Freedom of Information Act 2000 (FOIA)

Decision notice

Date: 9 April 2021

Public Authority: South West Yorkshire Partnership NHS Foundation Trust

Address: Fieldhead Hospital
Ouchthorpe Lane
Wakefield
WF1 3SP

Decision (including any steps ordered)

1. The complainant has submitted a series of multi-part requests for information to South West Yorkshire Partnership NHS Foundation Trust ('the Trust'). The Trust has refused to comply with them under section 12(1) of the FOIA as it says the cost of doing so would exceed the appropriate limit.

2. The Commissioner's decision is as follows:

   - The cost of complying with the complainant's requests would exceed the appropriate limit under section 12(1) of the FOIA and the Trust is not obliged to do so.

   - The Trust offered the complainant adequate advice and assistance and no breach of section 16(1) of the FOIA occurred.

3. The Commissioner does not require the Trust to take any remedial steps.

Request and response

4. On 16 April 2020 the complainant submitted a series of requests for information to the Trust in a single piece of correspondence. Given their voluminous nature, they are provided in the Appendix to this notice.

5. On 29 April 2020 the Trust responded. It refused to comply with the requests citing section 12(1) of the FOIA.

6. The complainant requested an internal review the same day. The Trust provided an internal review on 26 May 2020. It maintained its position and it explained how the complainant could refine their request to bring the cost of complying with it within the limit.

Scope of the case

7. The complainant contacted the Commissioner on 28 May 2020 to complain about the way their request for information had been handled.

8. The Commissioner's investigation has focussed on whether the Trust can rely on section 12(1) of the FOIA to refuse to comply with the requests. She will also consider whether the Trust complied with its duty under section 16(1) to offer the complainant advice and assistance.

Reasons for decision

Section 12 – cost of compliance exceeds appropriate limit

9. Under section 1(1) of the FOIA anyone who requests information from a public authority is entitled under subsection (a) to be told if the authority holds the information and, under subsection (b) to have the information communicated to him or her if it is held and is not exempt information.

10. Section 12(1) of the FOIA says that a public authority is not obliged to comply with section 1(1) if the authority estimates that the cost of doing so would exceed the appropriate limit.

11. Section 12(4)(a) provides that where two or more requests for information are made to a public authority by one person the estimated cost of complying with any of the requests is to be taken to be the estimated total cost of complying with all of them.

12. The estimate must be reasonable in the circumstances of the case. The appropriate limit is currently £600 for central government departments and £450 for all other public authorities. Public authorities can charge a maximum of £25 per hour to undertake work to comply with a request; 18 hours work in accordance with the appropriate limit of £450 set out above, which is the limit applicable to the Trust. If an authority estimates that complying with a request may cost more than the cost limit, it can consider the time taken to:

    - determine whether it holds the information
    - locate the information, or a document which may contain the information
    - retrieve the information, or a document which may contain the information, and
    - extract the information from a document containing it.

13. Where a public authority claims that section 12 of the FOIA is engaged it should, where reasonable, provide advice and assistance to help the applicant refine the request so that it can be dealt with under the appropriate limit, in line with section 16(1) of the FOIA.

14. In its submission to the Commissioner, the Trust has noted that the complainant has submitted 120 different questions about a number of different matters. The questions are grouped under five separate headings. It could be argued that each of the questions is a distinct request – making 120 requests. However, the Commissioner has viewed them as five, multi-question requests.

15. By way of an example, the Trust has discussed the following three of the complainant's questions:

    - How many patients died a few months after ECT/ SI/ restraint/ seclusion and what was the cause (whether or not ECT/ SI/ restraint/ seclusion was the cause)?

    - How many patients died by suicide within a months of receiving ECT/ SI/ restraint/ seclusion (whether or not ECT/ SI/ restraint/ seclusion was considered the cause)?

    - How many patients report memory loss/ loss of cognitive function?

16. The Trust has told the Commissioner that it discussed these questions with its Datix team, Datix being its incident management system. With regard to the first two questions, the Trust has explained that it could only extract the number of deaths and the cause of death (if known) from Datix, not if they occurred "a few months" after the interventions the complainant has listed. The clinical record of each individual would

therefore need to be reviewed in order to identify whether the deceased had been subject to any of the interventions in the months prior to death. In 2019, 336 deaths had been recorded including inpatient and community service uses. In addition, if the death was suicide there may have been an investigation which identified this information and therefore those reports would need to be reviewed. In 2019 there were 51 apparent suicides recorded – inpatient and community.

17. Similarly, with regard to the third question the Trust says it would need to take a hybrid approach of analysing data received from the Datix team, followed by scrutiny of individual records. It notes that in 2019 there were: 1218 incidents resulting in restraint; 414 incidents resulting in seclusion; at least 22 incidents reported by ECT suites; and 49 serious incidents reported.

