DAC BEACHCROFT

Mr Derek Winter
HM Senior Coroner for the City of Sunderland
Sunderland Civic Centre
Burdon Road
Sunderland
SR2 7DN

Dear Mr Winter

Inquest into the death of Daniel Rennoldson
Response to Regulation 28 Report; Prevent Future Deaths Response

We write in response to your Regulation 28 Report dated 17 June 2021 following your investigation into the death of Daniel Rennoldson. This response has been prepared by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust ("The Trust") and addresses the concerns as set out by HM Senior Coroner.

The Trust will respond to each of those concerns in turn.

The Trust considers that in future cases where there are concerns about operational issues, appropriate representation from the Trust would assist HM Senior Coroner in his investigation.

Response

The Trust is committed to ensuring that lessons are learned when any serious incident occurs. At the time of the incident a Serious Incident ("SI") Investigation was undertaken and the Trust formed an action plan. Both the SI investigation and action plan were shared with HM Senior Coroner in advance of the inquest.

Below is set out the response to each of HM Senior Coroner's concerns:

1. **There appeared to be no contingency to deal with more than one face to face response at a time, leaving other callers potentially at risk.**

   At the inquest HM Senior Coroner heard evidence in relation to Crisis Team contingency plans. Evidence highlighted the following information:

   a. There are 3 assessing teams available to carry out face to face assessments. This included an adult team, an older persons team and a team for children.
   b. On occasions where there were a number of assessments waiting to be undertaken on

commencing a shift, the usual multi-disciplinary meeting would be postponed to ensure that any potential delays were reduced.

a. The Crisis service has the capacity to respond to more than one face to face assessment:
    i. The day shift works between 08:00hours and 21:00hours and has 3 assessment teams. Each assessment team has a Working Age Adult (WAA) clinician and a specialist clinician (older adult or children and young person clinician).
    ii. The twilight shift works between 16:00hours to 3:30hours. This shift was agreed in order to provide additional support during the busiest part of the 24 hours period.
    iii. The nightshift works between 20:45hours and 08:15hours. From 21:00hours there are 2 assessment teams and a triage clinician, although staff are able to flex between roles to meet demands.
    iv. The above shifts have been agreed based on the intelligence of referral rates over a 24 hour period, allowing resources to be flexed to peak times.
    v. Each assessment team will respond predominantly to their area of specialism, but will also provide cross cover across pathways depending on pressure points. There is also flexibility to reconfigure assessment teams and utilise staff from mid-shift, home based treatment and/or shift coordination should patient need require this.

b. At the time of this incident, a member of the assessment team was on sick leave which reduced the assessment provision for that night only. At the time of DR's call, the children and young person's clinician was engaged in clinical interventions and the other assessment team were engaged in assessment at the time.

c. Notwithstanding point (b) above, the assessment team could have responded to a home visit for DR within the national recommended response time for Crisis services of 4 hours. DR however, had provided information to the assessing clinician that he wished to sleep and would prefer an assessment the following day.

d. It is common practice for Crisis Teams to cross cover and draw upon resources from other locality Crisis Teams should this be required.

e. Nationally, Crisis Services are recommended to provide a 4 hour response and therefore do not provide an emergency response. In the event an immediate risk is identified, the emergency services would always be the most appropriate contingency to ensure patient safety.

2. **Almost 12 hours had elapsed from Daniel's call to someone visiting his home address with no mechanism to identify cases, which had not been progressed.**

The Trust can confirm that there are already robust mechanisms in place to track referrals active to the Crisis Team, including those still awaiting an assessment.

The inquest heard that the following was in place when a referral was received:

a. The assessing team were notified of DR's call on their return to base. This provided an awareness of DR in the event he called back and requested an assessment at an earlier than planned time.
b. Referrals requiring an assessment the following day are handed over to the day duty team.
c. The assessment is placed on the Trust 'At a Glance Board' to ensure teams are able to see outstanding assessments. The assessment will only be removed from the 'At a Glance Board` once the assessment has an outcome of complete or the referral is closed to the service. The `At a Glance Board` is a wall mounted electronic system which is integral to the daily functioning and co-ordination of clinical work within the team. It is therefore unlikely that any assessment pending on this board would be missed.
d. The requirement for an assessment is discussed within the multi-disciplinary team meeting to discuss risk and prioritisation.

In the above instance, it was noted that DR told the assessing clinician that he would usually sleep between 05:00hours and 10:00hours. The day duty assessing team called DR at 10:30hours in order to organise an assessment however, the call was not answered and a message was left requesting a call back. The initial 6.5 hours that elapsed following DR's call with the triage clinician was therefore due to his request to rest.

At 11:00hours it is acknowledged that Mr Rennoldson's assessment was passed to another Crisis Team locality as they were considered more appropriate to undertake assessment and treatment. The Trust After Action Review acknowledged that there was learning to be undertaken in relation to patients who may cross two Crisis Team localities. On 9th June 2021a reminder and flow chart outlining the long standing cross boundary agreement was sent to the team and discussed in individual supervision.

The Trust action plan, already shared with HM Senior Coroner, highlights that where an assessment is agreed and considered an emergency in line with the urgent and emergency response times, an assessment should be carried out within 4 hours. The action plan confirms

that a monthly review of response times has been undertaken to ensure that agreed standards continue to be met. The Trust can confirm that within the monthly review there were no issues identified.

Response times continue to be monitored within the team on a weekly basis and any issues explored and addressed. Any breaches in response times are escalated and discussed at monthly Trust wide forums.

We hope that the information provided offers you the necessary assurances that the Trust already have in place effective contingencies and mechanisms to avoid delays and are committed to ensuring that the national recommended time of 4 hours for Crisis assessment is achieved.

Yours sincerely

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Executive Medical Director