21 March 2016

Southern Health NHS
NHS Foundation Trust

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29 MAR 2016

Dear Sir

Regulation 28 Report – Louise Dawn Locke

I write further to the above issued on 29 January 2016, following the conclusion of the inquest into the death of Louise Locke.

I note your areas of concerns, which I will address in turn, are as follows:

1. The Community Mental Health Service discharged Louise Locke prematurely and without carrying out a proper risk assessment of offering her adequate support.

You heard evidence from Kate Brooker-Corcoran, Associate Director for Adult Mental Health Services, and Carole Adcock, Head of Nursing who agreed with the concerns you raised in relation to premature discharge without a risk assessment in the context of patients being invited to attend appointments for second opinions away from their home area, with no means of support to get there.

The Adult Mental Health Management Team have discussed this and an action has been assigned to the Clinical Service Directors in each area to formulate a standard plan to ensure that patients requesting second opinions have access to these, and are not prematurely discharged if they advise that they are unable to attend their appointment. There is agreement across all areas that a second opinion offer should be individually negotiated to the needs of the service user, and that if someone alerts us that they cannot attend the appointment then other arrangements will be made to facilitate the appointment either through a different venue or through the consultant travelling to another area. The standard process will depend on the geography of each area and consultants working arrangements. These plans will be brought back to the Clinical Director [redacted] for sign off on the 21st April at the directors meeting. Risk assessments should take place prior to any discharge and this has been communicated through all learning events related to this RCA. The disengagement policy will be amended to reflect the process to follow disengagement from a second opinion.

2. There was no adequate system in place to collate and assess information from other agencies such that her risk profile could be reviewed and appropriate support offered.

Since the inquest we have amended our Standard Operating Procedure (SOP) in relation to patients who attend an Emergency Department, for a self-harm or overdose incident on 3 occasions within a four week period. These people will now be flagged within the Acute Mental Health Team (AMHT) and will be discussed within the MDT to review safety, risk and need and to agree whether any changes to their current care plan is required.

The wider information from other agencies that also have frequent and escalating contact with individuals will be collated and actioned through the High Intensity Usage Group and systems associated with this forum, as described below. There is two way sharing of information about this group of individuals between agencies in these forums.

3. The systems already in place in some parts of Hampshire for a multi-agency approach to high risk individuals do not apply to Winchester and so opportunities to recognise these people are being missed. There should be a consistent approach by Southern Health to suicide prevention across all of the areas it serves.

These High Intensity User Groups are multi-agency forums and include representation from Police, Ambulance, Community Mental Health, Hampshire County Council Safeguarding and Emergency Department staff. The revised SOP also ensures that AMHT staff will engage with the High Intensity User groups in their local areas to support consistent care planning.

Any patients identified as having presented to ED on three or more occasions are discussed at a High Intensity User Group (HUG). As discussed at the inquest these were already in place in the South and East areas, but are now developed within the North and West Areas – thus covering the whole Southern Health NHS Foundation Trust area.

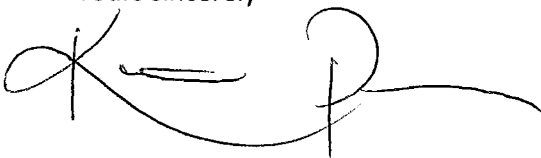
The detail of the SOP has been communicated at team levels through a variety of means including email and team meetings and will be shared to all staff via the Divisional Team Brief in March. The practice is now in operation across all AMHT services in Southern Health NHS Foundation Trust and will be monitored through the Adult Mental Health Acute Care Forum.

In order to ensure that learning from this case was shared across the whole of Adult Mental Health services the Root Cause Analysis (RCA) into the care and treatment that was provided to Miss Locke was discussed within the Adult Mental Health Service Development session on 3rd February 2016. This was attended by Clinical Service Directors, Area Managers, Heads of Nursing and Quality for all areas. In addition also present were the Associate Director, Clinical Director, Associate Director of Nursing and Italk Clinical Director. Communication took place in relation to the learning that came from the RCA and discussion followed regarding the Action Plan which received full commitment from them.

Further, an Adult Mental Health Services learning network event took place on 9 March 2016 at which 47 staff attended from across all Adult Mental Health services including inpatients, community and I talk - this included medical staff, team managers, team leaders and frontline clinicians. I understand that you were invited by [redacted] Associate Director AMH to attend this Learning Network and have therefore seen the agenda. I have enclosed within this response the actions and learning taken from the day that has been shared across all teams and the implementation of these will be monitored through the appropriate community and acute care forums and the AMH Quality and Strategy Board in order that we can provide ongoing improvements and assurances around reducing the likelihood of a recurrence of a similar nature with other patients.

Finally, given that we recognise that this is not just about sharing learning within Southern Health Foundation Trust on the 11th April 2016 [redacted] will be presenting the Louise Locke RCA, learning and actions taken to date with the Hampshire Wide Crisis Concordat Steering Group in order that any actions which require a multi professional approach can be included in the action plan for 2016 /17 and once these minutes are available I will share these with you for your information and assurance.

Yours sincerely



Katrina Percy
Chief Executive

Encs.