Southern Health NHS
NHS Foundation Trust

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Dear Colleague,

Review conducted by Mazars into Deaths of People with a Learning Disability or Mental Health need in contact with Southern Health NHS Foundation Trust April 2011 to March 2015

I wrote to you recently to inform you about the upcoming publication of a review of all deaths of people who use Southern Health services for Learning Disabilities and Mental Health in a four-year period. NHS England commissioned an organisation called Mazars to carry out the review, the report of which has not yet been finalised.

However it has come to our attention that the report has been leaked to the media, despite it not being finalised. We would not usually comment on a leaked draft report, but are concerned that this coverage may cause undue anxiety, especially amongst people who use our services and their families, and it prevents us from providing a comprehensive response at this time.

There are also serious concerns about the draft report's interpretation of the evidence.

We fully accept that our reporting processes following a patient death have not always been good enough. We have taken considerable measures to strengthen our investigation and learning from deaths including increased monitoring and scrutiny. These include:

- The launch of a new Procedure for Reporting and Investigating Deaths
- The establishment of a central investigation team which is working to improve the quality of investigations
- Increased executive oversight of the entire reporting process.

The review has not assessed the quality of care provided by the Trust. Instead it looked at the way in which the Trust recorded and investigated the deaths of people with whom we had one or more contacts in the preceding 12 months. In almost all cases referred to in the report the Trust was not the main provider of care.

We would stress the draft report contains no evidence of more deaths than expected in the last four years of people with mental health needs or learning disabilities for the size and age of the population we serve.

When the final report is published by NHS England we will review the recommendations and make any further changes necessary to ensure the processes through which we report, investigate and learn from deaths are of the highest possible standard.

We will keep you fully updated. Meanwhile we continue to work to improve care for all patients and everyone who relies on our services.

If you would like to discuss any of these matters further please contact me.

Yours Sincerely,

Katrina Percy
Chief Executive