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Our ref: PeM/kd/L242

21 July 2014

H.M. Coroner for Leicester City & South Leicestershire
The Town Hall
Town Hall Square
Leicester
LE1 9BG

Dear Mrs Brown,

Regulation 28 of the Coroners' rules re: Laura Page

Further to your Report dated 28 May 2014 in accordance with paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 I offer the following response.

We have investigated the matter that you raised relating to concerns about how the crisis team respond to failed visits, including the escalation of concerns and the threshold for requesting a welfare check.

Leicestershire Partnership NHS Trust takes these matters very seriously and I hope that you are satisfied that we have taken appropriate measures to prevent such an occurrence happening again.

The following actions have been taken:

(1) The clinician response to failed visits is not robust. Further practical efforts could be considered, including door access key fobs where appropriate.

The teams within the Crisis Service were notified of the outcome and the contents of the Regulation 28 at their team meetings and via email communication.

A clear process has also been developed and put in place to ensure that all failed visits are dealt with following the same process. This is detailed in the attached flow chart (Annex).

All staff have been issued a copy of the flow chart and the process discussed within team meetings. In addition the Operational Procedure for Crisis Resolution Team has been updated and re-issued to all staff to reflect this process (Appendix).

By way of explanation of the changes incorporated within the Flowchart we would draw your attention to the following:

The first visit by the team should where possible be carried out by a registered mental health practitioner (a member of staff who is registered with a professional body). This is to ensure that ongoing care can be planned.

If it is not possible to secure the engagement of a qualified practitioner, then this must be escalated to the Team Manager or Service Manager who will consider the relevant issues and have the authority to redeploy staff to assist the team by providing a qualified practitioner to visit. This will be documented.

In terms of the issue of key fobs, this is not a practical resolution to the problem of a failure to engage with the patient. However, the Police do have access to such fobs and consideration has been given to this in terms of obtaining access.

(2) The escalation policy should be reviewed to consider specific time targets for action.

This has been undertaken and the flowchart states specific time targets for action.

(3) The threshold for requesting a welfare check should be reconsidered.

This has been considered and the flowchart clarifies the threshold for requesting a welfare check.

(4) An analysis of failed visits and untoward outcomes across the service could be maintained and audited to ensure lessons are learnt and best practice shared.

The Crisis Service Manager is now undertaking a weekly audit check on failed visits to assure compliance in line with the new process, and is monitored through key line performance indicators.

We are aware that the difficulty in this case was essentially one of communication. We have endeavoured to make it clear to staff that they must do all that they can to engage with a patient. Where they are unable to do so, this must be dealt with in accordance with the Operational Procedure. This will enhance communication within the team so that a failure to engage will be seen by the relevant team. This will assist in the handover meetings.

Yours sincerely

Dr Peter Miller
Chief Executive

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