

West Park Hospital  
Edward Pease Way  
Darlington  
Co Durham  
DL2 2TS

27 SEP 2016

Direct Line: [REDACTED]  
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27<sup>th</sup> September 2016

Mr A Tweddle  
H.M. Coroner, County Durham and Darlington  
H.M. Coroners Office  
PO Box 282  
Bishop Auckland  
County Durham  
DL14 4FY

Dear Mr Tweddle

**Re: Pamela Gressman, deceased  
Regulation 28 Report**

Further to your letter 2 August 2016, I write to detail the actions we have taken relating to the concerns you identified during the inquest into Pamela Gressman's death.

You identified that you felt insufficient or no consideration was given to any physical effects which might ensue from her ingesting the foreign bodies that she reported she had, and which led to her period of hospitalisation, leading to the conclusion that little or no thought was given to any link between such items and her presentation with abdominal pain in January 2016. You felt that the absence of a clear treatment and observation plan in such circumstances could lead to a risk of similar fatalities in the future.

The Trusts internal serious incident report identified root and contributory causes resulting in a number of actions being progressed. We have now had the opportunity to review your findings and have outlined below the actions taken to date and those we are putting in place to reduce the risk of a similar incident occurring in the future:

- The findings and lessons learned from the internal investigation and inquest have been shared in detail with the ward multidisciplinary team, which continue through a variety of means across the Trust.  
**To be completed 30<sup>th</sup> September 2016**

- A review of the observation and engagement procedure will include consideration of a period of enhanced observations for a period of time following ingestion of a foreign object to enable close monitoring of any physical side effects but also to monitor if any foreign bodies are passed through stools. **Completed**
- Further case discussion and lessons learned from the incident is being held with all inpatient Consultant Psychiatrists and Modern Matrons.  
**To be completed 31<sup>st</sup> October 2016.**
- Additional training requirements identified for staff around the use of the Early Warning Signs (EWS) process in particular. Individual clinical supervision sessions are taking place to reinforce EWS and physical health monitoring processes with the ward staff, including that staff must not just record any deterioration but take action on this through seeking prompt medical advice.  
**Completed**
- Formal training sessions to be delivered to specifically include:
  - Consideration of the possibility of physical effects (sometimes delayed for days) following swallowing of foreign objects, in particular for patients with known history of this
  - Clarification of process to check if foreign bodies have been passed in stools by patient
  - The requirement to have a risk management plan and intervention plan to monitor and manage physical health care symptoms of concern and the need to record related observations (10 case notes to be audited).**To be completed 31<sup>st</sup> October 2016 (delayed due to the challenges of delivering training during the holiday period).**
- An SBARD (notification document) has been developed for all staff Trustwide in relation to improving patient safety and minimising the risk of a repeat incident.  
**Completed.**
- Recruitment of a Physical Health Practitioner for the West Park site to provide additional support, skill and expertise to ward teams.  
**Recruitment to commence September 2016.**
- Liaison colleagues to work with the local Emergency Department to ensure standard work is designed and shared to ensure X-rays are done of thorax and abdomen in such instances.  
**To be completed by 31<sup>st</sup> October 2016.**

The Directorate Quality Assurance Group will also ensure that the lessons learnt are shared across other inpatient areas so they can assure us that similar issues should not occur elsewhere. The Trust has corporate processes to both monitor completion

of serious incident action plans and to audit the effectiveness of those actions in creating change and improvement.

I hope that the information contained here, and in the action plan attached, provides you with the necessary assurance you require.

Yours sincerely



**Colin Martin**  
**Chief Executive**