18. Given the nature of the information requested, the way in which the Trust records information and the volume of records that would need to be manually reviewed, the Commissioner is satisfied that it would take the Trust far longer than 18 hours to comply with these three questions. If it took only 15 minutes to review one patient record, it would take the Trust almost 97 hours to comply with the first of the above questions alone. In line with section 12(4), because it would exceed the appropriate limit to comply with these three questions, the Trust is not obliged to consider the remaining requests.

19. The Commissioner is satisfied that the Trust is entitled to rely on section 12(1) of the FOIA to refuse to comply with the complainant's requests.

Section 16 – advice and assistance

20. Section 16(1) of the FOIA places a duty on a public authority to provide advice and assistance, so far as it would be reasonable to expect the authority to do so, to persons who propose to make, or have made, requests for information to it.

21. In its internal review response to the complainant, the Trust suggested that the complainant could submit a refined request by submitting one part of their request, for example, for information on serious incidents only. The Trust also advised that it could easily provide, for example, copies of leaflets and forms that it holds.

22. Faced with the volume of questions that the complainant had originally submitted, the Commissioner considers that the Trust offered adequate advice and assistance and that there was no breach of section 16(1) of the FOIA.

Right of appeal

23. Either party has the right to appeal against this decision notice to the First-tier Tribunal (Information Rights). Information about the appeals process may be obtained from:

    First-tier Tribunal (Information Rights)
    GRC & GRP Tribunals
    PO Box 9300
    LEICESTER
    LE1 8DJ

    Tel: 0300 1234504
    Fax: 0870 739 5836
    Email: grc@justice.gov.uk
    Website: www.justice.gov.uk/tribunals/general-regulatory-chamber

24. If you wish to appeal against a decision notice, you can obtain information on how to appeal along with the relevant forms from the Information Tribunal website.

25. Any Notice of Appeal should be served on the Tribunal within 28 (calendar) days of the date on which this decision notice is sent.

Signed

Pamela Clements
Group Manager
Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

APPENDIX

Please provide ECT information under the FOI act to the following questions: -

1. Please supply patient's information ECT leaflet.

2. Please supply patient ECT consent form.

3. Please supply any ECT reports/investigations

4. How many ECT in 2019?

5. What proportion of patients were men/women?

6. How old were they?

7. What were the diagnoses and in what proportions?

8. What proportion of patients were classified BAME?

9. How many were receiving ECT for the first time?

10. How many patients consented to ECT?

11. How many ECT complaints were investigated outside the NHS and CCG?

12. How many patients died during or soon after ECT and what was the cause (whether or not ECT was considered the cause)?

13. How many patients died a few months after ECT and what was the cause (whether or not ECT was considered the cause)?

14. How many patients died by suicide within a few months of receiving ECT (whether or not ECT was considered the cause)?

15. How many patients have suffered complications during and after ECT and what were those complications?

16. Have there been any formal complaints from patients/relatives about ECT?

17. If so, what was their concerns?

18. How many patients report memory loss/loss of cognitive function?

19. What tests are used to assess memory loss/loss of cognitive function?

20. Have MRI or CT scans been used before and after ECT?

21. If so what was the conclusion?

22. How does the Trust plan to prevent ECT in the future?

Please provide SERIOUS INCIDENT information under the FOI act to the following questions: -

1. Please supply SERIOUS INCIDENT REPORTS patient's information leaflet.

2. Please supply patient SERIOUS INCIDENT REPORTS consent form.

3. Please supply any serious incident reports/investigations

4. How many SERIOUS INCIDENT REPORTS in 2019?

5. What proportion of patients were men/women?

6. How old were they?

7. What were the diagnoses and in what proportions?

8. What proportion of patients were classified BAME?

9. How many were receiving SERIOUS INCIDENT REPORTS for the first time?

10. How many patients consented to SERIOUS INCIDENT REPORTS?

11. How many SERIUOS INCIDENT REPORTS were investigated outside the NHS and CCG?

12. How many patients died during or soon after SERIOUS INCIDENT REPORTS and what was the cause (whether or not SERIOUS INCIDENT REPORTS was considered the cause)?

13. How many patients died a few months after SERIOUS INCIDENT REPORTS and what was the cause (whether or not SERIOUS INCIDENT REPORTS was considered the cause)?

14. How many patients died by suicide within a few months of receiving SERIOUS INCIDENT REPORTS (whether or not SERIOUS INCIDENT REPORTS was considered the cause)?

15. How many patients have suffered complications during and after SERIOUS INCIDENT REPORTS and what were those complications?

