Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

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19 September 2016

Mrs Louise Hunt
HM Coroner, Coroners Court
Birmingham and Solihull Areas
50 Newton Street
Birmingham
B4 6NE

Dear Mrs Hunt,

REPORT TO PREVENT FUTURE DEATHS: PATRICIA ANN CLEGHORN

I write in response to the Prevention of Future Deaths report that was issued following the inquest into the death of Patricia Ann Cleghorn with assurance of the action that we are taking in relation to your concerns.

Patricia Ann Cleghorn sadly died from an intentional overdose whilst being cared for in the community by one of our Home Treatment Teams. She was awaiting voluntary admission to an in-patient bed, but as none were immediately available she received twice daily visits from the Home Treatment Team. She had stated her intention to take her own life and was self- medicating. At 17.00 on 14 December 2015 Patricia was seen at home in her bedroom by the Home Treatment Team and given a 5 mg diazepam tablet. This had a dramatic effect on her which was not appreciated by the healthcare assistant despite questioning by Patricia's husband and soon after this Patricia was found collapsed, an ambulance was called but she was declared dead by the Paramedics.

The conclusion by the Coroner was that her death had been contributed to by neglect.

The MATTERS OF CONCERN raised were as follows:

(1) The deceased could not be admitted to hospital as there were no inpatient beds available. I heard evidence at the inquest that had she been admitted it is unlikely she would have died when she did. The availability of acute mental health beds means the most vulnerable people are being cared for in the community with limited resources and care.

(2) The deceased had repeatedly stated that she would end her life by taking an overdose. Despite this she was left at home self-medicating drugs including amitriptyline, MST and oramorph. No formal risk assessment was undertaken and staff failed to appreciate what drugs she had available to her.

AVAILABILITY OF INPATIENT BEDS

In respect of issues raised in relation to the lack of availability of an inpatient bed (1) we are very sorry that this was the experience for Mrs Cleghorn and that she took her life during this period. We extend our apologies to her family and have undertaken significant work with the aim of preventing any future deaths of this nature.

I can confirm that the availability of acute mental health beds is sadly a national challenge and we are working collaboratively with Trusts across the region and nationally to try to accommodate demand, wherever possible. We recognise that at times this means that some vulnerable people are being cared for in the community.

As a result of the unfortunate death of Mrs Cleghorn we have taken immediate action to review our bed management processes and community processes, so that we can ensure that any patient awaiting access to an inpatient bed receives enhanced care from our community staff.

Some of the immediate actions include:

- Creation of an urgent care assessment team to concentrate specifically on the assessment of patients who are in crisis. This approach has been piloted and has demonstrated that having an urgent care assessment team improves outcomes for patients at this vulnerable time. The substantive team will be in place by the end of September 2016
- One consultant psychiatrist will form part of each home treatment team to ensure that all patients who are presenting high levels of risk have daily access to medical review or medical opinion. This will be in place across all of our home treatment teams by the end of October 2016

At the time of Mrs Cleghorn's death we had an average of 30 people awaiting admission to an inpatient bed, and a further 15 patients placed in out of area beds. At the time of writing this response I am pleased to report that we have just 2 patients waiting for access to a bed and only 1 patient placed in an out of area bed. This improvement is reflective of a range of work that has taken place within the Trust over the last few months to improve the flow of patients through our inpatient beds and enhanced skill and care provision within our community services and home treatment teams.

All of these patients have received:

- An updated risk assessment
- An updated mental health state assessment
- Proposed plan of inpatient care
- An agreed plan of care in the community whilst awaiting a bed

- An agreed review timetable for the patient (all patients must have at least a daily review but this may be increased as per need/risk
- A crisis plan agreed with patients and carers where possible, to include all relevant support contact details for service users in crisis and also highlights protective factors and relapse management (updated plan from August 2016 and compliance daily audit introduction)

This is now part of our standard policy approach to managing patients who are awaiting access to a bed within the organisation.

All patients waiting are reviewed on a daily basis by the bed management team and a clinical director to decide the level of urgency for access to the bed. Those requiring urgent access will be prioritised and if there is no bed capacity within the Trust all other local providers will be contacted to see if they have capacity, and if not private providers will be contacted.

More strategically we are working with our MERIT partners, who include; Dudley and Walsall Mental Health Partnership NHS Trust, Coventry and Warwickshire Partnership Trust and Black Country Partnership NHS Foundation Trust, across the region to develop consistent and unified pathways of care for patients in crisis.

MEDICATION

In respect of the concerns raised concerning a lack of formal risk assessment and failure to appreciate the drugs available to Patricia (2) we have liaised with colleagues including the Senior Nurse for Professional Standards, Head of Pharmacy Services, the lead for investigations, Clinical Service Managers for Home Treatment Teams and Home Treatment managers, and the following are our findings and proposed action plan:

Findings:

1. We do not consider it appropriate for a non-registered professional to have administered the first dose of the newly instituted benzodiazepine medication. Indeed this was a breach of our current Medicines Code which stipulates the following

   "3.5.12 Staff who are not registered nurses may deliver medication for self-administration by the service user. However where medication is to be administered, via any route, the person supervising the administration of the medication must be a nurse whose registration is recorded on the NMC professional register" and

   3.9.4 Schedule 2 and 3. Controlled Drugs, benzodiazepines and hypnotics - The administration of all Controlled Drugs including benzodiazepines and hypnotics must be witnessed by a second practitioner".

2. This has highlighted the need for us to clarify the role of non-registered staff in our community crisis teams, with particular emphasis on the scope of their role and to ensure that tasks delegated to them are within their sphere of competence.

3. Medicines supply and assessment of the stock of medication that the service user has access to should form part of the clinical risk assessment for service users in crisis in the community.

Where risks are identified then medicines supply should be tightly controlled and overall medicines possession checked regularly as far as possible. If indicated, following appropriate risk assessment we will work with service users and carers to remove excessive medication in the interests of safety. It has to be recognised that we have to work within reasonable limits which are determined by the services user's capacity and preparedness to fully disclose information and allow checks/searches. If our staff are in any way unsure that it is safe to supply medication, the team will need to consider whether to withhold supply and explain why.

Proposed Action Plan – All of the actions are in place with the exception of item 4 which will be delivered by the end of November 2016

1. We will take action with regards to managing the breach of policy

2. The Senior Nurse for Professional Standards issued a formal practice alert on 12th September 2016 to registered and unregistered clinicians in our crisis and community teams to reinforce the requirements for:

- Clinical Risk Assessments regarding risk of self-harm and/or suicide;
- Risk Assessments with regard to medicines management and self-medication;
- Safe administration of medication as per current Medicines Code and NMC Code.

We required staff to sign returns to say that they had read and understood the directive

3. We have established a Clinical Risk Management Group which is addressing:

- Clinical Risk Management approaches and training;
- Suicide Prevention;
- Improved implementation of crisis care plans.

4. The Head of Pharmacy will undertake an immediate review of the Medicines Code to ensure that these issues highlighted above are properly considered and addressed in the revised Code and supporting direction for staff. This will be reported through our internal governance arrangements by the end of November 2016.

We believe that the improvements identified above will enhance our current arrangements and would like to thank you once again for bringing these matters to our attention.
You may find it helpful if I was to write to you again in six months to update you on our progress and I will diarise this accordingly.

Yours sincerely

John Short
Chief Executive