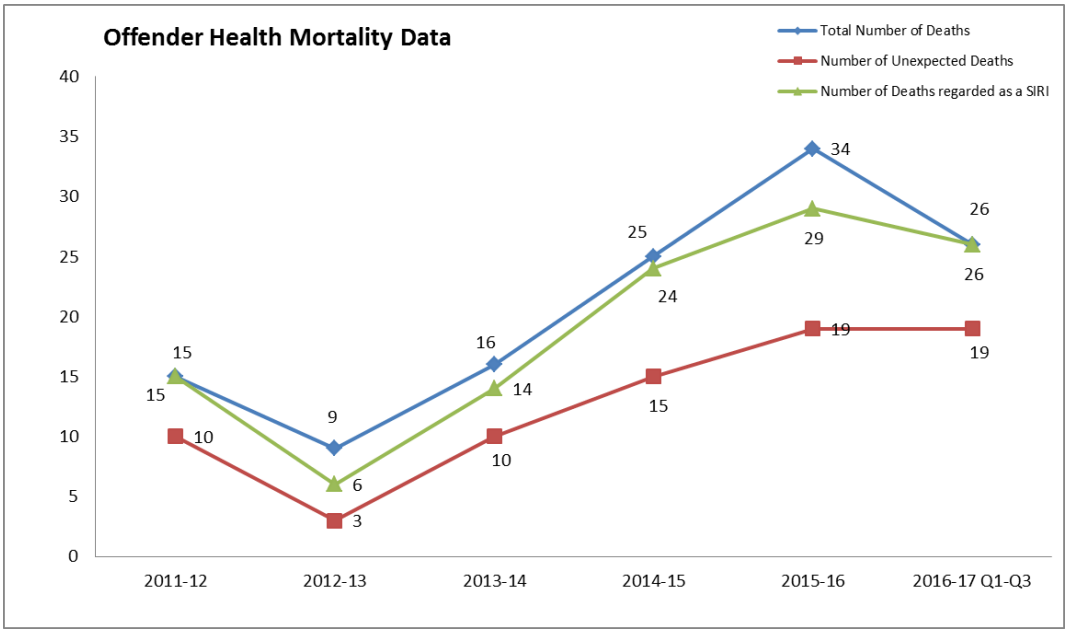
SSD - Total (see breakdown of services below)	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17 Q1-Q3	TOTAL
Total Number of Deaths	36	44	42	38	35	25	**220**
Number of Unexpected Deaths	19	19	19	23	10	15	**100**
Number of Deaths regarded as a SIRI	10	16	14	8	6	3	**57**
Number of Deaths Degree of Harm 5	20	13	7	16	5	4	**65**
SMS							
Total Number of Deaths	35	31	36	30	16	4	**152**
Number of Unexpected Deaths	19	10	17	15	3	4	**68**
Number of Deaths regarded as a SIRI	10	9	12	5	1	1	**38**
Number of Deaths Degree of Harm 5	20	5	6	11	1	0	**43**
IDD							
Total Number of Deaths	1	2	0	1	1	2	**7**
Number of Unexpected Deaths	0	0	0	1	0	2	**3**
Number of Deaths regarded as a SIRI	0	1	0	0	0	0	**1**
Number of Deaths Degree of Harm 5	0	0	0	0	0	0	**0**
CAMHS/Looked After Children							
Total Number of Deaths	0	1	0	1	0	1	**3**
Number of Unexpected Deaths	0	1	0	1	0	1	**3**
Number of Deaths regarded as a SIRI	0	1	0	1	0	1	**3**
Number of Deaths Degree of Harm 5	0	1	0	1	0	1	**3**
IAPT/ PT							
Total Number of Deaths	0	10	5	6	17	17	**55**
Number of Unexpected Deaths	0	6	3	5	6	7	**23**
Number of Deaths regarded as a SIRI	0	5	2	2	5	1	**15**
Number of Deaths Degree of Harm 5	0	7	1	4	4	2	**18**
Prescribed Services							
Total Number of Deaths	0	0	0	0	1	1	**2**
Number of Unexpected Deaths	0	0	0	0	1	1	**1**
Number of Deaths regarded as a SIRI	0	0	0	0	0	0	**0**
Number of Deaths Degree of Harm 5	0	0	0	0	0	1	**1**

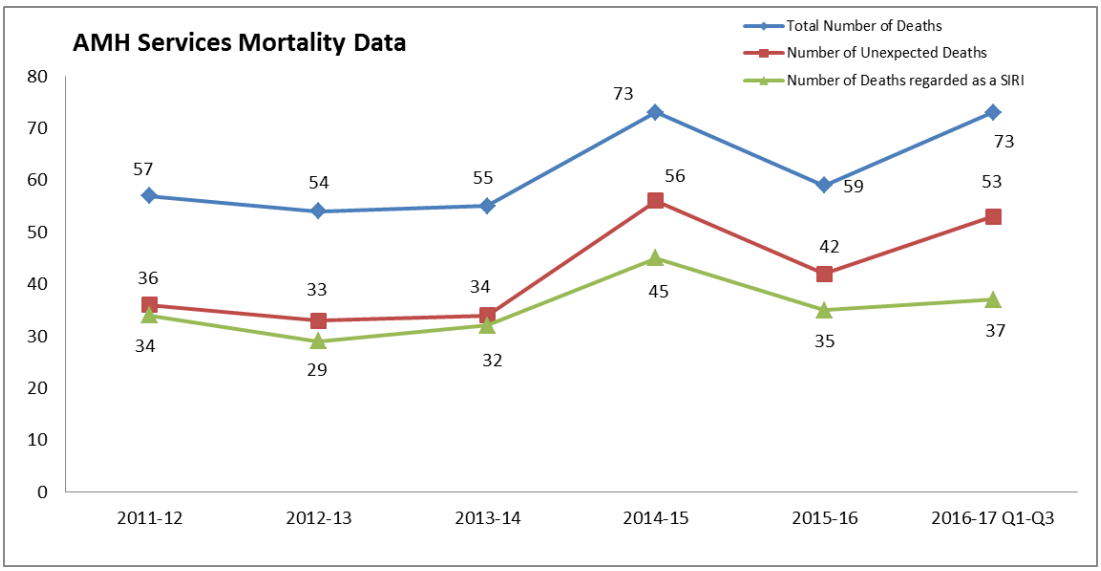
FORENSIC SERVICES - Excluding Offender Health	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17 Q1-Q3	TOTAL
