Norfolk and Suffolk NHS
NHS Foundation Trust

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6 November 2013

Private and Confidential
Ms Jacqueline Lake
HM Coroner
Norfolk Coroner's Service
69-75 Thorpe Road
Norwich
Norfolk
NR1 1UA

Dear Ms Lake

Re: Inquest into the death of Matthew Dunham concluded on 4 September 2013

I write in response to the report dated 12 September 2013 from Mr Armstrong. Following the conclusion of the inquest into the death of Matthew Dunham the Trust was asked to consider a number of aspects of service delivery under Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (investigations) Regulations 2013.

I respond to the areas you highlighted:

A) An emergency referral by the general practitioner to the assessment team on the 4th of April 2013 was not followed up within the normal time scale of four hours and it was two days before a telephone triage session took place and four days before an assessment was undertaken by a mental health nurse. This raises the need to ensure that emergency referrals are dealt with within the appropriate time scales and that policies and procedures are in force to make sure that this happens.

The Trust's internal investigation (Root Cause Analysis) identified this gap in responding to the requested assessment. Since this period the service has made a number of resource changes to be in a position to respond to referrals within the specified time period, according to the assessed urgency.

The Trust has implemented monitoring mechanisms for the four hour 'urgent referral' standard which is reported daily to commissioners and is monitored by senior managers and clinicians.

Additionally, the Clinical Team Leader for the Crisis Resolution and Home Treatment (CRHT) team reviews all assessment requests each day to confirm that contact was made within the 4 hour timeframe and that where possible this is a face to face contact. If this is not possible, then a minimum standard of telephone contact has been agreed and put in place. This includes an assessment of risk, support mechanisms available and ensuring the service user has contact details in case the situation deteriorates.

B) There appears not to have been a clear shared understanding between professionals as to which team it was appropriate to refer Mr Dunham to. There was some lack of understanding revealed as to whether a referral to the assessment team or the crisis resolution and home treatment team was appropriate. This highlights the need for there to be a clear understanding about the roles of each team and the interface between them.

The Trust's internal investigation recognised that with the symptoms presented to the practitioner on the 8 April 2013, it would have been proportionate to have requested the support of the Crisis Resolution and Home Treatment (CRHT) team.

To enhance the interface between the two clinical teams, Access and Assessment Team (AAT) and CRHT, a member of the CRHT is now based within the AAT. This enables joint working without any delay, supporting transition of care between the two teams. The Trust is monitoring its effectiveness in identifying people in need of this crisis support.

C) On the 8 April 2013, despite the fact that Mr Dunham was presenting as feeling suicidal and specifically that he had set up a noose in his flat the previous night, it was not thought appropriate to refer him to the Crisis team for appropriately robust intervention. This raises the issue of the basis upon which the risk of suicide or serious self harm is recognised and acted upon particularly where the person concerned has gone beyond vague suicidal ideation and moved towards contemplating some specific ways of ending his life.

The Trust accepts that on the 8 April Mr Dunham presented with a number of factors associated with people having suicidal thoughts. As noted above it is recognised that it would have been proportionate to refer Mr Dunham to the Trust's CRHT at that time. This would have enabled the opportunity for an assertive intervention aimed at identifying and supporting his needs.

The Trust's internal investigation recognised that the AAT is a new service (commenced in February 2013). The investigation recommended that an audit be completed to seek assurance on the robustness of the assessment structure, both from the perspective of the framework and clinician's individual judgements within it. This will provide the evidence to support further developments in the assessment of suicide risk alongside the Trust's current mandatory training programme. This audit is currently in progress and I would be happy to share a copy of its report upon conclusion.

D) A letter sent to Mr Dunham's general practitioner from the advice and assessment team was not draft appropriately. This raises the issue if the need for specific guidance to be given about how such letters should be drafted within a template structure.

The Trust's internal investigation identified that whilst all of the information was within the letter to the GP it was presented in a way that key aspects were not readily visible. To address this, the AAT have been working with general practitioners to develop a template that provides information in a manner to meet their needs. The agreed template is due to be implemented from the 18th November 2013

E) Most disturbingly the evidence at the hearing displayed a lack of coordination between mental health professionals involved in Mr Dunham's care. Specifically when a mental health nurse saw Mr Dunham on the 8 April he had no knowledge whatsoever that Mr Dunham was already being seen by a psychological wellbeing practitioner. This clearly demonstrates the need for effective information sharing between professionals involved in managing the care of a mentally ill person and the need for each and every professional to have access to all the records relating to the patient and details of interventions and actions by other practitioners. It is recognised that the Trust is working towards the implementation of a single electronic health record in 2014.

The Trust's internal investigation confirmed that the computer system employed by AAT at the time was able to scan all the Trust electronic health record systems with the exception of the electronic health record system named PC Mis. This meant that it was not readily identified if a patient was attending the Trust's Improving Access to Psychological Therapies (IAPT) service. The Trust has now implemented an updated system (Apervita) which is able to include the system PC Mis and therefore identify any current or historical care episodes an individual has with the IAPT service.

As you recognise, the Trust is in the process of working towards a single electronic health record across all of its services. This will bring together a number of different electronic and paper based record systems bringing a number of benefits to increase patient safety.

Thank you for bringing these matters to the Trust's attention which assists to provide focus in improving patient safety for service users. The Trust is committed to applying as much learning as possible from this tragedy.

Yours sincerely

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Acting Chief Executive