4th May 2021

Camden and Islington
NHS Foundation Trust

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Private and Confidential

Senior Coroner ME Hassell
Inner North London
St Pancras Coroner's Court
Camley Street
N1C 4PP

Dear Coroner Hassell

Re: Inquest into the death of Grazyna Walczak – Prevention of Future Deaths report

I am writing further to the inquest for Grazyna Walczak which was heard on 4th March 2021. Following the inquest, you issued a Prevention of Future Deaths report and I will address the matters of concern raised in this report in turn.

1. Ms Walczak was seen by a psychological wellbeing practitioner from the Camden and Islington iCope service two or three days before her death. She was assessed as being at low to moderate risk to herself.

However, she was not asked if she would agree to her family being notified of the situation and of her current mental ill health. Her son would dearly like to have been told what was happening and would have acted accordingly.

I heard evidence that iCope does not routinely ask their patients if families may be involved. This seems to be a policy worthy of reconsideration.

The iCope service has reviewed the policy on contact with clients' families in light of the PFD report. Up to now the service has not routinely collected information on 'Next of Kin' and would contact the person's GP if that information was needed. iCope does, however, quite often involve relatives or partners in aspects of treatment if appropriate and with the consent of the patient. The service takes the confidentiality of its patients very seriously, so would not want to make it mandatory for people to give NOK information in order to access the service.

However, in an emergency situation, where it might be necessary to contact someone very quickly, it would be prudent for the service to have that information available without having to go via the GP (which could cause a delay). The service has therefore agreed and implemented routinely asking for emergency contact details for all the people it sees, if they choose to share this information. It will be made clear that this information (an emergency contact name and telephone number) would only be used in emergency situations. The information will be recorded on the electronic case record so would be easily accessible to staff if it was needed (for example if someone became physically unwell during a session or we were very worried about risk and unable to get hold of the patient).

2. The 72 hour investigation report that should be produced within 72 hours of death, to enable fast learning that may be of immediate benefit to other patients, was not completed until last week, some five months after Ms Walczak's death.

That is obviously not acceptable and could put others at risk by a potential failure to learn.

The Trust recognises that delays in the reporting process represent a delay in learning and the opportunity to continuously improve patient safety when incidents occur.

This Trust has undertaken a review of the timeliness of 72-hour reporting to ensure adherence to meeting the requirements of the National SI Framework and to implement improvements in light of the prevention of future deaths report. This will ensure more timely reporting and organisational learning takes place.

A review of the data of returned 72-hr reports within the Trust has found that reports are not returned within the 72-hr timeframe and as a result a programme of work has been started to address this.

The following key recommendations were made and are being implemented

1. To undertake improvements in the 72-hour report submission process utilising quality improvement methods and monitoring and reporting progress through the existing reporting arrangements.
2. To formulate 72 hour reporting process maps for users to increase compliance and improved reporting quality.
3. To implement 72-hour reporting through the Datix patient safety incident reporting system to make reporting easier for the front- line staff.
4. To prepare a training package to enable implementation of reporting through Datix
5. To commence the training in the divisions
6. To evaluate the training package with the divisions after 3 months.
7. To monitor the programme of work through the Executive led Serious Incident Trust Forum and the Quality and Safety Programme Board

72-hour reporting: Programme of Work

This programme of work has started and will take place over the next 4 months with an evaluation of progress at the 4-month stage and further improvements will be initiated, if required after that. The programme of work will be monitored through executive led meetings.

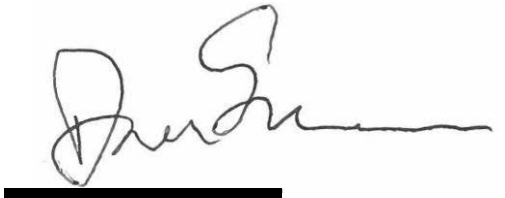
Date	Action	Progress/Completion
April 2021	Review of 72-hour reporting: Trust wide review of the 72-hour reporting process and analysis of data.	April 2021
April 2021	Presentation of the review to trust and divisional colleagues to agree action and next steps to enable programme of improvement work to commence.	April 2021
May - June 2021	Implementation of the reporting of 72-hour reports through the patient safety reporting system (Datix) to enable easier reporting.	May - June 2021
June 2021	Implementation of a training programme for divisional staff to support the implementation of the new system reporting process.	
	Monitoring arrangements	
April 2021	Weekly monitoring of compliance with 72-hour reporting.	Continuous
May 2021	Review of the monitoring of compliance with 72-hour reporting through the serious incident forum chaired by the Executive Director of nursing.	Continuous
April 2021	Review of the monitoring of compliance with 72-hour reporting through the serious incident forum chaired by the Executive Director of nursing and attended by the Executive Medical Director and the Divisional Directors and Clinical Directors.	Continuous
	Evaluation	
June 2021	Evaluation: Review of the new process and effectiveness of training.	June 2021
July 2021	Progress report to the Quality and Safety Programme Board 72-hour reporting compliance.	July 2021

The programme of work will be undertaken, in collaboration with the divisions, to ensure there is a clear understanding of the process, roles and responsibilities of all those involved in the process.

The Trust is committed to continuously improving systematic learning at the earliest opportunity by ensuring the timely submission of 72 -hour reports.

I hope that my response clarifies the position and provides you with the necessary reassurance. If you need any further information, please do not hesitate to contact me.

Yours sincerely



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Deputy Chief Executive
(Signed on behalf of [redacted], Chief Executive)
Camden and Islington NHS Foundation Trust