PRIORY GROUP OF COMPANIES

Trevor Torrington
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80 Hammersmith Road
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Friday 5 June 2020

Your reference: 12296/MH

By email:
coronersmanchestersouth@ukemail.icasework.com
[redacted]

Hard copy to:
Mr Christopher Morris
HM Area Coroner
Coroner's Court
1 Mount Tabor Street
Stockport, SK1 3AG

Dear Mr Morris

Re. Wayne Lee Millett

I am writing in response to the Regulation 28 Report dated 18 February 2020 issued following the Inquest touching the death of Mr Wayne Lee Millett.

Thank you for permitting an extension in respect of providing a reply in light of the very challenging circumstances presented by Covid-19. We have now had time to give due consideration to the concerns raised and our response is provided as per the below.

Our investigation

We acknowledge that greater emphasis should have been given to analysing the care plan in place for Mr Millett to include the staff's knowledge and understanding of it and that there was a gap between the prescriptive nature of the care plan and staff's adherence to it.

We would ask you to please note that:

- The SUI report and [redacted] report convey that *overall*, the care and treatment provided by staff to Mr Millett, a long-term patient who had been at the hospital since November 2013 was of an acceptable standard.
- The care plans themselves were of an acceptable standard and were regularly reviewed.
- As you rightly point out, Mr Millett often had bouts of abdominal discomfort and prior to the incident, these episodes were managed successfully including through the administration of Movicol. As such, from a practical perspective, staff were managing the risk on a day-to-day basis in accordance with good clinical practice.
- At the time the investigation was carried out and the report completed, the investigators were not aware of the cause of death as they had not seen the PME report.

You will also appreciate that given the nature and timing of an incident investigation and a coronial inquiry, there is sometimes a "mis-match" between the findings of a SUI report and an inquest and even experienced investigators often consider post-inquest – *with the benefit of hindsight* – that they could have looked at certain matters in more detail or with greater emphasis.

A learning organisation

In relation to your concern that we are not a learning organisation, please note we continue to invest significant time and resource in making continuous improvements to the services we provide to some of the most clinically challenging mental health patients in the UK. This includes in relation to incident investigations: in March this year, we recruited a highly-experienced serious incidents investigation officer (SIO) with a clear mandate to make improvements to our processes for the benefit of patients and staff including:

- Ensuring that all SUI reports are completed within 60 days with the full involvement of all stakeholders including relatives and family members;

- Delivering training to senior staff who are commissioned to complete investigations and prepare reports to ensure they have the necessary skills to identify key issues and convey those concisely and clearly in their written outputs;

- Strengthening the review process so that all draft serious incident investigation reports are reviewed by a team of senior staff which in all cases includes the Group Medical Director and the Director of Quality.

- Ensuring that action plans are drawn up based on the recommendations in the SUI report and these are monitored regularly by senior staff at site to ensure learnings are being embedded in clinical practice.

More generally in relation to incidents, we have systems and processes in place to ensure we learn from all incidents and near misses as expeditiously as possible. In July 2019, we invested in a new incident reporting tool (Datix) which has assisted us to report incidents more quickly and better analyse them both locally i.e. at each hospital and across the Healthcare Division as a whole.

In the event of a very serious incident, we always undertake a rapid review of the case with the aim of taking swift action, where it is deemed necessary, to help reduce the possibility of a re-currence of such incidents and until such time as the completion of the more detailed investigation. We circulate frequent bulletins and messages to our staff about the lessons learnt from incidents and near misses with policies and training courses amended and updated accordingly. The implementation and embedding of any improvement actions is monitored by our Healthcare Division Quality Team who scrutinise incidents themes and trends and where necessary undertake more individualised reviews of patient care.

Auditing compliance with patient care plans

Please note there are systems in place which ensure that patient care plans are regularly audited. These systems include Ward Managers and the Director of Compliance at each hospital having a responsibility for undertaking regular "spot-checks" by way of completing the monthly Quality Walk Rounds during which the care records of patients are reviewed and evaluated. Our Healthcare Division Quality Team also undertakes a formal annual audit of care plans. The 2020 audit was unfortunately delayed due to the Covid-19 pandemic but was completed last month with the audit results currently being analysed.

Patient Clozapine care plans

As above, we are very much a learning organisation and we saw the matters raised at the Inquest concerning Mr Millett as an opportunity to review the way in which we manage the prescription and management of Clozapine. We have now allocated a Clozapine learning and development module to all doctors and qualified nurses. We have also issued Clozapine guidelines and an associated care plan "template" which gives clear details on the potential side-effects of the medication and how best to manage those.

I trust that the actions outlined above will provide the assurances you seek in respect of this matter.

Yours sincerely,

[redacted]

DIRECTOR OF RISK MANAGEMENT.

Trevor Torrington
Chief Executive Officer
Priory Group