NHS
Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

Neil Carr

Chief Executive
Trust Headquarters
St George's Hospital
Corporation Street
Stafford
ST16 3SR

Tel: 0300 790 7000

Mr A Haigh
HM Senior Coroner for Staffordshire (South)
Coroner's Office
No 1 Staffordshire Place
Stafford
ST16 2LP

17th October 2019

Dear Mr Haigh,

RE: Maureen Margaret (known as Mandy) Jarvis

Thank you for your letter dated 11th September 2019, reporting a matter to us, in accordance with Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013.

May I take this opportunity to reassure you that following Mrs Jarvis' death, we undertook a thorough investigation into the care delivered by the Trust.

Following discussions both within the mental health Services in the Staffordshire and Stoke Care Group and across the wider Trust, I am now in a position to respond to your specific concerns, raised by you during the course of the evidence you heard at the inquest.

1. Area of concern; *" during her final admission to the George Bryan Centre Mrs Jarvis did not have a proper medical examination by a doctor. The reasons given for this were that she would not consent and that her condition never warranted this being done on a non-consensual basis. Among other witnesses I heard helpful evidence from the Consultant Psychiatrist [redacted] who indicated that this was a difficult area and also from [redacted] (the lead author of the Serious Incident Review) who believed there was a policy about physical health examination of admitted psychiatric patients and this should be disseminated to all staff involved."*

In response we can confirm that a policy and Standard Operating Process (SOP) existed at the time of Mrs Jarvis's death. These outline the responsibilities and expectations of inpatient staff to undertake physical health investigations on admission and also the expectation in the circumstance of refusal to consent to continue to attempt during the

admission. These documents are currently due for review as part of the continuous improvement and ratification cycle. Following changes in recording of investigations in our electronic health record system further guidance was developed to sit alongside these SOP's. I can confirm that these documents have been circulated to all the staff on our mental health inpatient wards and are being referenced in new inpatient staff local inductions.

In addition several actions have been completed to further enhance the physical health care of our patients admitted to our mental health units. These include:

- The ward staff on Milford Unit (previously the George Bryan Centre West Wing) have undertaken bespoke training in order to further develop their knowledge and understanding of common physical health difficulties.
- An electronic dashboard has been developed to provide an "at a glance" view of whether key physical health assessments and investigations have been completed and recorded on the electronic health record in the appropriate form. This is utilised in clinical discussions on the ward as a live audit tool.
- The ward has secured regular input from an Advanced Nurse Practitioner to specifically to support the physical health needs and monitoring of patients on the ward.
- Ward staff reminded to record consent and/or lack of capacity to consent to a physical health assessment within RiO and if either lacking preventing assessment to regularly revisit and record attempts.
- Dissemination of the Physical Health Policy and SOP as part of the junior doctors induction

Please find enclosed a copy of the full action plan developed as a result of the investigation.

I hope this response helps to address your concerns. However, if you require any further information please do not hesitate to contact me

Yours sincerely

Neil Carr
Chief Executive