Surrey and Borders Partnership NHS
NHS Foundation Trust

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Private & Confidential
Mr Richard Travers
HM Coroner for Surrey
Coroners Court
Station Approach
Woking
GU22 7AP

Friday, 16th January 2015

Dear Mr Travers

Inquest into the Death of Mr William Hafele
Regulation 28 Report – Action to Prevent Future Deaths Response

Further to the conclusion of the inquest into Mr William Hafele's death on 10th November 2014, you wrote to Surrey and Borders Partnership NHS Foundation Trust in accordance with Regulation 28 report to prevent future deaths, stating that during the course of the inquest the evidence revealed matters giving rise to concern.

We would, firstly, like to take this opportunity to offer our sincere condolences to Mr Hafele's family for their loss.

The areas of concern you raised that relate to our Trust and our responses are detailed below:

Training procedures, in respect of the Police and hospital staff on Elgar Ward, in the case of reports of missing persons. Critical information required to make an informed risk assessment as to whether HW was missing or absent was omitted. There was a lack of understanding of areas of responsibility and appropriate actions.

We have further emphasised the importance of the Missing Persons (MISPER) process to all our staff on these units, including making this a part of our improvement work in the reduction of the numbers of people who may be Absence Without Leave (AWOL). A member of the Clinical Assurance team is specifically assigned to wards with the view to ensure compliance with the MISPER agreement is tested.

Staff have been further clearly instructed to complete Appendix A of the MISPER agreement. This outlines details such as name and location of the unit reporting the missing person, the risk assessment zoning and clear justification for the category, personal details of the person who may have gone missing with an option to attach a

photo and description of general appearance. To ensure that relevant information is recorded and reported to the Police as part of the missing persons report, it is now expected practice for all staff to ensure that they upload this document onto our Electronic Patient System (RiO) in a timely manner. This will now be audited for completeness.

The decision to reclassify from missing to absent was not communicated to the hospital, as a result no enquiries or investigations were made by any agency to ascertain Mr Hafele's whereabouts. Ineffective communications between the Police and Elgar Ward.

A flow chart clearly outlining the process to make inquiries further to a missing persons report to the Police has been developed. It contains clear directions on the process that needs to be undertaken when someone has not returned to the ward. This standardisation of approach will support staff in making enquiries or investigations when a person using our services goes missing from the wards.

Adequate training on the Surrey Wide Response Agreement and Surrey Police Missing Person Procedure did not take place.

We have enhanced our focus on reducing the number of people who go missing from our wards and we believe the work we are doing through our improvement team as outlined in our Quality Improvement Plan will start to show positive results. We have a close working relationship with Surrey Police which has further been strengthened through the Crisis Concordat work we are doing. This is also providing the opportunity for us to learn together on aspects on which we can improve.

The MISPER agreement has been widely discussed in teams and presented at our managers meetings on a number of occasions. In addition mandatory training has now been arranged for all staff within the unit to be completed by the end of February 2015. To further ensure embedding of the process, we will now require our ward managers to undertake a quarterly audit on MISPER forms Appendix A & B and any emerging issues are discussed at our Acute Care Forum meeting.

We have included the concerns you have raised in our corporate action plan to ensure that there is ongoing learning from these. We would like to offer our sincere condolences again to the Hafele family for their loss and hope that the steps we have taken as outlined above assures you and them, that we have learnt and continue to learn from this event.

Please do not hesitate to contact me or [redacted] Director of Quality (DoN) if you require any further information.

Yours sincerely

[redacted]

Signed in the absence of Fiona Edwards by [redacted] Director of Quality and Deputy Chief Executive.