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NHS
Black Country and
West Birmingham
Clinical Commissioning Group

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7 April 2022

FOI-0296: Unexpected Deaths of Learning Disability and/or Autism Patients in Hospitals

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.

   Black Country & West Birmingham Clinical Commissioning Group (BCWB 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 Jan 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 Black Country & West Birmingham CCG does not hold this information. We advise that you redirect your request for information to the service provider/commissioner:

   Black Country Healthcare NHS Foundation Trust
   Trafalgar House - 2nd Floor
   47-49 King Street
   Dudley
   West Midlands
   DY2 8PS
   Email: bchft.foi1@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?

   Zero.

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.

   Please refer to question 2 response.

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

   Please refer to question 2 response.

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

   Please refer to question 2 response.

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)

   Please refer to question 2 response.

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?

   Please refer to question 2 response.