Norfolk and Suffolk NHS
NHS Foundation Trust

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28 JAN 2015

Our ref.ml/mp

21 January 2015

Ms J Lake
HM Coroner
Norfolk Coroner's Service
69-75 Thorpe Road
Norwich
Norfolk
NR1 1UA

Dear Ms Lake

Regulation 28 report following the inquest of Ms Jo Anne Nobbs on 3 December 2014

I write in response to your report dated 4 December 2014. Under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 you requested the Trust consider issues of service delivery following the conclusion of the inquest into the death of Ms Jo Anne Nobbs on 3 December 2014.

You identified a matter of concern relating to a correlation between Miss Nobbs' deteriorating physical and mental health, observing this was noted by some professionals but not investigated by the mental health team. This was despite Miss Nobbs attending the A& E department at Norfolk and Norwich University NHS Foundation Trust on at least 10 occasions between January and March 2014.

The reason for this was that the Community Mental Health Team was unaware of the frequency of Ms Nobbs' attendance at the acute hospital during this period. It is understood these attendances were in relation to her physical health and the acute hospital may not have assessed there to be a potential mental health need. Where an individual presents at the acute general hospital and there are possible mental health needs the Trust has an established Psychiatric Liaison Service, based in the hospital, to assist with assessment. In completing an assessment the Psychiatric Liaison Service can signpost patients to a range of services or refer them into the Trust's secondary care teams. They provide the GP and the Community Mental Health Team with a record of their contact. The Liaison Service saw Ms Nobbs on single occasions in 2012, 2013 and on 6 January 2014 following referral from the acute hospital.

Given the lack of contact with Ms Nobbs, the care coordinator was in the process of arranging a professionals meeting to consider next interventions, when they were informed of her death.

You additionally raised the concern regarding the absence of a changing plan when Miss Nobbs disengaged from services from March 2014 onwards. Notably, Miss Nobbs was not seen by the team from March to her death in June, save for a sighting of her in May by one of the team's support workers.

The Trust's internal investigation identified this was a matter of concern observing the clinical team did not follow Trust policy. This policy provides guidance for staff in the event of missed or cancelled appointments. The report made recommendation that work was undertaken with the team to improve this area of practice. I confirm the team have completed the recommendation. They have been refreshed on the Policy and provided evidence they are discussing missed appointments in their weekly clinical team meetings. We will be sharing this learning more widely within the Trust, via our Patient Safety Newsletter and internal forums.

If I can be of any further assistance please do not hesitate to contact me.

Yours sincerely

pp Michael Scott
Chief Executive