PRIORY

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Tuesday 20 January 2014

Private and confidential

Mr Andrew Tweddle
HM Senior Coroner for County Durham and Darlington
HM Coroners Office
PO Box 282
Bishop Auckland
Co Durham, DL14 4FY

Dear Mr Tweddle

Re. Mr David Peter Greenfield (deceased): Regulation 28 Report

I write to you further to the Regulation 28 Report which you have issued to the Priory Group in response to your investigation into the death of Mr Greenfield. Your investigation concluded on Wednesday 26 November 2014 and you found that Mr Greenfield had died unexpectedly as a result of his pre-existing natural heart disease combined with respiratory depression linked to obesity and the effects of the ingestion of drugs.

You have raised two particular issues of concern in your Regulation 28 Report. I have outlined these issues together with our response:

1. You have identified that not all of the staff who cared for Mr Greenfield were sufficiently experienced in dealing with patients who had both drug and alcohol problems. The risks of respiratory depression in patients such as the deceased were not fully appreciated.

   I hope that you will be reassured to learn that we have, in response to Mr Greenfield's death and your Regulation 28 Report completed an audit of the competencies of the medical staff working in our specialist wards such as those which provide a detoxification service. The audit has been led by the Priory Group Medical Director [redacted]. Where necessary staff have been transferred to other wards or provided with additional training in the very small number of cases where we have identified individuals have who do not have the full suite of competencies that we would expect.

We are taking increasing account of the risks to physical health where there is a co-morbid substance misuse and mental health problems. For example we are ensuring that a full baseline physical health assessment is in place at the point of admission and that potential physical health complications feature more prominently as part of the on-going risk assessment process.

With regard to the staff at Aspen Ward, Priory Hospital Middleton St George I hope that you will be reassured to learn that we have introduced a comprehensive training programme for them. The training provided to date has largely consisted of refresher training. We are in the process of sourcing and arranging more advanced level training as a means of ensuring high levels of expertise among the staff team.

Additionally I hope that you will be reassured to learn that the Priory Group has amended policy (H21) Non Medical Prescribing to include greater reference to the qualifications and experience of those non-medical staff who are prescribers together with a more detailed outline of the required competencies and the elements of professional development that need to be in place before staff are permitted to prescribe.

2. You have identified that patients who are admitted for alcohol detoxification are not necessarily screened for drugs. You have also pointed out that staff cannot be entirely certain whether a patient has drugs in his /her system due to the limitations in the risk assessment process and the possibility that patients may withhold such information.

   We are in agreement with you that we should routinely use urine drug screens across all of our detoxification services as part of the assessment process and where necessary on an on-going basis thereafter. Since the inquest we have reviewed this practice and learnt that a number of hospitals are routinely undertaking urine drug screens on those patients who are admitted for alcohol detoxification. Our intention is to ensure that our hospitals all have access to urine drug screening kits and that staff are aware that a test should be undertaken if there is any indication that the patient may be at risk of using illicit drugs prior to or at the point of admission. Our intention is to ensure that these kits are readily available at relevant hospital sites by the end of February 2014.

   I hope that you will be reassured to learn that the lessons learnt in respect of your investigation into the death of Mr Greenfield will be shared at the forthcoming Priory Group Consultant Psychiatrist Conference which is to be held on Monday 19 January 2014. We will also take the opportunity to integrate the lessons learnt from this tragic incident into our on-line training modules (this is an on-going piece of work however the relevant training modules are all due for review in spring 2015). We will also take the opportunity to raise these matters as part of future safety bulletins and at our internal meetings and conferences for example the lessons learnt from this case were presented at our Medical Directors Meeting which took place on Monday 19 January 2015.

I hope that this response provides you with reassurance as to the actions that we have taken and those that we are intending to take to reduce the possibility of an incident of this kind happening in the future.

Please do not hesitate to contact me if I can provide you with further advice or assistance in respect of this matter.

Yours sincerely,

[redacted]

[redacted]
Director of Safety

Copies to:
[redacted], Hospital Director: Middleton St George Hospital
[redacted], Director of Quality, Priory Healthcare Division
[redacted], Group Clinical Risk Manager