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NHS Trust

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Our ref: JH – June 18

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By email to Leicester.coroner@leicester.gov.uk
Lydia Brown
Assistant Coroner
Leicester City and South Leicestershire
The Town Hall
Town Hall Square
Leicester LE1 9BG

Re: John Hazlewood

Further to your report dated 21 June 2018, in accordance with paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, I offer the following response.

We have investigated the matters of concern that have arisen during the course of the inquest of John Hazlewood. Leicestershire Partnership NHS Trust takes these matters very seriously and I hope that you and Mr Hazlewood's family will be satisfied that we have taken the appropriate measures to prevent such an occurrence happening again.

The matters of concern you have raised are as follows:

1. The court heard that the on call Dr for psychiatry did not have remote access to Mr Hazlewood's medical records and this prevented her from being informed of his significant psychiatric history, and furthermore prevented her from writing a note of her discussions regarding his request to self-discharge. Therefore the knowledge that he had presented again via ED with a serious overdose was not available to his Consultant so an opportunity was missed to escalate his care. Many of the on call team do have remote access and the Leicester Partnership Trust are asked to consider this issue for all relevant clinicians in order to avoid future difficulties of communication.

Response

[redacted], Clinical Director, has confirmed that all trainees on the relevant rota in Adult Mental Health and Learning Disabilities service now have remote access to the same clinical systems they would be able to access if they were working on the Trust's sites. This means that all

psychiatry junior doctors and specialist trainees who cover the University Hospitals of Leicester NHS Trust out of hours have this access. In addition they also have access to the specific electronic patient record systems, regardless of their speciality, i.e. doctors working in adult services have access to the system used for child and adolescent mental health services and vice versa.

2. Mr Hazlewood's partner was repeatedly expressed to be his main or only protective factor from self-harm. She was not approached for information regarding his overdose, or her concerns regarding his escalating behaviour and this missed an opportunity for the fuller picture to be captured when considering care planning and mental health assessment. This is an issue that I have raised with the Leicester Partnership Trust before in the matter of William Abel and it appears that carers/families are still not being routinely involved in the care of mentally unwell patients. This can create intolerable pressures upon families and leads to poor outcomes such as in these 2 cases. LPT are urged to consider how this matter can be embedded in training and practice.

Response

Staff in our Assessment and Triage Team endeavor to elicit carers' and families' views regarding the care and treatment of patients, this enables us to gain an understanding of the whole person. However, this is clearly not always as effective as we would like. Although we implemented a number of actions in 2015 in response to the death of Mr. Abel, it is clear we need to continue to reinforce the importance of effective communication with families/carers. With this in mind, our senior Matron will complete work with the teams to ensure all staff in our Mental Health Triage team have a supervision session with the focus on family and carer involvement in the assessment process and discuss ways in which they can improve this within their working practice. This will be completed by October 2018. We have also provided all staff within the Mental Health Triage and Crisis teams with a copy of the NICE guidelines which covers the benefits of family/carer involvement and all staff receive a Whole Family Approach Bulletin every two months which highlights and shares good practice and learning. We have also commenced a review of the current record keeping audits to expand the family/carer section of the audit. Our compliance will continue to be monitored through our weekly record keeping audits and form part of our monthly clinical governance agenda.

3. The court was assured that the induction process had been changed to improve knowledge regarding on call procedures and availability of medical record access. No information was available, via audit, of whether this amended process is successful. LPT should ensure that the outcomes of their welcome changes are being effectively monitored to ensure clinicians have appropriate training and understanding given the frequent rotations of staff and the importance of the on call system being robust and reliable.

Response

Following Mr Hazlewood's inquest, in addition to the actions taken in response to the serious incident investigation findings, further improvements have been made to the central duty rota (CDR) induction processes. The doctors on the central duty rota cover the LRI out of hours.

An induction for the central duty rota doctors was held on 3.08.18 that involved consultants and clinicians from different services that contribute to the CDR on call rota (Crisis team, mental health triage team, liaison team and child and adolescent mental health team). The induction presentations will be video recorded to enable ongoing access for future new starters. In addition this session included a site induction at the LRI for the current CDR on call doctors. The induction provided a comprehensive programme, and will be delivered at every rotation when new doctors join.

The central duty rota on call guide has been updated in July 2018 after collaboration with other consultants and the current cohort CDR on call doctors to ensure that it meets their needs.

[redacted], Consultant Psychiatrist & Associate Medical Director (Postgraduate Medical Education) did an evaluation of the induction feedback, 12 out of 12 trainees participated in the feedback. All 12 rated the induction as good or very good in content, 11/12 rated the quality as good or very good.

We hope this reassures you that we have taken appropriate action in response to your findings regarding doctors' access to medical records systems, involvement of patients' families and on call procedures to provide safe and effective care in order to reduce the risk to our future patients.

Yours sincerely

Dr Peter Miller
Chief Executive