Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

Medical Director/Consultant Psychiatrist
[redacted]

Secretary [redacted]
(Direct Line) [redacted]
Email: [redacted]
The Opal Centre, Tickhill Road, Balby, Doncaster, DN4 8QN

Our Ref: [redacted]

27 April 2016

PRIVATE & CONFIDENTIAL

Mr M A Beresford
Assistant Coroner
South Yorkshire (East District)
Coroner's Court & Office
5 Union Street
Off St Sepulchre Gate West
Doncaster
DN1 3AW

Dear Mr Beresford

Re: **Jason Derek Vaughan (Deceased)**
24.10.1971 – DOD 23.09.2015

I write in response to your letter dated 11 March 2016 addressed to my Chief Executive, Mrs Kathryn Singh.

I am writing in my capacity as the Medical Director for the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and on behalf of the Chief Executive.

You commenced an investigation into the death of Mr Vaughan on 25 September 2015 and concluded matters on 4 March 2016. In your letter dated 11 March 2016 you enclosed a Regulation 28 report addressed to the Chief Executive.

In Section 5 of your Regulation 28 report you highlight your concerns.

In Section 7 of your Regulation 28 report you ask for a formal response from the Trust within 56 days of your 11 March 2016 Regulation 28 report. You have highlighted 29 April 2016 as the date by which you would expect to receive the report. With all due respect I believe that the 29 April 2016

date is a little short of the 56 days in which we are required to respond but I hope that our haste in supplying you with the relevant data shows that we are committed to providing you, and therefore the public, with a timely response given the seriousness of the matter.

You have outlined three matters of concern and I wish to provide you with a response to each of them starting with an exact facsimile of each concern you raise.

1. ***The effectiveness of the IAPT electronic patient clinical records system (SystemOne) may be limited, in some instances, by there being inserted insufficient written narrative detail (e.g. as to medication commencement dates, doses, changes etc.) to accompany the coded data entries in the drop down box selection.***

   SystmOne (the software title does not have an 'e' where one would normally expect it) is a widely used electronic patient record system within the National Health Service. It is used by many NHS Trusts and General Practitioners.

   With the highly desirable move from paper based records to electronic systems in the NHS we now have the ability to access data quickly, from multiple sites, without the vagaries of handwriting interpretation.

   However, regardless of the sophistication of any recording system in healthcare, it is only as good as the data that is inserted into it. Clinical record keeping is a corner stone of safe and effective health care. In addition it demonstrates to patients what has been discussed and actioned. Adequate record keeping is a priority for this organisation. However I fully accept that there are going to be times when even the best practitioners will make records which, with hindsight, are not at an accepted standard. In addition from time to time there will be practitioners who have a more global issue with clinical record keeping. It is hoped that we have systems in place through supervision and learning from incidents in order to minimise the risk of this occurring. This is a risk that is universal in all healthcare organisations.

   Electronic systems can support adequate record keeping but ultimately it still depends upon a staff member to input data. In your Regulation 28 report you gave examples regarding medications management. Recording adequate data regarding medication management is absolutely key in healthcare. This is because it is an essential part of the management of the majority of patients with severe mental disorder, and often plays a part in those with less severe mental health conditions. All medications have side effects, some of them serious. It is for this reason that I would agree with you wholeheartedly that recording adequate data regarding medications management is essential. However there does not appear to be a systemic issue with the SystmOne tool which prevents the recording of invaluable data.

   The Trust is in the middle of a multi-million pound electronic patient record procurement. We hope that in 18-24 months we will have a record system that offers further improvements to the way we deliver healthcare within RDaSH.

2. ***The existing IAPT risk assessment tool utilises a numerical rating system which has, as its starting level 1, "things feel so bad that you think about killing yourself", and which does not allow for the recording of a less threatening position, thereby not providing a means of reflecting a deterioration, is a patient's state of risk, over time, to the current Level 1 status".***

   The IAPT risk assessment tool is one part of the overall assessment and record keeping process in the IAPT system. As with all risk assessments, it is the global assessment through triangulation of data sources that allows for accurate decision making. A risk assessment in

itself is simply one component of this and must never be seen to replace overall clinical judgement.

