East London
NHS Foundation Trust

**Information Governance**
The Green
1 Roger Dowley Court
Russia Lane
London
E2 9NJ

**Telephone:** 020 7655 4131
**Email** elft.foi@nhs.net
**Website:** https://www.elft.nhs.uk

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**Our reference: FOI DA3612**

I am responding to your request for information received 1 November 2020 which you clarified on 5 November 2020. This has been treated as a request under the Freedom of Information Act 2000.

I am now enclosing a response which is attached to the end of this letter. Please do not hesitate to contact me on the contact details above if you have any further queries.

Yours sincerely,

Keshia Harvey
Information Governance Manager

If you are dissatisfied with the Trust's response to your FOIA request then you should contact us and we will arrange for an internal review of this decision. If you remain dissatisfied with the decision following our response to your complaint, you may write to the Information Commissioner for a decision under Section 50 of the Freedom of Information Act 2000. The Information Commissioner can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Tel: 0303 123 1113
Web: www.ico.org.uk

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**Request:**

**Hi there, I am writing to you under the Freedom of Information Act 2000 to request the following information.**

**Question 1.** **Please could you let me know: - How many serious incidents were recorded by your NHS Mental Health Trust in the years 2018,
2019,
and so far in 2020?**

**Clarification:** **Hi there,**

**Thank you for your reply. By serious incident I mean those incidents that are reported as such according to the NHS Framework: https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf**

**I am just pasting the definition here:**

**A Serious Incident Requiring Investigation (SIRI) also known as a Serious Untoward Incident or Serious Incident) may be defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:**

**• Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;**

**• Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm;**

**• A scenario that prevents or threatens to prevent a provider organisations ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;**

**• Allegations of abuse;**

**• Adverse media coverage or public concern about the organisation or the wider NHS;**

**• Never Event (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers). A full list of Never Events can be found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/21 3046/never-events-policy-framework-update-to-policy.pdf**

Answer: Please see the table below of the number of Serious Incident Investigations that were undertaken:

| **Year** | **No. of Serious Incidents Investigations** |
|---|---|
| 2018 | 158 |
| 2019 | 131 |
| 2020 | 107 |

**Question 2. Of these serious incidents, how many were for unexpected deaths? Please could I have the figures for**
**2018,**
**2019,**
**and so far in 2020.**

Answer: Please see the table below:

| **Year** | **No. of Serious Incidents Investigations re unexpected deaths** |
|---|---|
| 2018 | 66 |
| 2019 | 66 |
| 2020 | 68 |