Southern Health NHS Foundation Trust fined after deaths of two patients

Southern Health NHS Foundation Trust has been fined £2m after a series of management failings led to the deaths of two vulnerable patients at different facilities owned by the Trust.

The Health and Safety Executive (HSE) prosecution follows the deaths of 45-year-old Teresa Colvin at a Southampton Mental Health Hospital and the death of 18-year-old Connor Sparrowhawk at a specialist unit in Oxford. Both centres were under the management of Southern Health NHS Foundation Trust.

Oxford Crown Court heard both HSE investigations found a series of management failings leading up to both deaths including a failure to control risks, and failures in planning.

Southern Health NHS Foundation Trust, pleaded guilty to two breaches of Section 3(1) of the Health and Safety at Work etc. Act 1974. For the breach relating to Teresa Colvin, the sentence was a £950,000 fine. For the breach relating to Connor Sparrowhawk's death, the sentence was a fine of £1,050.000.

HSE's deputy director of field operations Tim Galloway said: "These tragic incidents could have wholly been avoided with better supervision and planning. Instead two families are left utterly devastated and let down by those who had a duty of care for their loved ones.

"The Trust was responsible for caring for those suffering with mental health issues and caring for those with learning difficulties. On these two occasions it failed these two patients and their families.

"Our thoughts remain with Connor Sparrowhawk and Teresa Colvin's families as they continue to come to terms with these avoidable tragedies.

"In particular, we would like to pay tribute to Dr Sara Ryan, Connor's mother, for her continued campaigning on these tragic issues."

BACKGROUND OF CASE

Death of Connor Sparrowhawk

On 4 July 2013, 18-year-old Connor Sparrowhawk died after suffering an epileptic seizure in the bath at the Trust's specialist unit, Slade House in Oxford.

An investigation by the Health and Safety Executive (HSE) found that despite Mr Sparrowhawk's vulnerability and previous suspected seizures, he was allowed to use the bath alone with checks from staff taking place every 15 minutes.

Tim Galloway added: “Southern Health was aware of the patient’s condition and there had been a number of warning signs prior to the incident taking place. Allowing Connor to use the bath unsupervised was an obvious risk and a serious management failing.”

Death of Teresa Colvin

Following Connor’s death, NHS England published the independent Mazars report in December 2015 into the deaths of people with a learning disability or mental health problem at Southern Health NHS Foundation Trust

In response to the report, and following an assessment of all the deaths that occurred on Southern Health premises from April 2011, HSE concluded that one death met the criteria for a full HSE investigation.

On 26 April 2012, Teresa Colvin was found slumped and unconscious at a telephone kiosk at Woodhaven Adult Mental Health Hospital in Southampton. She died a short time later following treatment.

It became clear during HSE’s investigation that the Trust failed to act on the findings of assessments that it could better control the risks associated with the use of phones with cords. There had been a history of patients across the Trust, including those at Woodhaven, using phone cords as a ligature.

Tim Galloway added: “The known risk of patients across the Trust using phone cords as ligature was never sufficiently addressed. This ultimately led to the death of this vulnerable patient.”

Notes to Editors:

1. The Health and Safety Executive (HSE) is Britain’s national regulator for workplace health and safety. We prevent work-related death, injury and ill health through regulatory actions that range from influencing behaviours across whole industry sectors through to targeted interventions on individual businesses. These activities are supported by globally recognised scientific expertise. www.hse.gov.uk
2. After 1 April 2015, the Care Quality Commission (CQC) took responsibility in England for patient and service user health and safety for providers registered with them. Prior to this date, HSE had enforcement responsibility, hence its investigation and subsequent prosecution on this occasion.
3. More about the legislation referred to in this case can be found at: www.legislation.gov.uk/
4. HSE news releases are available at http://press.hse.gov.uk

Journalists should approach HSE press office with any queries on regional press releases.