NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Private & Confidential
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Email: [redacted]

Date: 20th May 2019

REGULATION 28 REPORT FOLLOWING THE DEATH OF NORA THERESA BRUTON

Dear Mr Hodson

May I please open this letter by expressing my sincere condolences to the family of Nora Bruton and thank you for highlighting your areas of concern to me in relation to the care she received. We have taken your comments very seriously and I detail below a number of actions taken which I hope will prevent future deaths of this nature.

On 17/01/2019 you commenced an investigation into the death of Nora Theresa Bruton. The investigation concluded at the end of an inquest on 22nd March 2019. The conclusion of the inquest was a narrative conclusion as follows:

'Death was by drowning whilst under the influence of alcohol. It was not known how the deceased came to be in the water, nor was it known what her intention was when she entered. Her mental health had declined, which was contributed to by gaps in her care, but it was likely her death could not have been prevented'.

The medical cause of death was confirmed as:

1a) DROWNING

1b) ALCOHOL INTOXICATION

On 15/11/2018, Nora Bruton was found face down in a pond in Babbs Mill Park, Kinghurst, Birmingham by a member of the public who summoned the emergency services, but who subsequently declared her deceased at the scene. Post-mortem and toxicological evidence indicate that her death was from drowning, and that she was under the influence of alcohol at the time of her death. The deceased had a long-standing history of alcohol dependence syndrome and mixed anxiety and depressive disease and was under the care of mental health services. The evidence indicates that there was insufficient assessment and formulation around the impact of increased alcohol on her suicidal thinking and risk to self, as well as there being other contributory factors such as lack of referral to Addiction Services and a lack of communication and accurate recording of crisis calls between the Home Treatment Team and the Community Mental Health Team.

The MATTERS OF CONCERN that you have raised are as follows. –

1. A recommendation contained within the RCA report to carry out a review of the Clinical Risk Assessment training to incorporate clear risk formulation and management around harmful substance abuse, had been carried out, but this has had not been adequately disseminated to clinicians on the ground. Consideration therefore should be given to ensuring proper dissemination of this revised training to all treating clinicians as a matter of urgency;

I am able to confirm that a working group has now been established to devise a pilot of reviewed clinical risk training both in terms of content and the way it is delivered. We are in the final editorial stages of a new Dual diagnosis policy which will be launched across the organisation by the end of July 2019 which also confirms the guidance, policy and practice to be adhered to when treating patients with dual diagnosis. Referral processes from acute care to alcohol and substance misuse providers have now been formalised and the Trust is now formally referring patients to these providers rather than relying on self referral by service users.

2. A review of the protocol for communicating crisis calls to all teams involved in care delivery to ensure a robust system of communication has not been acted upon. I heard evidence that prior to Nora's death there had been two separate incidents which led to significant patient harm and/or death which involved gaps in crisis call communication. Consideration should be given to ensuring this review takes place and the protocol appropriately modified as a matter of urgency;

We have taken the opportunity to strengthen our internal arrangements for communicating crisis messages through the development of a dedicated crisis email address within our Home Treatment Teams. During the hours of Monday to Friday 0900 to 1700 hours, there is dedicated support to manage this system and to allocate calls. This system has been evaluated positively and is now being rolled out to our Community Mental Health Teams.

We have also increased the capacity of our out of hours service by putting a senior clinician (Band 7) on duty each evening from 4pm – 2am to manage and triage activity across our Home Treatment Teams. They take calls as well as assess if additional support is required. Alongside this we have re-organised how calls are taken by administrative staff and handed over with a signature to qualified staff to action.

3. I heard evidence that the Home Treatment Team model was undergoing a process of review and overhaul, and that this process had taken approximately 18 months to date but there was no estimate of when this would be completed by. Consideration should therefore be given as to ensuring that this review is concluded as a matter of urgency and any changes to the Home Treatment Team model are implemented with similar urgency.

I am pleased to advise you that since this inquest, we have increased the capacity of our Home Treatment Teams and are now 'over-recruited' to medical positions (3 instead of 2). We have also increased the nursing resource. We are currently recruiting to new team manager posts and psychology posts to help strengthen the capacity and skill of the team further.

Upon closing this letter, may I please express my thanks to you again for sharing your concerns with the Trust.

Yours Sincerely

Chief Executive Officer
Birmingham and Solihull
Mental Health NHS Foundation Trust