16. Have there been any formal complaints from patients/relatives about SERIOUS INCIDENT REPORTS?

17. If so, what was their concerns?

18. How many patients report memory loss/loss of cognitive function?

19. What tests are used to assess memory loss/loss of cognitive function?

20. Have MRI or CT scans been used before and after SERIOUS INCIDENT REPORTS?

21. If so what was the conclusion?

22. How does the Trust plan to prevent SERIOUS INCIDENTS in the future?

Please provide restraints information under the FOI act to the following questions: -

1. Please supply RESTRAINTS patient's information leaflet.

2. Please supply patient RESTRAINTS consent form.

3. Please supply any Restraints/investigations

4. How many RESTRAINTS in 2019?

5. What proportion of patients were men/women?

6. How old were they?

7. What were the diagnoses and in what proportions?

8. What proportion of patients were classified BAME?

9. How many were receiving RESTRAINTS for the first time?

10. How many patients consented to RESTRAINTS?

11. How many RESTRAINTS were investigated outside the NHS and CCG ?

12. How many patients died during or soon after RESTRAINTS and what was the cause (whether or not RESTRAINTS was considered the cause)?

13. How many patients died a few months after RESTRAINTS and what was the cause (whether or not RESTRAINTS was considered the cause)?

14. How many patients died by suicide within a few months of receiving RESTRAINTS (whether or not RESTRAINTS was considered the cause)?

15. How many patients have suffered complications during and after RESTRAINTS and what were those complications?

16. Have there been any formal complaints from patients/relatives about RESTRAINTS?

17. If so, what was their concerns?

18. How many patients report memory loss/loss of cognitive function?

19. What tests are used to assess memory loss/loss of cognitive function?

20. Have MRI or CT scans been used before and after RESTRAINTS?

21. If so what was the conclusion?

22. How does the Trust plan to reduce restraints in the future?

Please provide SECLUSION information under the FOI act to the following questions: -

1. Please supply patient's information SECLUSION leaflet.

2. Please supply patient SECLUSION consent form.

3. Please supply any SECLUSION reports/investigations

4. How many SECLUSION in 2019?

5. What proportion of patients were men/women?

6. How old were they?

7. What were the diagnoses and in what proportions?

8. What proportion of patients were classified BAME?

9. How many were receiving SECLUSION for the first time?

10. How many patients consented to SECLUSION?

11. How many SECLUSIONS were investigated outside the NHS and CCG ?

12. How many patients died during or soon after SECLUSION and what was the cause (whether or not SECLUSION was considered the cause)?

13. How many patients died a few months after SECLUSION and what was the cause (whether or not SECLUSION was considered the cause)?

14. How many patients died by suicide within a few months of receiving SECLUSION (whether or not SECLUSION was considered the cause)?

15. How many patients have suffered complications during and after SECLUSION and what were those complications?

16. Have there been any formal complaints from patients/relatives about SECLUSION?

17. If so, what was their concerns?

18. How many patients report memory loss/loss of cognitive function?

19. What tests are used to assess memory loss/loss of cognitive function?

20. Have MRI or CT scans been used before and after SECLUSION?

21. If so what was the conclusion?

22. How does the Trust plan to prevent SECLUSION in the future?

Please provide MEDICATION ERRORS information under the FOI act to the following questions: -

1. Please supply patient's information MEDICATION ERRORS leaflet.

2. Please supply patient MEDICATION ERRORS consent form.

3. Please supply any MEDICATION ERRORS reports/investigations

4. How many MEDICATION ERRORS in 2019?

5. What proportion of patients were men/women?

6. How old were they?

7. What were the diagnoses and in what proportions?

8. What proportion of patients were classified BAME?

9. How many were receiving MEDICATION ERRORS for the first time?

10. How many patients consented to MEDICATION ERRORS?

11. How many MEDICATION ERRORS S were investigated outside the NHS and CCG?

12. How many patients died during or soon after MEDICATION ERRORS and what was the cause (whether or not MEDICATION ERRORS was considered the cause)?

13. How many patients died a few months after MEDICATION ERRORS and what was the cause (whether or not MEDICATION ERRORS was considered the cause)?

14. How many patients died by suicide within a few months of receiving MEDICATION ERRORS (whether or not MEDICATION ERRORS was considered the cause)?

15. How many patients have suffered complications during and after MEDICATION ERRORS and what were those complications?

16. Have there been any formal complaints from patients/relatives about MEDICATION ERRORS?

17. If so, what was their concerns?

18. How many patients report memory loss/loss of cognitive function?

19. What tests are used to assess memory loss/loss of cognitive function?

20. Have MRI or CT scans been used before and after MEDICATION ERRORS?

21. If so what was the conclusion?

22. How does the Trust plan to prevent MEDICATION ERRORS in the future?