Total Number of Deaths	1	5	4	2	11	4	**27**
Number of Unexpected Deaths	1	4	1	2	9	4	**20**
Number of Deaths regarded as a SIRI	1	5	4	2	11	3	**26**
Number of Deaths Degree of Harm 5	1	3	1	1	7	3	**16**
Rampton Mental Health							
Total Number of Deaths	0	1	1	0	2	0	**4**
Number of Unexpected Deaths	0	0	0	0	1	0	**1**
Number of Deaths regarded as a SIRI	0	1	1	0	2	0	**4**
Number of Deaths Degree of Harm 5	0	0	0	0	1	0	**1**
Rampton Women's							
Total Number of Deaths	0	2	2	0	2	0	**6**
Number of Unexpected Deaths	0	2	0	0	2	0	**4**
Number of Deaths regarded as a SIRI	0	2	2	0	2	0	**6**
Number of Deaths Degree of Harm 5	0	2	0	0	2	0	**4**
Community/Low Secure							
Total Number of Deaths	1	1	1	1	6	4	**14**
Number of Unexpected Deaths	1	1	1	1	5	4	**12**
Number of Deaths regarded as a SIRI	1	1	1	1	6	3	**13**
Number of Deaths Degree of Harm 5	1	0	1	0	3	3	**8**
Medium Secure							
Total Number of Deaths	0	1	0	1	1	0	**3**
Number of Unexpected Deaths	0	1	0	1	1	0	**3**
Number of Deaths regarded as a SIRI	0	1	0	1	1	0	**3**
Number of Deaths Degree of Harm 5	0	1	0	1	1	0	**3**

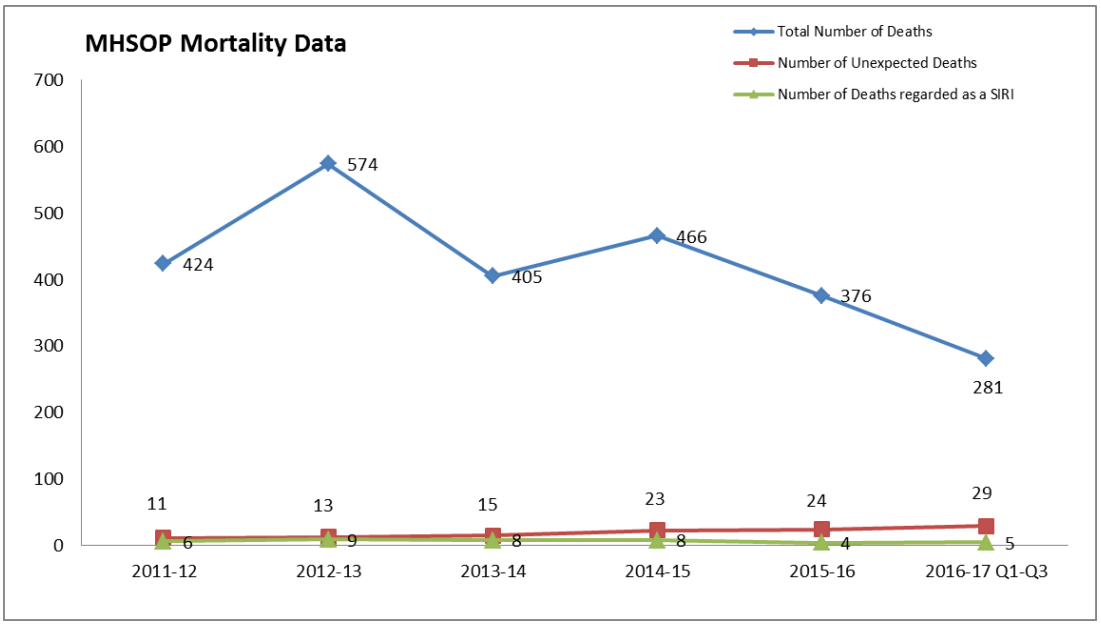
FORENSIC SERVICES - Offender Health	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17 Q1-Q3	TOTAL
Total Number of Deaths	15	9	16	25	34	26	**125**
Number of Unexpected Deaths	10	3	10	15	19	19	**62**
Number of Deaths regarded as a SIRI	15	6	14	24	29	26	**114**
Number of Deaths Degree of Harm 5	11	3	7	11	18	17	**67**
HMP Doncaster							
Total Number of Deaths	3	1	1	4	5	4	**18**
Number of Unexpected Deaths	2	0	0	2	3	3	**7**
Number of Deaths regarded as a SIRI	3	0	0	4	3	4	**14**
