NHS
Norfolk and Suffolk
NHS Foundation Trust

Trust Management
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Hellesdon Hospital
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[redacted]

Ms Yvonne Blake
Area Coroner for Norfolk
Norfolk Coroner Service
County Hall
Martineau Lane
Norwich
NR1 2DH

16 August 2021

Dear Ms Blake

Re; Regulation 28 notification regarding the care of Terrence Tuttle

I write in response to your letter dated 9th August 2021 outlining your concerns regarding the care and treatment of Terrence whilst an inpatient at the Queen Elizabeth Hospital in Kings Lynn. I am very sorry to hear about the sad death of Terrence. Should this letter be shared with his family, I would like to pass on my condolences to them.

Having reviewed the notification I am surprised this has come to our Trust. I have discussed this with colleagues at the Queen Elizabeth Hospital (QEH) to ensure we do not duplicate responses. It is regretable that we were not asked to provide information on the concern prior to the conclusion of the inquest, as I understand it we were advised that we were not an interested party. I am confident that we would have been able to satisfy your concern immediately given the opportunity.

Out of the concerns listed below I would advise that NSFT are able to respond to the second part, in italics, of the first point only. The other points would be for the QEH to respond to:

1. Lack of proper dietician assessment and *mental health review at an early stage*.
2. Inaction when Mr Tuttle was losing weight even though his intake was recorded, no-one acted upon this.
3. Ability to assess Mr Tuttle adequately under the Mental Capacity Act.
4. Inability to care for a mentally unwell patient with physical health problems, including gastric problems, who is refusing to eat.
5. Refusal to include family members in caring for (after over 20 years in a care home) a patient who was in unfamiliar surroundings and their better knowledge of his usual presentation.
6. Apparent lack of recognition that serious harm did occur for this patient who was described as appearing cachexic.

It may be helpful to outline the role of the Mental Health Liaison Teams within our acute general hospitals. The team are a triage assessment team and do not provide direct 'hands on' care specifically in relation to physical interventions, for example dietry advice or nutritional balance activities. The team will advise on mental illness symptoms, diagnosis, compassionate least restrictive care and de-escalation techniques. The team will provide both nursing and medical input in relation to treatment including psychotropic medication and monitoring whilst the patient is on the acute ward. They may also arrange for transfer to a mental health ward once the patient is physically fit for discharge but requires further support in relation to their mental wellbeing. Where a capacity assessment is required for a decision on a physical health issue or intervention, the team may assist in respect of mental illness symptomology and the potential impact on a persons capacity. However the decision maker will be the physical health expert.

In Terrence's notes I can see clear and regular communication between the ward and the Liaison Team, approximately two weeks post his admission the team were asked and attended the ward to assess Terrence. He was not able to participate in this but the ward reported that he had been non-compliant with his anti-psychotic medication for approximately one week. Although non-compliant, Terrence was not displaying signs or reporting symptoms of psychosis. The Liaison Team discussed this with the team Consultant Psychiatrist who advised to stop the medication due to the time lapse, concentrate on improving his physical state and re-assess. If the medication was reinstated this would require invasive monitoring procedures. These measures were with the caveat that if he deteriorated mentally to consider a Mental Health Act assessment for detention.

The ward contacted the team again on 1st March as Terrence had improved physically although still refusing food and fluids. He was seen on 2nd March, the team concurred he was depressed and an anti-depressent was commenced. Terrence was discussed within the daily team meeting and reviewed face to face regularly. Terrence was commenced on Amisulpride oral liquid to treat any emerging psychotic symptoms and was compliant with both medications. The team noted an improvement in mental wellbeing on 10th March albeit he continued to refuse food and fluids. Terrence was further reviewed in respect of his medications and presentation by a Consultant Psychaitrist on 11th March. The team attended a best interests meeting on 12th March where the proposal was to move Terrence to a new nursing home which could cater for his enhanced needs.

The community mental health care co-ordinator kept in contact with the ward and the social worker, the plan being that once discharged the Community Mental Health Team would review Terrence in his new accomodation.

I hope that this information satifies your concern.

Yours sincerely

Dr [redacted]
Interim Chief Executive