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17th May 2022

Mr D D W Reid
HM Senior Coroner
Worcestershire Coroner's Court
Stourport-on-Severn
Worcestershire
DY13 8UN

Sent via email to: Coroner@worcestershire.gov.uk

Dear Mr Reid

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

Thank you for forwarding on your 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 Emily Caldicott.

In your report, you highlighted the following points of concern and I will respond to these concerns together, as each concern represents a sequence of events.

Concerns

1) The Jury were satisfied that on the evening of 21.03.20, when Emily [redacted] which resulted in her death, staff on Holt Ward, Newtown Hospital, Worcester, failed to carry out an adequate assessment of Emily's capacity to make a decision about taking Lorazepam to reduce her extreme anxiety and distress, and had they done so, they would have found that she lacked capacity, in that regard, and would have administered an intramuscular injection of Lorazepam in best interests.

2) In the note that she made about these events on Carenotes, dated 22.03.20, staff nurse [redacted] recorded as follows:

"I offered her oral Lorazepam, but she refused, however [Deputy Ward Manager] stated unable to give IM Lorazepam due to her being an informal patient and had already had IM Lorazepam administered under best interests on 19.03.20. On the balance of probability, Emily had capacity to understand that she was informal and that we could not administer medication under MAPA therefore team decided that IM should wait for further guidance from medic following his assessment for S.5(2)"

3) In her evidence, staff nurse xxx, denied that this was the test which was applied when deciding whether or not to give IM Lorazepam to Emily but was unable to explain why she had written otherwise in Carenotes and why she had not corrected herself when making her statement only 2 weeks after the incident, save to say that she had been distressed by what happened.

4) In her evidence, Deputy Ward Manager xxx, said that the reason she had not administered IM Lorazepam to Emily was because she had assessed her capacity to make a decision about such medication during an incident outside the nurses office about an hour before the [redacted], and had concluded that she did have capacity to refuse it. She said that she had not formally assessed Emily's capacity thereafter because she did not think Emily required Lorazepam. She said that Staff Nurse xxx had recorded the test she applied wrongly in the Care Notes because she may not have understood what she was saying.

5) By their conclusion, the Jury found that if an adequate assessment of Emily's capacity had taken place, she would have been given IM Lorazepam "in best interests", that this would have quickly relieved her anxiety and distress, and that her death would probably have been prevented.

6) Although staff on Holt Ward were undoubtedly having to deal with a very difficult situation in this case, I am concerned that if such a decision has to be made, in similar circumstances in the future, staff may not apply the correct test under Mental Capacity Act 2005, and there is therefore a risk of future deaths occurring.

Response

Capacity Assessments and the decisions to administer medication against a patient's will, will always be a matter of clinical judgment at the time. All staff on Holt Ward are well trained to make these assessments in difficult and challenging situations and do so on a very frequent basis. The Deputy Ward Manager who undertook the capacity assessment outside the nurses station is extremely experienced in such assessments and knew Emily very well, having nursed her over several years. Whilst this member of staff undertook the capacity assessment, she did not herself document it. It was instead documented several hours later by another member of staff, and this has led to an inaccurate note being made of the assessment which was carried out, and the discrepancies you described in the evidence given and the note written.

The decision to administer IM Lorazepam will always be as a last resort, when clinically indicated and again based on clinical judgment.

Capacity Assessment training is a part of the training undertaken by all Registered Mental Health Nurses (RMN) during their substantive training. Therefore, all staff, upon qualification as an RMN will have received appropriate training in both Mental Health Act (MHA) and Mental Capacity Act (MCA).

In addition to this substantive training, the Trust has a robust training programme in place which refreshes this substantive training.

MCA and MHA are covered as part of Mental Health staff induction training. There is also a requirement for staff to carry out refresher training in both MHA and MCA every 3 years.

Mental Capacity Act training continues to evolve in response to audits, Serious Incident investigations and feedback from practitioners. The present package for initial MCA training consists of four e-learning modules from the Health Education England resources.

000 MCA: Mental Capacity Act and Safeguarding (30 mins)
000 MCA: Mental Capacity and Best Interests (30 mins)
000 MCA: Assessing Mental Capacity (30 mins)
000 MCA: as Part of Human Rights (30 mins)

These provide all the theory and then practitioners need to attend a facilitated learning event (90 mins) that takes them through undertaking a mental capacity assessment and best interest decision using the recording forms. Practitioners are encouraged to bring anonymous real case examples to work through. We also work through DoLS applications and if relevant to the cohort, touch on Court of Protection applications.

Every three years practitioners have to refresh their knowledge around MCA and DoLS. With kind permission of the BBC some documentaries based on Court Judgements are being used for this at the moment. The documentaries are watched with an accompanying dialogue from a Professor in Medical Ethics and Law enabling staff to consider how the MCA impacts upon care and practice. There is also an on line assessment at the end staff must complete to pass the course

Training is recorded on each staff members Electronic Staff Record (ESR) which shows a traffic light system, indicating when each training is in date, coming up for renewal, and out of date. Staff will receive automatic messages 3 months and 1 month before each mandatory training is due for renewal. In addition to staff receiving this notification, their line manager will also receive the notification so that they are aware of staff training needs. Mandatory training is also reviewed by senior members of staff on a monthly basis in order to ensure all staff training remains in date.

At the time of Emily's death, the percentage of staff who had completed and were up to date with mandatory MCA training was 100%. Currently, at the time of writing, the percentage of staff who have completed and are up to date with mandatory MCA training is 100%.

In addition to the training programme provided by the trust, there are policies in place to support staff and offer guidance and to ensure that the trust are working in accordance with MHA and MCA.

All staff are also aware of the MHA and MCA codes of conduct and where to find these, should they need to refer to them. The Trust also has a Mental Health Act Team and a Legal Team, both of which staff are able to contact, if advice is required.

Staff members all have regular one to one supervision sessions with their line manager, and if any areas where the member of staff requires support are identified, support can be put into place and, if required, the trust do operate a performance management pathway to provide additional support to staff.

In reviewing this Regulation 28 and during the inquest process, the trust has highlighted documentation on Holt Ward as a concern. In this case, there were examples of staff members not writing their notes at the time, staff not writing details of their own assessments and instead allowing another member of staff to write a summary of the events several hours later, staff members not checking the notes when written by somebody else. This has resulted in inaccurate and confusing documentation.

Documentation training is delivered within the trust, both as a mandatory training element but also as an additional session provided to individual teams to highlight the importance of accurate documentation and the implications that inaccurate documentation can have both in relation to patient care, and in staff being able to defend their practice. This training is to be expanded over the next year and will include both clinical and legal elements.

Following on from the inquest, the team on Holt Ward underwent a reflection session with senior managers and the trust solicitor. The specific issues highlighted in this regulation 28 order were discussed, and the importance of accurate and timely documentation highlighted.

I trust that the foregoing has adequately addressed the Regulation 28 report issued subsequent to the inquest into the death of Emily Caldicott.

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

[redacted]
Chief Executive