HMP Hatfield							
Total Number of Deaths	1	0	0	1	1	0	**3**
Number of Unexpected Deaths	1	0	0	1	1	0	**3**
Number of Deaths regarded as a SIRI	1	0	0	1	1	0	**3**
HMP Lincoln							
Total Number of Deaths	*	*	*	2	2	3	**7**
Number of Unexpected Deaths	*	*	*	2	1	3	**4**
Number of Deaths regarded as a SIRI	*	*	*	2	2	3	**7**
HMP Lindholme							
Total Number of Deaths	1	1	0	1	4	3	**10**
Number of Unexpected Deaths	1	1	0	1	2	3	**6**
Number of Deaths regarded as a SIRI	1	0	0	1	3	3	**8**
HMP Moorland							
Total Number of Deaths	0	0	3	2	3	4	**12**
Number of Unexpected Deaths	0	0	1		1	3	**3**
Number of Deaths regarded as a SIRI	0	0	3	2	2	4	**11**
HMP New Hall							
Total Number of Deaths	1	0	0	0	0	1	**1**
Number of Unexpected Deaths	1	0	0	0	0	1	**1**
Number of Deaths regarded as a SIRI	1	0	0	0	0	1	**1**
HMP Nottingham							
Total Number of Deaths	3	1	5	3	3	3	**18**
Number of Unexpected Deaths	2	0	5	3	3	2	**13**
Number of Deaths regarded as a SIRI	3	0	5	3	2	3	**16**
HMP Ranby							
Total Number of Deaths	0	0	4	3	5	0	**12**
Number of Unexpected Deaths	0	0	4	3	4	0	**11**
Number of Deaths regarded as a SIRI	0	0	4	3	5	0	**12**
HMP Stocken							
Total Number of Deaths	2	1	0	1	3	0	**7**
Number of Unexpected Deaths	2	1	0	1	2	0	**6**
Number of Deaths regarded as a SIRI	2	1	0	1	3	0	**7**
HMP Wakefield							
Total Number of Deaths	0	0	1	1	0	0	**2**
Number of Unexpected Deaths	0	0	0	1	0	0	**1**
Number of Deaths regarded as a SIRI	0	0	0	0	0	0	**0**
HMP Whatton							
Total Number of Deaths	4	5	2	7	5	4	**27**
Number of Unexpected Deaths	1	1		1	0	0	**3**
Number of Deaths regarded as a SIRI	4	5	2	7	5	4	**27**
