NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

[redacted]

Legal Department
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Date: 17 May 2021

[redacted]

Mrs Emma Brown,
Area Coroner,
Birmingham Coroner's Court,
50 Newton Street,
BIRMINGHAM B4 6NE

Dear Mrs Brown,

Re: Prevention of Future Deaths report into Azra Parveen Sultan

May I open this letter by reinstating the apologies of our Trust for the tragic death of Azra Parveen Sultan. Azra was an inpatient on Ward 2 at Mary Seacole House when she sadly died by suicide having attached a ligature to her en-suite bathroom door. This was clearly an immensely tragic and distressing time for Azra's family, friends, her fellow service users on the ward and the staff that were caring for Azra. Our sincere condolences are reiterated to all who were and continue to be affected by her death.

During the course of the inquest the evidence revealed matters giving rise to concern as follows:-

1. On the 4th May 2020 Azra's mother and daughter had been in telephone contact with the nurse in charge on the ward expressing concerns that Azra had messaged them to say she had attempted suicide using shoelaces as a ligature. The nurse spoke to Azra who denied making a ligature, Azra's neck was examined and she had no marks from ligature use. The shoelaces from one pair of shoes were removed but other shoelaces, clothing and bedding were left in her possession as it was felt that Azra was not at an immediate risk. She was not believed to be at immediate risk because, whilst it was a feature of her mental state common to many patients that she would regularly talk about not wanting to live and requesting an overdose, there was no evidence that she had made an active suicide attempt and she had no history of suicide or self-harm attempts. The fact that she was now saying that she had attempted to make a ligature was a change in her presentation (her previous suicidal ideation had centred around requesting assistance to overdose), it was also of significance that she was saying one thing to her family and something different to a clinician. BSMHT accepted that the information was significant and therefore there ought to have been consideration of it by her treating team with a review of her risk and observation levels. However, no record at all was made of the family's concerns and the account given by Azra. Her risk screen was not updated, an incident report was not raised, and the information was not included in handover to the next shift or at the next MDT on the 6th May. Therefore, it was not considered at an MDT meeting on the 6th May 2020. Due to the COVID19 pandemic Azra's family could not attend that meeting and raise their concerns directly. Microsoft Teams was used by some clinicians to attend the MDT on the 6th May but was not made available to Azra's

family nor was a telephone number to dial into the meeting. BSMHT has put in a system for a form to be completed in advance of an MDT which requires the family's input to be sought, placed on the form and considered in the MDT. It is my concern that this is equivalent to the family being included in the meeting (prior to COVID families were invited to attend MDTs): there is the potential that information will not be recorded accurately or will not be understood in written form, it also doesn't afford family the opportunity to hear the plan arising from the meeting and provide their views. There is no reason why attendance by a remote platform or telephone line at the meeting itself cannot be offered to family for all MDTs.

Our Family and Carer Strategy and pathway prioritises the principles and practice of high quality family and carer engagement in all aspects of care. One component of our patient safety work is the implementation of robust and consistent multidisciplinary team standards which includes enhanced family engagement. We will ensure that families views are central to the care planning process prior to and during the MDT and that there is a clear feedback process to the family post MDT so as to ensure and assure the family that their views have been considered. We are working with our family and carer network to seek views on the format of post MDT written correspondence. This will supplement verbal feedback either over the phone or via a virtual platform.

We are consistently auditing our practice around our minimum MDT team standards which includes a minimum standard about securing and reviewing the patient and carer view within the MDT meeting. The data below in figure 1 shows our position for February, March and April 2021 respectively. We report our position on this standard each month to our regulators the Care Quality Commission.

Figure 1: Audit Results for Securing and Discussing Patient and Carer View in MDT

With regard to involvement of families in formal MDT meetings we will involve families within the MDT meeting itself where this is clinically appropriate. It will not always be appropriate as such decisions will be influenced by a number of things such as:-

- Consent of the patient
- Relationship between the patient and family members
- Issues of confidentiality with regard to the content of the MDT discussions
- Issues that may impact on risk to self or others
- Safeguarding concerns

We would like to assure you that there are a range of ways in which we aim to ensure meaningful engagement with families outside the formal MDT process and this year we have specific quality goals relating to carer engagement including:-

Improve the involvement carers in service user care and recovery	Measures of success:- % of carers registered on RIO % of carers with a completed carer engagement tool

We will report on our level of improvement with this priority through our Integrated Quality Committee on a quarterly basis. On a monthly basis our Family and Carer Pathway Group will review performance to celebrate improvement and to identify any barriers that we need to remove to improve performance in challenged areas.

2. I am concerned that within BSMHT's inpatient units there will be a continuing risk from other doors in the bedroom area (including the main bedroom door) even when the en-suite bathroom doors are fitted with pressure sensor alarms. Although the outer face of a bedroom door will be on a communal corridor, service users on level 1 and 2 observations will have periods where they are unobserved in their rooms and could wedge a ligature at the top of a door so that it wasn't obviously visible from outside.

When considering the safety of our inpatient environment, we approach this using a framework that incorporates the triad of physical, relational and procedural security and controls. We have commenced a full review of all of these controls to strengthen the safety of our acute inpatient wards. The results of the review and the associated recommendations will be presented to our Integrated Quality Committee for approval, who in turn report directly to our Trust Board of Directors.

As part of this review we are recommending that we develop a work programme to apply continuous door pressure alarm systems to the bedroom doors on a number of our wards. This is a significant piece of work and we are prioritising the wards to which we will initially apply these systems based on acuity of patients and ligature history prevalence. We have established an expert group to assist us in determining the prioritisation process which includes a mental health expert from the Quality Team at NHS England and our Mental Health Quality Lead from Birmingham and Solihull Clinical Commissioning Group. We will have reached a decision on prioritisation and the associated timeline by the end of May 2021. There are a number of factors that will contribute to the timeline for delivery including:-

- Manufacturing times
- Installation Timeframes
- Safe access to operational acute inpatient wards to carry out works
- Temporary bed closures whilst the work is being undertaken which may impact on our ability to admit patients during periods of high occupancy
- The potential of a third wave of Covid

We would like to assure you in the meantime that all of our doors comply with existing standards in that there is no door furniture (such as handles, hooks etc) that could be used as an anchor point. The only anchor points are therefore the top, bottom and hinge of the door. Our choice of alarm system is one of the latest innovations in that it has pressure sensors on all of these areas of the door – so no matter where pressure is applied, the alarm will trigger.

We are also establishing a rolling capital programme to support ongoing ligature works to all of our Estate.

We are conscious that the pressure sensors are just one control to improve patient safety and we therefore feel that is important to stress that reducing harm from ligatures relies as much on the relational and procedural controls as it does on the physical. The risk review process currently being undertaken by our expert group places equal emphasis on each of the three areas, as addressing the physical environment alone will not reduce this risk to its minimal level. Examples of these other areas include; a review of our therapeutic observational practice, a review of staffing levels and skill mix and monitoring and supervision of the implementation of our new care plans.

Please be assured that as an organisation we are taking all the steps we can to reduce risk from ligatures and will continue to work with families and carers to ensure that they are involved in Patient care, where the patient wishes for this. In addition, the BSOL system continues to work to improve services and to learn from events. There is a multiagency oversight group in place which has delivered against key recommendations and continues to work to implement learning.

Yours sincerely,

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Executive Director of Quality and Safety (Chief Nurse), Birmingham and Solihull Mental Health NHS Foundation Trust	**Chief Nurse, Birmingham and Solihull Clinical Commissioning Group**

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