Norfolk and Suffolk NHS
NHS Foundation Trust

Trust Management
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Hellesdon Hospital
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26 MAY 2015

Our Ref: MS/mp

20 May 2015

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

Dear Ms Lake

Regulation 28 report following the inquest of Mrs Barbara Mayer on 11 March 2015

I write in response to your report dated 23 March 2015. Under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 you requested the Trust consider issues of service delivery following the conclusion of the inquest into the death of Mrs Mayer on 11 March 2015.

You recorded four areas giving rise to concern. I will address these in order:

1. [redacted] was showing signs of carer fatigue, but this was not followed up

Caring for someone with mental health needs is a challenging experience and can have mental and physical effects. It is imperative that carers are supported in their role and provided with proportionate assistance when required. In [redacted] case we did not fully appreciate the impact of caring was having. For this, the Trust apologises.

The Trust is implementing the 'Triangle of Care' model which prescribes a therapeutic alliance between service user, carer and staff member that promotes safety, supports recovery and sustains wellbeing. The model, created by the Carers Trust, is aimed at partnership working.

The Trust is nearing completion of the first stage of this multi year plan. This involved services completing a self assessment tool, creating an action plan for areas requiring development. The Trust Executive hear regular updates on its progress as we are committed to significant cultural change in how we engage and support carers.

2. **Although seen regularly by the Crisis Team, Mrs Mayer was seen by a number of different people as a result of which no trusting relationship could be established. She had to repeat her history at each visit to a different person about personal matters.**

The Crisis Resolution and Home Treatment (CRHT) team provide a 24 hour service, assessing and supporting service users with intensive treatment for defined periods of time. It has a team of fifty staff supporting a significant number of people across a large geographical area. These factors mean that planning and coordinating consistent staff contact with a service user is a challenge.

The Trust recognises the impact this can have for service users and their carers, especially during times of crisis. The Trust is planning to review the functions of the CRHT over the forthcoming months. Included within this review will be how we can improve the consistency of staff engaged with the service user. I would like to provide you with an update on progress in early September.

3. **Different treatments were offered to Mrs Mayer without the reasoning or their efficacy being discussed.**

This is recognised to be important because it is difficult to make informed decisions if the individual is not in receipt of all the required information. The Trust supports the best practice of informed decision making and is sorry this was not evident for Mrs Mayer.

This is an area of practice which has significance across the Trust. The Trust will be emphasising this aspect of practice through its structures for learning, such as clinical forums and patient safety newsletter.

4. **Mrs Mayer required help urgently on 14 November 2014 but due to an increase in demand no one was available to see her until 16 November 2014. It is understood Doctors are now called out and an on call manager can be contacted in such situations.**

This was a contributory factor in the events leading to Mrs Mayer's death. The Trust is sorry that significant demand for the CRHT team meant they could not visit Mrs Mayer until late on Saturday 15 November 2014. As Mrs Mayer was going to sleep it was appropriate to agree to defer the visit until the next day. Mrs Mayer died during the night.

The Trust is experiencing increasing demands for all of its services at a time of being challenged to make savings. It is recognised that when services such as the CRHT team reach levels of capacity there has to be robust mechanisms for escalation and contingency. To this end the localities across the Trust are reviewing their escalation plans for services such as CRHT and the Dementia Intensive Support Teams, both of which are required to respond to incoming referrals.

Thank you for raising these matters of concern, as they align with the Trust's desire to take all available learning from this tragic event.

I propose to write again in September with an update of the CRHT review and contingency plans but if I can be of any further assistance please do not hesitate to contact me.

Yours sincerely

[redacted]

Michael Scott
Chief Executive