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27 March 2018

Mr A Cox  
HM Assistant Coroner  
Worcestershire Coroner's Court  
The Civic  
Martin's Way  
Stourport-on-Severn  
Worcestershire  
DY13 8UN

Dear Mr Cox

**Re: Inquest touching the death of Gail Bannister  
Regulation 28 report to prevent future deaths - response**

Thank you for your letter dated 9 February 2018, and the enclosed Regulation 28 report. I have read your report with great care and note the concerns that you have raised as a result of the coronial inquiry into the death of Gail Bannister.

In your report, you highlighted the following points of concern and I will respond to each in turn:

- 1) The rationale behind discharging Mrs Bannister from the HTT to CARS was that she had been seeing too many different people. It was felt that by concentrating her care in the hands of the community Consultant Psychiatrist and a Care Co-ordinator, who would arrange the psycho-social services she would benefit from, this would improve her treatment. The fact that the Care Co-ordinator did not see her frustrated and undermined this approach.***

It was the expectation of both the discharging clinicians, and the community Psychiatrist that a Care Co-ordinator would be frequently involved with Mrs Bannister. This is also documented in the plan of care set out by the community Psychiatrist following her appointment with Mrs Bannister on 16th August 2017, when the Care Co-ordinator was also in attendance. As heard in evidence during the inquest, the Psychiatrist was under the impression, that following this appointment, weekly visits from the Care Co-ordinator were in fact taking place.

It is extremely concerning that it transpires that, with the exception of the above mentioned joint appointment on 16th August 2017, no contact was made by the Care Co-ordinator with Mrs Bannister.

I confirm that the Trust is addressing this matter in an appropriate manner. I am sure that you will appreciate the confidentiality obligations which I face, which means that I am unable to share specific details with you and other Interested Persons.

- 2) *During the inquest, I was told that the deceased's husband tried to speak to members of the care team who were based at Studdart Kennedy House when a crisis developed. It took him several hours to get through. I was told that there is only one phone line and that this is a known and recurring problem.*

An action plan has been put in place to install a telecommunications system which will provide a digital telephone system (VOIP). This will enable call waiting and call forward/transfer automatically.

An initial review of the current system has already taken place and a contractor survey of Studdart Kennedy House has been agreed and funded by Worcestershire County Council (who own the building). This costings survey was undertaken on 21st and 22nd March 2018, however has not yet been received by the Trust.

It is hoped that a capital bid will be completed by the end of April 2018 and sent to the Finance Director for approval, with work to begin following this.

Unfortunately, a date for completion cannot yet be given as this will depend upon external contractors, however, I would like to offer re-assurance that this matter is being given the attention required.

In the meantime, interim measures have been implemented, consisting of a mobile telephone being used by Adult Mental Health staff to use to contact the site/duty worker and communication has been given to all staff to advise them of this interim measure and the appropriate contact telephone numbers to use.

I trust that the foregoing has adequately addressed the Regulation 28 report issued subsequent to the inquest into the death of Gail Bannister. Should you require any progress updates or clarification in relation to this matter, please do not hesitate to ask.

I confirm that I have not forwarded a copy of this response to any other Interested Person and would therefore be grateful if you could do so as appropriate.

I also confirm that the Trust is content for both the regulation 28 report and the response to be released or published should the Chief Coroner wish.

Yours sincerely



**Sarah Dugan**  
Chief Executive