The IAPT risk assessment tool was formulated by York University and is a well-recognised tool with a robust evidence base that is used by most if not all IAPT services.

I have enclosed some examples that have been written by a practitioner in the Doncaster IAPT Service that might add some narrative richness to the explanation as to how the risk assessment tool forms only one part of the clinical interview. In the enclosed scenarios, the practitioner has developed three situations:

A patient who is

- Low-risk
- Intermediate risk
- Higher risk

In each section I hope you will be able to see how a risk assessment tool would lead to further discussion with the patient during each clinical encounter and that there would be a very clear expectation that the practitioner would provide a narrative account at the end of the assessment. The risk assessment tool is not there as a rating scale as such and the points within it are not to be regarded as such. The questions do not form part of an escalation of risk protocol but a system that has been designed to facilitate a clinical discussion. I hope that the scenarios allow you to see what might occur in an interview if a patient were to give certain responses.

The patient risk is managed during each and every clinical encounter involving a practitioner within the IAPT Service. This ensures that dynamic factors are responded to.

In addition I have taken the liberty of providing you with the following documents:

- Guidance on referrals to Improving Access to Psychological Therapies (IAPT).
- IAPT Operational Policy.
- Action Plan following SI 2015/31212.

The action plan highlights how the IAPT service continually appraises the effectiveness of any tools it might use. In this case the Service Managers have been actively considering an alternative tool called the 'Columbia Suicide Severity Rating Scale'. After proper deliberation the services have elected not to use this tool because they do not believe it would offer improvements compared with the current system. Again for the avoidance of doubt, I wish to emphasise that any tool used would simply add value to robust clinical decision making based on data from a number of sources including clinical interview. We would never manage risk solely based on any tool regardless of how effective it was deemed to have been in research studies.

3. ***It may not be universally recognised by all mental health practitioners, that the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2015) has identified an increasing number of suicides amongst middle aged males and also socio-economic factors becoming increasingly common in suicides.***

In the enclosed action plan SI 2015/31212, you will see that the IAPT Teams have been involved in three separate workshops where the findings from the Confidential Inquiry into Suicides and Homicides were discussed.

In addition we have continued our overall Trust Education Programme by developing a newsletter which will go out to all mental health practitioners within the organisation summarising some of the risk factors involved in completed suicide. I have enclosed this for your information as it focuses on the issue of suicide in middle aged men. In addition this will be noted in an email that is sent from our Communications Department to all practitioners within the Trust.

Although suicide is a terrible and tragic event, it is still relatively uncommon when one considers the prevalence of mental health disorder in our communities. In the scenario you asked us to focus on, namely the increased risk of suicide in middle aged men, we treat many individuals who would fall into this category. Very few of them indeed will go on to commit suicide, thank goodness. Consequently, simply identifying this factor alone would be difficult to translate into a suicide prevention act. However, this factor, along with other risk factors (e.g. substance misuse, recent life event, chronic pain condition etc) would focus practitioners on taking a particular interest in a person's history to ensure that adequate assessment occurred.

The Trust is part of a national movement called 'Sign up to Safety'. The Trust has chosen five priority areas to focus on, one of them being reducing the number of annual suicides to zero if possible. We are going to re- launch this campaign having had a very successful initial start. I can provide you with details regarding this important safety intervention should you want to know more.

I hope that my response adequately addresses all three points you raise in your Regulation 28 report. If you feel that any points require clarification or further attention, please do not hesitate to contact me either directly or via the Chief Executive's office depending on how you would like to maintain communication channels.

I have met Ms Mundy on a number of occasions and I have found it very helpful. If you wish to have your own meeting with us, or whether you would like to be included in a joint meeting with Ms Mundy in the future, please let me know.

Yours sincerely

[redacted]

Executive Medical Director
Consultant Psychiatrist
In Substance Misuse
And
Director of Research

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