Coventry and Warwickshire Partnership NHS
NHS Trust

Our Ref: SG/PM/AJJ

1st September 2015

Ms Catherine Mason
Senior Coroner for Leicester (City & South)
Coroner's Court Office
Coroner's Court
Town Hall
Town Hall Square
LEICESTER
LE1 8BG

Dear Ms Mason

Re: Master Bradley David Griffiths

Thank you for the Regulation 28 Report to Prevent Future Deaths (PFD) following the inquest into the death of Bradley David Griffiths, 18th November 2012.

We welcome the Coroner's interest and concern in this case and in ensuring that future deaths are prevented and that any risks to patients including those who transfer out of area are managed safely.

Your PFD report raised the following 'Coroner's Concerns':

"Evidence was heard from [redacted] who was Bradley's Health Visitor. [redacted] explained that she only saw Bradley once, which was for the birth visit on 30th April 2012. Although two appointments were made with Bradley's mum for the 6 week routine check to take place, his mum did not keep them. After the second failed appointment Ms Mackie telephoned Bradley's mum on 26th June 2012 and was informed by her that she had separated from Bradley's father and she and Bradley were living in the Northampton area with friends and that she had registered with a new GP. However, she would not tell [redacted] where she was living or the details of her new GP. As a result [redacted] sent Bradley's records to the "No Trace" storage at the Child Health Department with the expectation that they would be sent to the next assigned Health Visitor."

Your action to be taken details:

"In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action."

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The Trust would like to confirm the following:

At the time of Bradley's death, our processes for the Transfer Out of case notes and information, did not robustly account for instances where families did not provide a forwarding GP address, or where they provided incorrect details. Following the incident of Bradley's death in 2012, the Trust had recognised the concerns that you have raised following the inquest in your PFD report. We can confirm that we had taken steps to develop and then implement robust arrangements for ensuring children's 'Transferred Out of Area' records and arrangements for ensuring appropriate levels of contact with receiving areas, are carefully considered; and in circumstances where staff are unable to locate a child/family. The arrangements that we had already proactively put into place were:

- Completing a 'No Trace' process/checklist, and a follow up review after 3 months;
- Supervision of each case, by a Pre-School Manager, to ensure all avenues have been considered, prior to 'No Trace' status being applied.

The arrangements described above were later incorporated into the Health Visiting Standards document (August 2014). We have kept these arrangements under review, as part of normal process, to ascertain whether any additional improvements can be made to strengthen the process in place.

I am sorry that there was not the opportunity to confirm the changes in practice that we had made following Bradley's death. I hope this provides you with the assurance that you require that the Trust did recognise that there was a gap in its service provision and had taken steps to rectify this at the earliest opportunity, shortly after Bradley's death, thereby preventing a recurrence with other patients under our care.

Yours sincerely,

Simon Gilby
Chief Executive
Coventry and Warwickshire Partnership NHS Trust

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