A teaching trust of Brighton and Sussex Medical School

Sussex Partnership NHS
NHS Foundation Trust

Our Ref: INQ/13/118
Your Ref: VHD/LP/INQ16/14

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Swandean
Arundel Road
Worthing
West Sussex
BN13 3EP

Tel: [redacted]
Fax:
Email: [redacted]

Miss Veronica Hamilton-Deeley
HM Senior Coroner
The Coroner's Office
Woodvale
Lewes Road
Brighton
BN2 3QB

Dear Miss Hamilton-Deeley

Re Danuta Corbett

I am writing further to your report, written pursuant to the Coroners & Justice Act 2009 and the Coroner's (Investigations) Regulations 2013, regarding the Inquest in to the very sad death of Danuta Corbett.

The concerns your report highlight relate to our policy for leave for non detained patients and, specifically, how staff managed the leave that had been agreed for Danuta from 1 November 2013, and how the plans made on 4 November 2013 were recorded.

We acknowledge that despite having planned to support Danuta to return home over that weekend to collect some belongings, this did not happen. The primary reason was due to difficulty releasing a member of staff during what was an extremely busy weekend. Clinicians understand that leave can be an integral part of a person's care plan and so when a patient needs to be supported by a member of staff then every effort is made to facilitate this.

It is with much regret that the record keeping on Monday 4 November 2013 was so poor. Neither the detailed assessment carried out by the consultant during the ward review, nor the assessment completed by the nurse in charge shortly afterwards, were properly documented. This is a requirement of the leave policy, and a fundamental part of good clinical practice.

The consultant psychiatrist has learnt a great deal from this experience. She now carefully reviews the notes taken during ward review, which are typically scribed by the junior doctor present. As you heard at the Inquest, the nurse did not make a note at all. This was because the incident happened shortly after her assessment and she was so distressed by what happened that she went home and did not return to work for several days. It is quite normal for nursing staff to write in patient notes toward the end of the shift. However, on her return the nurse ought to have written a clearly marked retrospective note. She did not do this after being advised at the time by the acting Matron that this was not appropriate. We have since reinforced with staff that should these quite extraordinary circumstances arise again then a retrospective note must be completed.

Finally, it is clear that the communication with the agency nurse who was accompanying Danuta should have been much better. The nurse responsible acknowledges this and will always ensure proper handovers take place in the future.

[redacted]

It seems unlikely that any of the shortcomings highlighted by this very sad case would have prevented the tragic outcome. However, all the staff involved in Danuta's care have carefully reflected on what happened and used the learning to improve their practice.

I hope this information is helpful and I confirm that we have no objections to it being shared or published by the Chief Coroner.

Yours sincerely,

[redacted]

Lisa Rodrigues CBE
Chief Executive