Black Country Partnership NHS
NHS Foundation Trust

Headquarters
Delta House
Delta Point
Greets Green Road
West Bromwich
B70 9PL

Tel: 0845 146 1800
Fax: 0121 612 8090
Web: www.bcpft.nhs.uk

Mr Zafar Siddique
Her Majesty's Senior Coroner
H.M. Coroners' Office
Smethwick Council House
High Street
Smethwick
B66 3NT

9th December 2014

Dear Sir

Inquest touching the death of Kirsty Lisa Pritchard - Response to Report to Prevent Future Deaths

We write in response to your Regulation 28 report to the Black Country Partnership NHS Trust ('the Trust') dated 17 October 2014. Within that report, you raise the following three matters of concern (in accordance with your ruling on this matter at the conclusion of the inquest) as follows:

1. The Root Cause Analysis Report by the Black Country Partnership NHS Trust confirmed that there were issues in relation to the communication of information. Specifically, the evidence presented at the inquest confirmed that CHTT contacts with Ms Pritchard following discharge were not reported back to the inpatient Consultant in charge for review and assessment of risk of self-harm in a timely fashion; and

2. I am concerned that the ability to undertake effective management of patient risks of self-harm and suicide ideation upon discharge may be compromised if the Consultant in charge or equivalent is not made aware of worsening symptoms and that effective systems are not in place to action this; and

3. In addition, I am concerned that there were deficiencies in the systems in place for contacting and finding the patient. In this case the patient had contacted the CHTT with a real and immediate risk of self-harm and it took over 5 hours to find her despite the fact that the Police managed to locate her very quickly when they were subsequently contacted.

These matters of concern have been considered in detail by the Trust and our response on each issue, including action taken or proposed and the timetable for that action is as follows:

Issue 1

The Trust processes, including the function and service provided by CHTT, are currently under review as part of a wider mental health strategy review. This is taking place in order to modernise services, improve quality of care and access to services. This review will also ensure a seamless service across both the adult and older adult population. The plan is to implement agreed changes to the current system by April 2015.

The current process has been that at the time of Ms Pritchard's death was that CHTT should report directly to the consultant responsible for CHTT rather than the inpatient consultant.

Since the death of Ms Pritchard several actions have been taken to ensure that a more robust process is put in place pending the outcome of the trust-wide mental health strategy review. These are as follows:

- In reach to the inpatient settings has been strengthened to ensure that CHTT are present in all ward discharge planning meetings. The effectiveness of this is being reviewed through a current workshop evaluation with the team in order to ensure continued process improvement and maximum effectiveness.
- The communication with consultants to raise any concerns has been reinforced by recirculating the medical escalation flow chart (Appendix 1) to all CHTT and inpatient staff both clinical and non-clinical so that it is clear which individual any concerns about risk should be raised with.
- The advice given to individuals not currently under the care of CHTT or inpatient services that require immediate advice or support remains to attend A&E in the first instance.

At the time of her death Ms Pritchard was not under the care of CHTT or inpatient services. When Ms Pritchard contacted CHTT on 16 January 2013 she was advised to attend A&E for further support and treatment. The rationale for this is as follows:

- Within working hours there is a Psychiatric Liaison Service available at the A&E department at Sandwell General Hospital who are able to provide support and advice in a crisis situation.
- The Psychiatric Liaison Service have a one hour response time which is shorter than the response time expected from the CHTT due to the local nature of service.
- A&E is fully equipped and staffed to deal with any physical healthcare problems or issues relating to medication which may need immediate attention prior to mental health treatment.
- Access to A&E is guaranteed twenty four hours per day.
- The CHTT team provide an out of hour's service from the Oak Unit, which is based in the A&E department.
- Patients can be triaged and referred to the most appropriate service depending on their immediate needs.

Ms Pritchard was advised to attend A&E on 16 January 2013 having contacted CHTT, however there is no evidence that she presented herself at A&E on that occasion. Action has now been taken to ensure that at the start of each shift the CHTT team leader generates a list of all patients referred to A&E so that these can be followed up to ascertain if the patients did attend. This ensures that further action is taken if required. (the protocol for cold calls will be followed if non-attendance is established – see further explanation below).

Issue 2

The Trust recognises that there were a number of factors that may have impacted on the escalation of Ms Pritchard's contact with CHTT prior to her death and as such the trust has taken a number of actions to address these issues:

- The communication with consultants to raise any concerns has been reinforced by recirculating the medical escalation flow chart (Appendix 1) to all CHTT and inpatient staff both clinical and non-clinical so that it is clear which individual any concerns about risk should be raised with.
- All staff should be equipped to deal with risk assessment and management as part of the multi-disciplinary approach. The mental health division has identified an additional need for further staff training in responding to and recognising risks to and by service users in relation self-harm and suicide. STORM (Skills Based Training on Risk Management) training is prioritised to CHTT staff and other front line crisis services. There is a rolling plan over the next 36 months which commenced in November 2014 to capture all staff as well as new starters.
- The STORM programme is now underway with in house staff trained to deliver training that can be tailored to the local population needs. (See appendix 2 for Strategy for roll out of STORM training across Mental Health Division.)
- STORM is a recognised two day risk management course using interactive methods;
- The training builds a skills set for suicide risk assessment and safety planning (crisis management);

- The training will be a requirement for all adult mental health practitioners involved in both in-patient and community settings;
- All staff involved in risk management will receive updated training every 3 years;
- Staff will need to demonstrate the required skill sets in order to complete the course successfully.
- Solution Focussed Therapy (SFT) is also being rolled out to staff within the Acute Pathway. Staff have been trained in-house to deliver this training to ensure that it meets local needs. SFT is a skill based therapy that supports an individual's coping skill development by enhancing their existing strengths. There is a team of fifteen trainers now in place with a roll out programme starting in 2015.

Issue 3

Following the initial contact, the CHTT made attempts to contact Ms Pritchard by telephone throughout the morning of 20 January 2013 but were unsuccessful. Five telephone calls were made between 0915 hours and 1225 hours. Due to knowledge of the patient's previous history of self-harm CHTT then visited the property but could not get a response. The attending staff members knocked on the front door and window and looked into the lounge window. They also tried to gain access via the rear of the property however they were unable to gain access. The CHTT attempted to contact Ms Pritchard's next of kin and tried an alternative address in Tipton recorded in the patient notes. Checks were made with A&E who had no record of Ms Pritchard attending. As a result the CHTT subsequently contacted the police to conduct a 'safe and well' check as they understood that entry to the property would need to be forced.

In response to the concerns raised regarding the timescale for this response, a protocol has now been developed to address these issues. Where a service user is assessed to be in immediate risk of harm or death, and if telephone contact cannot be established with the service user within 30 minutes the CHTT are to carry out a cold call of the service user's home address/ last known location within 1 hour. If CHTT are unable to gain access or locate the service user they are to contact the police to conduct a 'safe and well' check.

The protocol seeks to outline actions to be taken by staff in order to escalate immediate concerns over a service user's safety. The protocol is outlined in appendix 3.

We would like to take this opportunity and extend an invitation for the Coroners to come and visit our services which will provide an understanding of how we practice individualised risk management as well as how our staff have to strike a fine balance between maintaining patient safety when at the same time gaining the patients' trust to build up therapeutic relationships with them. We have to manage this balance between care and control and it is fundamental to our practice that we can continue to make individualised judgement calls for each and every patient.

Yours sincerely

D Mason

[redacted]
Divisional Director for Mental Health