Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

Direct Line: [redacted]
Fax:
Email:

[redacted]

13 October 2014

By email: [redacted]
Andrew Tweddle LL.B.
H M Senior Coroner for County Durham and Darlington
H M Coroners Office
PO Box 282
Bishop Auckland
County Durham
DL14 4FY

Dear Mr Tweddle

Regulation 28 Report in respect of the death of Mr Jeffrey Gash

Thank you for your Regulation 28 report dated 18 August 2014 in respect of the above individual and your findings from the inquest into his death. I have tried to address each of your concerns in turn below, and have summarised key actions (with timescales) in the appended action plan.

1. **The Crisis Team nurse accepted in evidence (that she) should have been more forceful and detailed in exploring with the deceased his new symptoms, auditory hallucinations and hearing voices which evidences a lack of training and understanding of the nature of and importance of an appropriate level of telephone assessment.**

   As you have described, the individual nurse involved in the care of Mr Gash recognised in the inquest that she should have been more detailed in her questioning of him in relation to specific symptoms. This individual has, since the inquest, spent some time reflecting on this with her clinical supervisor. In addition, from September 2013 to January 2014 the individual nurse went through a period of informal capability management. During this time she did not undertake the shift co-ordinator role responsibilities and worked all shifts alongside a more senior and experienced member of the team. She observed best practice assessments and then her assessment practice was observed and

evaluated. Once the observing expert clinician, Advanced Practitioner and Team Manager were all satsified that she had acheived the appropriate levels of competence she was able to resume the shift co-ordinator role.

Since that time, periodic checks of her assessments (and assessments done by the rest of the team) have been undertaken by the Consultant Psychiatrist to provide assurance that they are of appropriate quality. This has also enabled us to provide specific feedback to staff as needed to help them develop and improve. We are now assured that the individual nurse has increased her competence and knowledge in telephone assessment skills together with an overall improvement in team performance.

2. **No evidence was provided at the inquest to indicate a formal Trust policy on when to decline home visits on the grounds of personal safety and security and the nurse relied upon being told of concerns about visiting this property from colleagues but did not record the same or any explanation for her decision. The absence of a clear policy and a policy for recording decisions made or understanding and training thereon is an area of concern.**

In relation to your specific comments about Trust policy, the Trust Clinical Risk Assesment and Management (CRAM) policy outlines the responsibilities for staff to determine potential risks and the need to document these within the clinical record. The risks identified in relation to visting Mr Gash at home should have been assessed within the gudiance provided by that policy and recorded in the clinical record. Decisions about making lone or accompanied visits to the home should have been recorded in the clinical record and the processes in the Trust Health and Safety workbook also provide guidance on assessing whether a home visit is appropriate or not.

The Trust also has a Lone Working Procedure which should be completed for all staff who may in the course of their duties have periods where they are working alone including in the context of a high risk visit. This is to some extent addressed within the SUI report where it is documented that a more assertive approach may have helped within the engagement findings. The policy lead for these areas will be asked to review the relevant policy against your findings and ensure that these are fully taken into account and an implementation plan produced accordingly.

In relation to recording the information from colleagues, and the individual nurse's decision making on the shift in question, there is already an 'alerts' section in our electronic care record which staff are asked to use to document risks in a way that this information is available to all staff working with a specific patient. The Team Manager has previously highlighted the importance of recording this with the team, but since Mr Gash's inquest has further reinforced this via team meetings. In addition, the Head of Service for Durham and Darlington AMH Services has asked the Crisis Team Manager to share your recomendations with the Specialty's Acute Care Group in order that the Trust standard operational policy for Crisis Teams can be strengthened accordingly.

I also acknowledge the conclusions from the inquest that further options may have been available in the absence of Mr Gash agreeing to see the crisis team at the hospital base, and indeed am aware of instances where staff have used alternative venues for appointments. Staff have been reminded of the need to explore and utilise alternative appointment venues.

