Kent and Medway NHS
NHS and Social Care Partnership Trust

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Christopher Morris
Assistant Coroner for Central and South East Kent
C/O Senior Coroner for Central and South East Kent
Elphicks Farmhouse
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Kent
ME15 0SB

By post and email

Dear Mr. Morris,

Julie Margaret Rose deceased
Regulation 28 – Prevention of Future Deaths Report

I refer to your letter of 14 December 2015 enclosing the Prevention of Future Deaths Report, arising out of the inquest into the Death of Julie Margaret Rose, which was received by my office on 22 December 2015. I am most grateful for you bringing these matters to my attention. I am also very grateful for you having agreed to an extension for the Trust providing its response as it now means that I am able to confirm what action has been taken.

In your letter you set out the following concerns, which I will deal with in turn.

1. **Although the Trust's Unable to make Contact Protocol ("the Protocol") had been reviewed since Miss Rose's death, I am concerned that it is insufficiently clear as to when the Crisis Resolution Home Treatment Team members should request a police welfare check in respect of patients who have been identified as 'Red' for the purposes of the Trust's R A G rating system.**

   In particular, I am concerned the Protocol does not specifically stipulate circumstances where a request for a welfare check is mandatory (for example, after a certain period of time has elapsed since contact was last, and/or after a certain number of attempts at contact and/ or after attempts at telephone contact and a home visit have been unsuccessful.

   i) I am aware that at the inquest you heard evidence from [redacted] Acting Assistant Director for East Kent Acute Mental Health Services about the considerable efforts the Trust had begun implementing to mitigate the risk of similar deaths occurring. Following the inquest, the Trust continued in this work in addition to taking further steps, in particular, making changes to the 'Unable to Make Contact' Protocol. The Protocol has been subject to a further

review and amended. I enclose a copy of the new Protocol which is now in use and which is subject to a three month pilot.

ii) You will note that that the new Protocol gives clear guidance to staff, setting out details of the steps that they must take when a service user has missed a planned contact/call with the Crisis Resolution Home Treatment Team (CRHT), starting from those required within the initial hour.

iii) The protocol highlights the importance of involving family members, friends, carers and other professionals where a concern is raised to try to make contact and to gain collateral information.

iv) The next step is for a risk assessment to be reviewed and a plan of next steps agreed. Where following these initial steps (including contacting family) has occurred but they have still been unable to make contact, the Protocol requires that the team make a home visit and take the risk assessment with them.

v) The protocol is clear that if no contact is made then staff must attend the home address as soon as clinically indicated and that staff should prioritise workloads accordingly, based on risk assessment and taking with them a hard copy of the most recent risk assessment. Staff may want to try to arrange to meet a carer or next of kin at the address that may have been previously agreed, as a means of accessing the address.

vi) If, after attendance at the service users home, they still cannot be reached, they have the option of asking the Police for support. Staff will need to do that via a 999 call where the risk indicates the need for this, and wait for police at the scene with the risk assessment hard copy to share with them.

vii) The new Protocol needs to be read in conjunction with the recently finalised 'Acute Service Line Welfare Check Protocol' which is a document that has been jointly developed with Kent police. A copy of this is enclosed for ease of reference. The 'Welfare Check Protocol' is applicable to in-patient's and people under the care of the Crisis Resolution Home Treatment team.

viii) The priority and focus is that the right people with the right information will take urgent steps to reach the service user. This may or may not be with the assistance of the police and there is an expectation by the police that we as a Trust have taken all necessary steps to make contact first.

ix) The 'Welfare Check Protocol' describes how Police will carry out a 'welfare check' when a request is made to police about an individual, if it is an emergency and there is a real concern that something serious is about to, or has already, occurred to the relevant individual on those premises.

x) The police will respond because it enables a professional intervention if an individual is in need of immediate assistance due to a health condition, injury or some other life threatening situation. Unless this threshold is reached, police have no duty, and therefore no power, to take any action once outside those premises.

xi) This is why the Trust 'Welfare Check Protocol' now focuses on the up to date information on risk, being available to those who attend properties in an attempt to establish contact.

2. **In the course of the hearing, I heard evidence that the Protocol has been 'reinforced' across the Crisis Resolution Home Treatment Team. Notwithstanding this, a shift coordinator who gave evidence was clearly not conversant with the Protocol, raising questions as to the adequacy of the steps taken by the Trust to date in this respect.**

i) Louise Clack, who was the senior member of Trust management at the inquest has briefed about the evidence given by the shift coordinator. The lack of conversance with the policy was disappointing. An immediate action from this was taken to ensure that the contents of the policy are highlighted to staff in shift handovers and team meetings, and where necessary, for this to be dealt with during individual supervision.

ii) There have also been recent changes in the structure of the Crisis Resolution Home Treatment teams, meaning that there is an experienced practitioner in the form of a clinical manager who are on shift for extended hours, including up to midnight and at weekends, that operational staff in the CRHT can seek advice from. This is in addition to the On Call Manager and Consultant rotas that were already in place.

iii) The new 'Unable to Make Contact' Protocol was launched at the Acute Leadership Forum, with training given on 8 March 2016, cascaded to all CRHT teams. This has also been circulated to all matrons and managers and training is being provided at minuted team meetings. It has also been highlighted in the Acute Service Line Lessons Bulletin. The same process was used to launch the Acute Service Line Welfare Check, which has been effective.

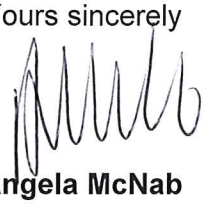
iv) The new Protocol is being piloted in CRHTs trust wide for 3 months to help the teams to understand what changes may need to be made, in order to make this a robust and workable process. All CRHT staff have been asked to provide details to their manager each time the protocol is used during the pilot period with details of how it worked and of the outcome of events so that these can be audited. The outcome of this monitoring will be collated in mid June and will then report back into Patient Safety.

v) The auditing process will also help ensure consistency of use and help us identify if there are any issues relating to the understanding of application of the Protocol with certain staff so that this can be picked up in supervision.

vi) The results of the audit of this pilot can also be fed into the overarching policy that we are currently finalising with the Kent Police to cover all of the Trust's working with them and to ensure a consistent approach based on the identified risk with that employed by the community teams.

I hope that the above shows that the Trust does take very seriously the matters that have been raised in the PFD report and that we are continuing to work hard to deal with these issues.

Yours sincerely



Angela McNab
Chief Executive