HMP North Sea Camp							
Total Number of Deaths	*	*	*	0	1	1	**1**
Number of Unexpected Deaths	*	*	*	0	0	1	**0**
Number of Deaths regarded as a SIRI	*	*	*	0	1	1	**1**
HMP Lowdham							
Total Number of Deaths	0	0	0	0	2	2	**4**
Number of Unexpected Deaths	0	0	0	0	2	2	**2**
Number of Deaths regarded as a SIRI	0	0	0	0	2	2	**4**
HMP Morton Hall							
Total Number of Deaths	*	*	*	*	*	1	**1**
Number of Unexpected Deaths	*	*	*	*	*	1	**1**
Number of Deaths regarded as a SIRI	*	*	*	*	*	1	**1**

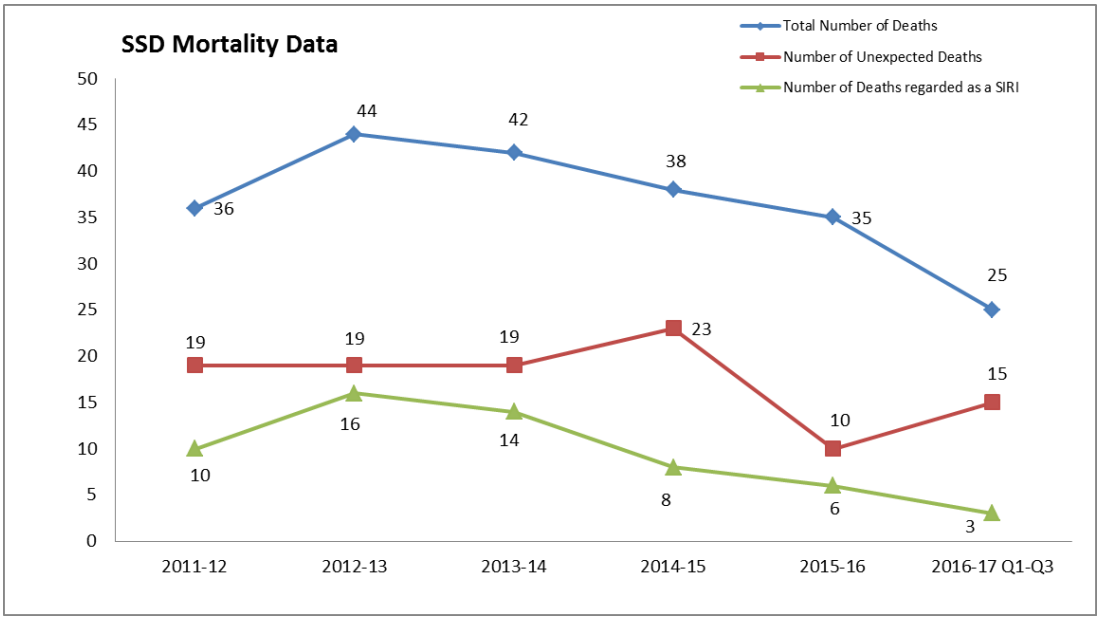
The graphs below show the overall trends at Trust level, Offender Health, Adult Mental Health, Mental Health Services for Older People and Specialist Services. This is broken down by the total number of deaths, the number of unexpected deaths and the number that were reportable as a SIRI.






AMH Services Mortality Data
Total Number of Deaths
Number of Unexpected Deaths
Number of Deaths regarded as a SIRI
80
70
60
50
40
30
20
10
0
57
54
55
73
59
73
36
33
34
56
42
53
34
29
32
45
35
37
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17 Q1-Q3


MHSOP Mortality Data
Total Number of Deaths
Number of Unexpected Deaths
Number of Deaths regarded as a SIRI
700
600
500
400
300
200
100
0
424
574
405
466
376
281
11
13
15
23
24
29
6
9
8
8
4
5
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17 Q1-Q3


SSD Mortality Data
Total Number of Deaths
Number of Unexpected Deaths
Number of Deaths regarded as a SIRI
50
45
40
35
30
25
20
15
10
5
0
36
44
42
38
35
25
19
19
19
23
10
15
10
16
14
8
6
3
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17 Q1-Q3