3. **Notwithstanding the fact that the deceased declined to attend the hospital for a face to face interview, insufficient weight was given to the reason therefore and whether domestic and other pressures were militating against him attending were not properly considered, if at all.**

4. **Given that there was an insufficiency of enquiry into the deceased's state of mind and in particular a failure to further explore the issue of him claiming to hear voices, an inadequate assessment of risk was undertaken and it was accepted by the Trust in evidence that there ought to have been a face to face consultation with the deceased and that had he not agreed to it voluntarily, then there ought to have been a compulsory assessment**

   Since Mr Gash's sad death, the individual nurse has critically reflected upon this at length with the team manager during her period of informal capability management described under point 1 above. I agree that more in-depth exploration of his reasons for not wishing to attend should have been undertaken. The Trust Did Not Attend policy does highlight that the nurse should have contacted the GP immediately to agree a management plan, in situations where high risks have potentially been identified. As noted above, the individual nurse has undergone a period of observed practice such that the Advanced Practitioner and Team Manager are now satisfied that she would now manage this situation differently, in that issues would be explored in more depth. We are also confident that she would now, and has been shown to, use colleagues within the team for additional opinions, and make better use of medical staff for consideration when a formal assessment under the Mental Health Act may be requried. Your recommendations in relation to this have been shared with the team as a whole to ensure that their practice reflects the specific actions we have completed with the individual nurse.

5. **The clinical risk assessment and management policy document (version 5) which was presented in evidence fails to clarify the nature and detail of what form of risk assessment needs to be completed when a non in-person face to face is being undertaken. Thus, the notes entered on the PARIS system were unclear as to their author's view of the risk of self harm where it was accepted in evidence that full details of the assessment of risk and its conclusion are central to the crisis team process. The Trust has carried out an SUI. Certain recommendations have been made and are implemented. The inquest, however, as evidenced above, revealed other issues not dealt with by the SUI and therefore a complete re-evaluation of the deceased's contact with the Trust should be undertaken taking into account the evidence given at the inquest so that a complete overview of Trust policy dealing with the above matters and any other such review might uncover can be considered by management and if agreed, implemented.**

A further review of the Trust's contact with Mr Gash will be undertaken, incorporating other matters arising from the inquest. The review will include the efficacy and relevance of the current Trust policy guidance and an analysis of compliance with that guidance included in the review.

A Trustwide review of the clinical risk (CRAM) policy and practice is currently underway, with initial reports due in the spring; the information from this Serious Untoward Incident investigation and the inquest will be fed into that review.

Further training and development in suicide prevention is planned for early next year. Implementation plans for the new policy and the training will be evaluted to ensure compliance.

In conclusion, the Adult Mental Health Directorate had begun several pieces of improvement work prior to the inquest to address some of the concerns, and can only apologise if these were not clear through the evidence given by staff. However there are also a number of Trust-wide issues highlighted through the inquest process which will take a little longer to fully address. The implementation of the actions relating specifically to issues within the gift of the Adult Mental Health Directorate within the action plan attached will be monitored via the Directorate's Quality Assurance Group on a monthly basis to ensure completion. In addition review of the effectiveness of the actions, and policy compliance will be reported to the Locality Management and Governance Board. Any Trust-wide actions identified will be allocated to an appropriate action plan owner and monitored by the Patient Safety Team by their governance processes to ensure they are completed to an appropriate standard.

The Diretorate Quality Assurance Group processes will also ensure that the lessons from this case and associated learning are shared across other in-patient areas and crisis teams in order that they can assure us that similar issues should not occur elsewhere. The Trust has corporate processes to both monitor completion of serious incident action plans and to audit the effectiveness of those actions in creating change and improvement.

I hope that the information contained here, and in the amended action plan attached, provides you with the necessary assurance you require.

Yours sincerely

[redacted]

Martin Barkley
Chief Executive