

**Information Governance**

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

**Email** [elft.foi@nhs.net](mailto:elft.foi@nhs.net)

**Website:** <https://www.elft.nhs.uk>

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**Our reference: FOI DA4038**

I am responding to your request for information received 9 December 2021. I am sorry for the delay in responding to your request. 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](http://www.ico.org.uk)

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Chair: Mark Lam

Chief Executive: Paul Calaminus

*We care*

*We respect*

*We are inclusive*

**Request:**

**Question 1:** Please tell me for the years a) 2019/20 and b) 2020/21 the number and, where available, rate of patient safety incidents reported within the Trust.

Answer: Please see table below:

2019/2020	2020/2021
11982	11909

**Question 2:** Please provide separately for a) 2019/20 and b) 2020/21 the number and percentage of the patient safety incidents from question 1 that resulted in severe harm or death

For context, I read in this NHS Improvement document on page 20 that Trusts are required to record the above information.

[https://www.england.nhs.uk/wp-content/uploads/2020/08/Detailed\\_requirements\\_for\\_quality\\_report\\_update.pdf](https://www.england.nhs.uk/wp-content/uploads/2020/08/Detailed_requirements_for_quality_report_update.pdf)

Answer: Please see table below:

2019/2020	2020/2021
87	111

**Question 3:** Please provide me with a brief overview of the FIRST FIVE patient safety incidents in 2020/21 that resulted in severe harm or death (i.e. the incidents identified in question 2b above), withholding any identifying information that would run into a Section 40 exemption.

If the information for 2020/21 is not yet available, or if there were zero incidents in 2020/21, please provide me with a summary of the first five incidents from 2019/20 instead.

Answer: Please see table below:

1	Service user was found by police deceased at home.
2	Suspected suicide attempt. Service user had to be intubated and treated in ITU
3	Service user took his own life and died of asphyxiation.
4	Service user found deceased. Cause of death by Hanging.
5	Service user found deceased in his hotel room.