Birmingham and Solihull
Mental Health
NHS Foundation Trust

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Mrs Louise Hunt
HM Senior Coroner for Birmingham &
Solihull Areas
50 Newton Street
Birmingham
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12 March 2019

Dear Mrs Hunt

REGULATION 28 REPORT – PREVENTION FO FUTURE DEATHS
MR PAUL PRICE (DECEASED)

Thank you for contacting the Trust regarding the outcome of the inquest held in relation to Mr Price. We do appreciate you raising your concerns with us so that we can improve future care for our patients.

As you stated in your report, the deceased had a history of depression and anxiety. He first exhibited suicidal ideation in March 2018. He was assessed by the mental health team. He had a full assessment by a consultant on 04/05/18 and was prescribed further medication. He presented to the emergency department at City Hospital on 15/05/18 having taken an overdose. He was then assessed by his GP on 16/05/18 when he denied any suicidal ideation and said his actions had been a cry for help. His GP spoke to him on 21/05/18 when he seemed better. On 01/06/18 the window in his room was found to be damaged and was repaired and closed. The mental health team were contacted as there were concerns about his wellbeing. The mental health team advised their systems were down and they would ring back however no one rang back.

There were no concerns about him on 02/06/18 and 03/06/18. On 04/06/18 he was found on the ground outside his room having fallen from the window. His intentions at the time are unclear. He was taken to the Queen Elizabeth hospital where he was pronounced deceased at 13.06. Following a post mortem the medical cause of death was determined to be multiple injuries.

During the course of the inquest the evidence revealed matters giving rise to concern. The matters of concern that you raised were as follows:

1. Paul was seen for a full assessment on 04/05/18. The summary of that attendance in a letter was not received by the GP until 29/05/18. In the meantime Paul had attended his GP with ongoing concerns about his mental health and requesting further medication. The delay in receiving critical information about vulnerable patients could put them a risk and result in over prescribing medication. In addition I was told that the IT systems for Birmingham and Solihull Mental Health Trust and the GPs are incompatible meaning that letters have to be faxed or posted causing further delay.

   I am pleased to be able to advise you that since issuing this Prevention of Future Deaths report, we have implemented significant improvements in relation to both the quality and timeliness of communication with GPs. This includes the full roll out of a hybrid mail system across the Trust. On 5 March 2019, we enabled a new feature within Hybrid Mail called Docman. This feature dramatically reduces the time it takes for GPs to receive letters from the Trust. Instead of letters being posted, they are sent electronically and we have worked in partnership with our Local Clinical Commissioning Group to ensure that GP practices have the necessary IT infrastructure to receive such communication. Letters sent to GPs via Docman will normally arrive at their destination on the same working day and are released from Hybrid mail every 15 minutes. Faster communication between healthcare professionals ensures that relevant information is accessible when needed and as a result improves the service user experience and outcomes.

   In addition to this we have implemented a monthly monitoring process to ensure that letters are provided within the nationally required 2 week timescale.

2. A call was made to the Mental Health team on 01/06/18 raising a concern about Paul's mental health. The caller was told that the computer systems were down and the mental health team would call back – they did not call back. There is concern that staff are not accurately recording information and arranging follow-up.

   To immediately address this issue we have 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 our administrative staff and handed over with a signature to qualified staff to action. In the longer term we are seeking to recruit additional staff to our Home Treatment service and have submitted a business case to our Commissioners in this regard. Given the urgency of this issue, we have decided to proceed with recruitment to this team ahead of funding confirmation. Recruitment is about to go live.

   In addition, we have placed an additional safeguard in place via our out of hours main switchboard, whereby in the event of failure to secure a response from clinical

staff due to competing demands, advice will be sought from a clinician in our bed management team who are available 24/7.

We do hope that this additional infrastructure will help to mitigate the likelihood of any future incidents. We should highlight at this stage that whilst we will always try our very best to respond to patients in crisis, a crisis telephone line is not commissioned via BSMHFT from our Commissioners. The commissioning of this service is via NHS111 who are required to provide support and respond to crisis calls. We are however aware that a lack of mental health professionals within NHS111 can lead to increased demands on our own services.

We sincerely hope that the improvements outlined above will assist patients who find themselves in crisis.

Yours sincerely

John Short
CEO, Birmingham and Solihull Mental Health NHS Trust