Freedom of Information Act 2000 (FOIA)

Decision notice

Date: **7 April 2021**

Public Authority: **Camden and Islington NHS Foundation Trust**
Address: **St Pancras Hospital**
4 St Pancras Way
London
NW1 0PE

Decision (including any steps ordered)

1. The complainant submitted to Camden and Islington NHS Foundation Trust (the Trust) a 110 part request for information relating to electroconvulsive therapy (ECT), serious incidents, restraints, seclusion and medication errors. The Trust refused to comply with the requests as it said it would exceed the cost limit under section 12(1) of FOIA to do so.

2. The Commissioner's decision is that the Trust was correct to apply section 12(1) of FOIA and that it was not therefore obliged to comply with the requests. The Commissioner also considers that the Trust provided the complainant with advice and assistance in accordance with its obligations under section 16 of FOIA.

3. The Commissioner does not require the Trust to take any step as a result of this decision notice.

Request and response

4. On 16 April 2020, the complainant wrote to the Trust to submit a 110 part request for information relating to electroconvulsive therapy (ECT), serious incidents, restraints, seclusion and medication errors[1].

5. The Trust responded on 4 September 2020. It refused to comply with the information request citing section 12(1) of FOIA as its basis for this refusal because it considered that complying with this request would exceed the appropriate cost limit. In accordance with its FOIA section 16 obligations, the Trust invited the complainant to narrow down the request so it could be reconsidered.

6. Remaining dissatisfied with the response received, on 5 September 2020 the complainant wrote to the Trust to request an internal review.

7. On 16 September 2020, the Trust provided the complainant with the outcome of its internal review. The Trust upheld its original position.

Scope of the case

8. The complainant contacted the Commissioner on 18 September 2020 to complain about the way her request for information had been handled.

9. The scope of this case and the following analysis is to consider whether the Trust was correct to apply section 12(1) of FOIA to the request in this case and whether it complied with its obligations under section 16 of FOIA.

Reasons for decision

Section 12 – cost of compliance exceeds the appropriate limit

10. Section 12 of FOIA allows a public authority to refuse to deal with a request where it estimates that it would exceed the appropriate cost limit to:

- either comply with the request in its entirety, or

[1] The wording of this request has been reproduced and attached to this decision notice – see Annex 1.

- confirm or deny whether the requested information is held.

11. In this case the Trust relied on section 12(1), meaning that it estimated that it would exceed the cost limit to comply with the request in its entirety.

12. The estimate must be reasonable in the circumstances of the case. The appropriate limit is £600 for central government departments and £450 for all other public authorities. The cost of complying with a request should be calculated at the rate of £25 per hour - 24 hours work for central government departments; 18 hours work for all other public authorities. In forming a cost estimate a public authority can take into account the time taken to:

    (a) determine whether it holds the information

    (b) locate the information, or a document which may contain the information

    (c) retrieve the information, or a document which may contain the information, and

    (d) extract the information from a document containing it.

13. The appropriate limit for the Trust is £450 or the equivalent of 18 hours work.

14. The Commissioner notes that the Trust in relation to the present request explained to the complainant that, due to the wide scope of her request, complying with her request would exceed the cost limit.

15. The Trust stated that it had established that *"just to answer question 7 alone '(of the medication errors what were the diagnoses and in what proportions)' would take more than 18 hours of work to locate, retrieve and extract the requested information from patient records."*

16. The Commissioner asked the Trust to provide her with a detailed estimate of the time it would take to comply with the requests. In its response to the Commissioner, the Trust explained that it had revisited the request and had spent 18 hours attempting to comply with it.

17. The Trust told the Commissioner that on 12 March 2021, with the intention of reaching a compromise, the Trust provided the complainant with a fresh response which included the information compiled following this sampling exercise. A copy of this fresh response was also sent to the Commissioner. The Trust informed the Commissioner that even after this recent response the complainant remained dissatisfied.

18. The Trust stated that it has *"been able to provide the requestor with 64 answers to her 110 questions now."*

19. The Commissioner notes that the copy of the spreadsheet demonstrates that the Trust's approach was to examine each question individually. The information provided covers information about the age and ethnicity of patients in relation to the set of questions about restraints, seclusions and medication errors.

20. The Trust stated that its *"clinicians measured the time it took to search one record and, in some cases, took a sample of 3 records and used the minimum time taken to calculate the total time, ensuring that our estimates are realistic and supported by evidence."*

21. The Trust explained that, as the scope of the request is very broad, the relevant information it holds is recorded in different systems. It states that its systems are designed primarily for the management of individual cases rather than for providing data in response to information requests.

22. By way of example and to illustrate the sampling exercise, the Trust stated that in order to respond to question 7 in relation to restraints, it would be required to extract all cases of restraint incidents for 2019 from its electronic recording system (*DATIX*) and export the case references to a spreadsheet. That would have to be followed by searching in a different system which holds service users' records (*Carenotes*). The Trust explained that it carried out this exercise for 3 cases and on average it took 8 minutes to complete extraction of the information necessary in relation to one case reference. The Trust added that DATIX recorded 500 incidents of restraint during 2019 and in order to comply only with this part of the request, it would require 4000 minutes (500 incidents x 8 minutes) or 66 hours.

23. The Trust also confirmed that its evidence was based upon the quickest method of gathering the requested information and its databases were always used where possible.

24. On the basis of this explanation from the Trust, the Commissioner is satisfied that the Trust has demonstrated that the estimate of the time necessary to comply with the request was reasonable. The Commissioner also notes that the request is extremely lengthy and from reading it, it appeared likely that compliance with it would exceed the cost limit.

25. Based upon the Trust's submissions, the Commissioner accepts that the Trust's cost estimate was reasonable and therefore section 12(1) was correctly engaged in relation to the complainant's request. Therefore,

the Commissioner concludes that the Trust correctly applied section 12(1) of FOIA in this case.

Section 16 – Advice and Assistance

26. Under section 16(1) of FOIA the Trust is obliged to provide the complainant with advice and assistance to help enable the complainant to refine the request to fall within the cost limit or explain why this would not be possible.

27. The Commissioner notes that the Trust on both occasions, in its initial response and the outcome of the internal review, stated that *"in line with section 16 FOIA, we invite you to narrow your request to a specific topic and we will be more than happy to consider your request."*

28. As the Trust has provided advice and assistance in this case, by offering to reconsider the complainant's request if the complainant would reduce the scope of the request, and voluntarily complied with some of the request, it complied with its obligations under section 16(1) of FOIA.

Right of appeal

29. 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

30. 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.

31. 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 .....

Ben Tomes
Team Manager
Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Annex 1

The formulation of the information request submitted by the complainant on 16 April 2020 was as follows:

"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?*"