Care Quality Commission
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Mrs Louise Hunt
HM Coroner, Coroners Court
Birmingham and Solihull Areas
50 Newton Street
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Dear Mrs Hunt

Regulation 28 Report in relation to the Inquest touching on the death of Patricia Ann Cleghorn
Ref: 112029 - Patricia Ann Cleghorn - (LH/AS)

I write in response to the Report to Prevent Future Deaths that was issued following the Inquest into the death of Patricia Ann Cleghorn, with assurance of the action the Care Quality Commission (CQC) is taking in relation to your concerns.

Birmingham and Solihull Mental Health NHS Foundation Trust ('the Trust') is the CQC Registered Provider of services received by Mrs Cleghorn. In May 2014 we carried out a comprehensive inspection of the Trust and it was rated 'Good' overall. We will be carrying out a fully comprehensive re-inspection in 2017 and intend to use the issues highlighted in your Report as a 'key line of enquiry'.

The CQC became aware of Mrs Cleghorn's death upon receipt of the Regulation 28 Report. As a result of the Report we made a request to the Trust for a copy of their investigation into the death and received a copy of the Trust's Root Cause Analysis report (RCA). Based on the RCA we required the Trust to provide us with the following information:

- What training do qualified and unqualified staff receive in the home treatment team with regards to medication management and administration?
- What is the Trust policy/guidance for staff on monitoring medication reconciliation?
- Did the records detail whether the nurse who administered the diazepam to the Mrs Cleghorn at 5pm had a case discussion with the prescriber afterwards and if so what was the nature of the discussion?

The Trust responded to the questions and supplied us with their checklist to support the process of medicine reconciliation. We were concerned that the information received specified that the nurse who had visited was unqualified but that the RCA did not. We contacted the Trust to confirm that the nurse was unqualified.

A quarterly meeting between CQC and the Trust took place 15th September 2016 where we discussed what actions they had taken. We will be meeting with the Trust again in December 2016 to review the impact of their action plans.

Matters of Concern raised in your Report:

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.*

There remains a shortage of acute beds in this Trust and in other Mental Health Trusts in the region. This shortage will continue to impact on vulnerable people in the community. The provision of acute mental health beds rests with the Trust and with the clinical commissioning groups (CCGs), The role of the CCGs is to get the best possible health outcomes for the local population, by assessing local needs, deciding priorities and strategies, and then buying services (including mental health services) on behalf of the population from providers such as this Trust. The CCGs also check on the quality and safety of such services.

Whilst this shortage continues, the risk that another person will take his or her life remains high.

This Trust has taken action to reduce that risk by the creation of an urgent care assessment team and the availability of consultant psychiatrists to provide medical review. CQC will continue to meet with the Trust's nominated individual to monitor their action plan in December 2016 to ensure they (the Trust) continue to take action to minimise the risk to vulnerable people in the community.

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.*

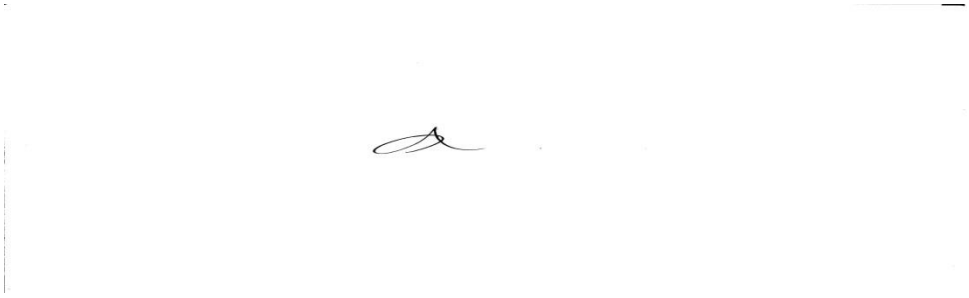
The likelihood of other people being exposed to the same risks remains. However, the Trust found that it was wrong for non-registered professionals to administer the first dose of a new medication and was a breach of the current medicines code. As a result, they will be reviewing and clarifying the role of non-registered staff in the crisis team. The crisis teams, as part of the clinical risk assessment, review medicine they provide and medication that people have access to in their home. CQC is currently considering whether enforcement action is required at this stage.

With the actions identified by the Trust implemented, the risk to vulnerable people on home treatment will be low.

The CQC local Inspection team continue to meet with 'local services' and in addition we will formally review the actions put in place by the Trust and their impact of those actions on patients at our quarterly meeting with the Trust in December 2016.

Should you require any further information, please do not hesitate to contact me.

Yours sincerely



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Head of Hospital Inspections (Mental Health), Care Quality Commission