NHS
Norfolk and Suffolk
NHS Foundation Trust

Trust Management
1st Floor Admin
Hellesdon Hospital
Drayton High Road
Hellesdon
Norwich
NR6 5BE

Private & confidential
Ms Jacqueline Lake
Senior Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich
NR1 2TN

5 November 2019

Dear Ms Lake

Re: Regulation 28: Report to Prevent Future Deaths (17/09/2019) – Tyla Katherine Joan Cook

In response to the concerns raised in the above report in relation to Norfolk and Suffolk NHS Foundation Trust, I have provided details below of actions taken or proposed to be taken to address these issues.

Concern 1:
It was agreed at the CETR meeting on 9th August 2017 that Tyla was to be seen by the Eating Disorder Service. He was not seen until 25th October 2017. The evidence was the 11 week delay in seeing Tyla was due to a heavy caseload and the practitioner having to remove other cases from his caseload before he was able to work with Tyla.

Trust response to concern 1:
In order to prevent delays accessing care when a service user presents with complex co-morbid mental health conditions the following process has been developed.

The care coordinator will ask other teams to joint work and/or provide consultation to ensure all relevant expertise is promptly accessed. Input from another team will be prioritised according to risk and not held on a waiting list if there is an urgent need. Any concerns regarding capacity and access to care will be escalated to the locality operational manager.

A service user may have a care co-ordinator from one team, such as Youth, and a co-worker from another team, such as Eating Disorders. The teams will work closely together to ensure that relevant interventions and treatments are offered in line with the service user's care plan. Reviews and meetings will include professionals from all the care teams involved. The service user and family/carer will be kept informed throughout.

Concern 2:
There were no written up-to-date care and crisis plans in place. The most recent written care plan related to Tyla being an inpatient at the Dragonfly Unit, from where he was discharged on 9 August 2017. The written plans were therefore several months out of date. This is against Trust Policy.

Evidence was heard that at a CETR meeting on 6 November 2017 a period of a further 3 months was requested to prepare an up-to-date written care plan. In the event, and despite the family's repeated requests for plans in writing, it was decided that the care plan could be commenced by 30 November 2017, on the basis Tyla's input into the care plan was important and it would take time to gain his meaningful input. The evidence was that there were oral plans in place which were relayed to

the parents (including at times of distress), who continued to request plans in writing. The high level of distress and anxiety within Tyla's home was recognised. An interim written plan was not considered nor that a written plan may have helped the family in providing support to Tyla. Steps have been taken by the Trust to recognise when up-to-date written care plans are not in place and it is understood that staff have undergone some work in improving the quality of care plans. However, in this case an active decision was made not to update the written plan for some time. Further evidence did not reveal any insight into the support a written plan could have given the family to support Tyla.

Trust response to concern 2:
NSFT recognises the importance of care plans for all service users and that these need to be done in collaboration with the service user and their families / carers if possible. However, in some circumstances this can take time in which case an interim care plan will be put in place whilst a more comprehensive and collaborative plan is being developed.

In addition Tyla's discharge from Dragonfly was not planned and so there was not an opportunity at that point to adjust the care plan or crisis plan in preparation for his return to community services. We have recognised that we did not have a robust process in place to ensure this does not happen in the future.

We have developed the attached process whereby in the future, for any service user who is discharged from an inpatient unit without the normal discharge planning process happening, we will ensure that on leaving the ward the service user and their family / carers are provided with written emergency contact information and an interim safety plan.

The care co-ordinator must arrange to review the service user within 7 days as per national standards. At this meeting they will review the care and crisis plan and update accordingly. They will provide written copies to the service user and their family / carers as appropriate. There will be a CPA meeting arranged within 28 days to further review the care and crisis plan with the whole team working with the service user.

In some circumstances service users do not wish to share confidential information with their families or carers. However, we recognise the importance of still sharing emergency contact information and a safety plan with families and carers.

A programme of training being rolled out offers training in care planning and crisis or safety planning with all staff which will ensure the above changes are embedded within teams.

Concern 3:
The review carried out by the West Norfolk Clinical Commissioning Group in May 2019 recommended a multi-disciplinary learning event involving participants from Norfolk and Suffolk Foundation Trust, Queen Elizabeth Hospital, Norfolk County Council and East of England Ambulance Service Trust be developed and implemented to train staff on how to apply good non-technical skills (teamwork, leadership, task prioritisation and communication) when responding to an emergency. At the inquest it became clear that no steps have been taken to organise this event and there is confusion as to who is responsible for arranging this learning event. The care providers indicated it was for the West Norfolk Clinical Commissioning Group. The West Norfolk Clinical Commissioning Group do not appear to accept responsibility for organisation of the event. Tyla died on 15 November 2017. The West Norfolk Clinical Commissioning Group review was published 8 May 2019. No steps have been taken with regard to this learning event, save East of England Ambulance Service Trust who has been in contact with the West Norfolk Clinical Commissioning Group. There is concern that a multi-disciplinary learning event will not be organised and will not take place.

Trust response to concern 3:
There is a multi-agency meeting fixed for the 4th November which our Head of Patient Safety, Saranna Burgess, will attend with representatives from all the other organisations involved to plan this.

I trust that the above responses address your concerns.

Yours sincerely

Jonathan Warren

Jonathan Warren
Chief Executive

Chair: Marie Gabriel CBE Chief Executive: Jonathan Warren
Trust Headquarters: Hellesdon Hospital, Drayton High Road, Norwich NR6 5BE
Tel: 01603 421421 Fax: 01603 421341 www.nsft.nhs.uk