Surrey and Borders Partnership NHS
NHS Foundation Trust

Quality Directorate
Trust HQ
18 Mole Business Park
Randalls Road
Leatherhead
Surrey KT22 7AD
Tel:
Fax
Email: [redacted]

15th July 2015

Bridget Dolan
Assistant Coroner
Coroner's Office
Wester Sussex Record Office
Orchard Street
Chichester
West Sussex PO19 1DD

Dear Mrs Dolan

Inquest into the death of Wanda Stachurska – REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Further to the conclusion of the inquest into Mrs Stachurska's death on 17 November 2014, you wrote to Surrey and Borders Partnership NHS Foundation Trust in accordance with the Regulation 28 report to prevent future deaths, stating that during the course of the inquest the evidence revealed matters giving rise to concern. We would like to take this opportunity to offer our sincere condolences to Mrs Stachurska's family for their loss.

The areas of concern you raised that relate to our Trust and our responses are detailed below:

1.That the quality of the mental health risk assessment may be diminished if:

(a) mental health staff are not aware of relevant SASH policies when working at East Surrey Hospital;

(b) the use of untrained staff as interpreters for mental health assessments is the norm rather than an exceptional or emergency occurrence;

(c) staff members who are not health care professionals are asked to interpret during mental health assessments are not given any training or guidance as to how to carry out this role.

1a) We have worked with our colleagues at East Surrey Hospital to ensure that a shortcut to Surrey and Sussex Hospital (SASH) policies is loaded onto all of our Psychiatric Liaison staff's computers to ensure ease of access for our staff. The SASH policy relating to using translation services has been made available as mandatory reading for our staff working at SASH.

1b) As a local protocol, we have now mandated that where possible two staff will undertake an assessment when the use of a Translator is required, and full discussion between the staff will take place prior to a discharge plan being

confirmed. It is hoped that this will reduce any cultural misunderstanding and aid in better interpretation of the information.

1c) In SASH's procedures it is outlined that a member of staff can be used as the interpreter in an emergency situation. However when using a member of staff as an interpreter, Psychiatric Liaison Services will ensure that this member of staff must be a healthcare professional and is aware of their accountability, responsibility and confidentiality duties.

We have reminded our staff to ensure that they record clearly in our electronic patient records any decisions made regarding the use of an interpreter and outline the rational for using staff for this role. It has also been mandated that staff check that any use of an interpreting service is adhering to the East Surrey Hospital interpreter and translator policy and that they record in the patient records their compliance to this policy for that interaction.

2. Neither SASH nor SABP had considered that they should undertake a serious incident review into the case despite the death of a patient only a few hours after discharge.

(a) An opportunity to learn lessons from the above events has hence been delayed and potentially been lost;

We agree that an opportunity for prompt learning has been lost due to the delay in investigation. We however want to stress that we do take learning from such events seriously and as such we will be following up with the team concerned to ensure that the actions that have been agreed are embedded in practice, to prevent any future adverse events.

In this instance at the time of the incident coming to light, we believed that the lead provider in the care at the time of the death was going to report and lead the investigation process and as due process we would have taken part in the investigation. Unfortunately in this instance all the communication regarding the responsibility for the serious incident investigation was managed through the HM Coroner's Office instead of directly with our acute care provider colleagues as per our general practice. We have taken steps to ensure that when such issues arise we as providers make contact with each other early and agree reporting and investigation responsibilities.

Our Board and commissioners will be made aware of your letter and the actions we have taken to strengthen our processes going forward. We hope that the steps we have taken as outlined above assure you and Mrs Stachurska's family that we have learnt and continue to learn from Mrs Stachurska's death. Please do not hesitate to contact me if you require any further information.

Yours sincerely

[redacted]

Director of Quality and Deputy Chief Executive (Nurse Director)

cc

Fiona Edwards, Chief Executive
[redacted] – Medical Director
[redacted] - Director of Children & Young People Services
[redacted] Director Risk & Safety (DDoN)