Dudley and Walsall Mental Health Partnership NHS Trust
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DY2 8PS

Margaret J Jones (Assistant Coroner)
Coroner's Office
No 1 Staffordshire Place
Stafford
ST16 2LP

RE: Amanda Hawkins Deceased
Ref: [redacted]

Thank you for your letter dated 26th November 2014 following the inquest into the death of Amanda Hawkins.

The Trust has taken the opportunity to carefully review the Regulation 28 report issued following the conclusion of the inquest into Miss Hawkins' death and, as an organisation; we are now in position to provide a full response.

Firstly we would like to reiterate our very sincere condolences to Miss Hawkins' family. The death of someone close is always hard to bear, even more so in such tragic circumstances and as a Trust we are extremely sorry for the distress that the Hawkins family must be experiencing. We would like to reassure you that upon hearing of Miss Hawkins' death, the Trust launched an immediate and thorough incident investigation which looked at all of the relevant events leading up to this tragic event. The purpose of this investigation was to help us to review the services provided and establish if there were any lessons to be learned as a result.

In addition to this investigation, the organisation also conducted an investigation (in line with the Trust's Complaints Management Policy) after it was initially reported that Miss Hawkins had gone missing.

If you would find it helpful, the Trust would be happy to provide you with a copy of the completed investigations once they have been finalised.

<u>First concern</u>

Within your letter dated the 26th November 2014 you raise 2 points of concern. The first of these is that:

"The moves following closure of various homes or changes in funding and step down in services offered to Amanda resulted in her increased vulnerability".

As part of the requirements of Miss Hawkin's care package, she resided at a number of different placements since the need for a supported placement first arose after her admission to St Matthews Hospital, Burntwood in 1990. Her longest duration supported placement commenced in November 1991, whereby she resided at Pinfold House, Darlaston until the closure of this facility in 2009. As a result Miss Hawkins was transferred to Oak House, Walsall a supportive living placement provided by Caldmore Housing, where she remained until this residential home was also closed in October 2011. In response to the closure of Oak House, Miss Hawkins' placement

was transferred to Lonsdale House where she remained until her care was transferred to Moxley Court in 2013.

The investigation/review highlighted that at the time of her placement it was appropriate for Miss Hawkins to reside at Moxley Court as it was felt that the step down in placement was clinically appropriate for Miss Hawkins. She had previously had a consistent care team (from CRS South) with who she generally engaged well with. The clinical appropriateness of this step down is further supported by the fact that Miss Hawkins was assessed as being able to maintain her own safety in the community without the need for further assistance in this regard.

Our staff undertake individualised risk management in respect of each individual patient. This requires a fine balance between maintaining patient safety, whilst at the same time gaining the patient's trust to build up therapeutic relationships and independence so that their care can be managed in the least restrictive setting. We have to manage this balance between care and control carefully and it is fundamental to our practice that we can continue to make individualised judgement calls for each and every patient as part of the clinical decision making process.

Miss Hawkins was being seen at least twice per day by staff at Moxley Court and having 10 hours of dedicated time per week from the staff based at the placement. It was known that Miss Hawkins had a long history of leaving the placements that she resided in and there had been occasions where she had failed to return to her placement, as agreed, at Pinfold House, Oak House and Lonsdale House. At the time of her disappearance from Moxley Court, Miss Hawkins, her family and her care co-ordinator had a consistent plan in place of how to manage occasions when AH failed to return to her placement in the evening.

It is the Trust's view that in cases where there is a history of patients spending a prolonged time out of the placement they reside in, it will be the responsibility of the panel responsible for the allocated funded package of care to develop a risk assessment. The risk assessment would aim to identify how the risk of the patient not returning to the placement could be mitigated and identify what further support can be provided to the patient to enable effective engagement with the community services in a safer and more supportive manner.

The investigation / review recommended that where step down to 24 hour care provision is being managed through the panel process, utilising placement providers to manage an increase in independent living, the care plan should:

1. Identify the rational for a change in care provision;
2. Identify the amount of clinical time required to support the patient effectively;
3. Identify the time allocation and level of input being provided by the placement provider; and identify the time allocation and level of input being provided by staff representing the Trust.

The investigation process also identified that consideration should be given as to whether it is appropriate for the transfer of care to a new team to take place when patients move placements, or whether responsibility should remain with the existing team (for an initial period of time at least).

<u>Second concern</u>

In respect to your second point of concern:

"That Hospital appointments were sent to Amanda at her home address when she did not have sufficient understanding to deal with correspondence and that care co-ordination workers were not made aware of missed appointments and that there was therefore no follow up and that the lack of follow up led to her increased vulnerability".

As part of the Trust's investigation into the circumstances around the death of Miss Hawkins, the issue of missed appointments and the associated follow up was looked at in some detail. The Trust concedes that Miss Hawkins was known not to respond effectively to correspondence and

did not always keep outpatient appointments, however, in the main she generally engaged well with services, although at times she did not attend appointments. This was particularly evident with regards her outpatient appointments following her transfer to the North Sector CRS, with Miss Hawkins failing to attend appointments on 11th September 2013, 13th November 2013, 19th February 2014 and 21st May 2014.

The Trust utilises the Oasis electronic system which logs and records appointments and instances when patients fail to attend. The Trust does however acknowledge that letters from North Community Recovery Service (CRS) medical teams were not copied to the care coordinator or placement provider for them to be aware of the appointments that Miss Hawkins did not attend and therefore no subsequent follow up was made. This is acknowledged as an area of improvement for the Trust which will be managed through the Trust's embedding lessons processes. Therefore, going forward within CRS North outpatient letters are now copied to the care coordinator and in addition to this, the Trust has convened a Working Group to look at long term solutions to this issue; this Working Group is being led by the Trusts Head of Recovery Services.

Where appropriate, consideration will also be given to copies of such letters being sent to placement providers, however this would need to be done in line with existing policies regarding consent and the sharing of information.

Furthermore where patients receive care as part of a placement, the care plans for such patients should indicate how the patient will attend outpatient appointments and whether anyone needs to attend with them and who this will be. It is the aim of these two changes to ensure that all care professionals are aware of non-attendance of appointments and that this will ensure that there is effective follow up.

If you require any further information in respect to the case or should the family of Miss Hawkins require any further information or support in respect to the investigation into Miss Hawkins death please do not hesitate to contact the Trusts Clinical Governance Department on 01384 65200

I hope that this response adequately addresses the matters of concern raised in your letter and please do let me know if I can be of any further assistance.

Yours Sincerely

Gary Graham
Chief Executive Officer