NHS
Norfolk and Suffolk
NHS Foundation Trust

Ms Jacqueline Lake
Norfolk Coroner's Service
County Hall
Martineau Lane
Norwich
NR1 2DH

Trust Management
Main Administration Block
Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE

31st May 2022

Chair: [redacted]
Chief Executive: [redacted]

Dear Ms Lake

I write in response to the prevention of future deaths issued on 11th April 2022 in relation to the tragic death of Tracy Wood who died on 3rd June 2021. The inquest concluded on 7th April 2022 with a conclusion of misadventure, a number of concerns were raised as part of the inquest process and summed up in the conclusion. I will address these within this response but firstly would wish to extend my heartfelt condolences and sincerely apologise to Tracy's loved ones and friends for the sad loss of this young woman whilst under our care.

For ease I outline the concerns raised below with our action in response:

1. **Tracy Wood was placed on Yare Ward, an acute ward which was staffed in accordance with "Safer staffing levels". We heard that additional staffing could be requested if necessary. The ward was described by witnesses as "busy" and at times "chaotic". Staff were not always available to give Tracy one to one talk time which was recognised as being important to her and for her mental wellbeing, so much so a note was placed in red and bold on her SBAR records "If we are allocated to TW 1-1 we need to make sure we are doing it, she needs consistency". Evidence was heard that steps are being taken to recruit more staff and also to retain existing staff and that this is a national problem. The evidence was that the staffing levels are still not sufficient, and that recruiting staff remains a problem.**

   The Trust has committed to ensure that staffing on all our inpatient areas is within safe limits this includes nurses, support workers and other allied health professionals as well as medical staff. In response to vacancies, within the context of a national shortage and retention crisis of staff in the NHS, the Trust has embarked on an ambitious recruitment campaign which includes holding recruitment fairs across the region, attracting overseas nurses, social media campaigns, full page adverts in national newspapers, medical and nursing journals, continual refreshed adverts on the NHS Jobs website, incentives and improved development opportunities.

   At the time of Tracy's stay on this ward the ward did not have a permanent Consultant Psychiatrist, this has since changed and a permanent medic is in situ, this appointment supports the multi-disciplinary team in providing consistency which in turn brings stability to the ward environment. Equally the senior nursing presence has been increased with the recruitment of a Deputy Lead Nurse to support the Lead Nurse and enhancing the Matron and Clinical Nurse Specialist cohort across the hospital site.

   The inpatient wards are part of a quality improvement project to enhance and increase therapeutic activities including 1:1 time, exercise and fitness, external and ward-based art and craft activities amongst other initiatives.

2. **Following Tracy self-ligaturing on the evening of 1 June 2021 the Duty Psychiatric Doctor was called to attend to see and assess Tracy but did not attend. She was assessed by nursing staff but she was not seen by a Psychiatric Doctor as requested by them, until the next morning during a review meeting.**

   In discussion with the Matron for this area her account is that the Duty Doctor was asked to attend however had to prioritise other tasks given that Tracy was unharmed and responding well to 1:1 discussion with the staff on the ward. This is reflected in the patient record. The next morning Tracy was seen by her regular doctor who knew her well. It is noted within the record that the ward staff were aware the Duty Doctor had not been able to attend but they did not escalate any further concerns for the reasons stated. However, it is not clear if the Duty Doctor discussed this decision with the senior on-call medic; an action for the Trust has been to improve the induction for junior and trainee doctors to include the escalation process for both psychiatric and physical health concerns and to implement improvements to the handover format.

3. **Tracy self-ligatured with a bandage on 30 March 2021 and a note was placed on her SBAR records in red and bold "Do not give Tracy bandages due to ligature risk". On 1 June 2021 Tracy was given a bandage, at her request, before leaving the ward for a community visit. Evidence was heard that following a "risk assessment" it was acceptable for this decision to be made by a Band 6 Nurse when the bandage was used off the ward and not on the ward where the original ligaturing incident had occurred. The instruction not to give the bandage did not specify whether this applied on or off the ward. There was no discussion with a Doctor or any other clinical staff when making this decision. There was no record of the bandage being given to Tracy in the written records and no record of the rationale for the decision being made.**

   Senior nursing staff at Band 6 level have completed their basic training, preceptorship programme and gained sufficient work experience and clinical skills within an inpatient setting to enable them to be in charge of the ward. Undertaking a risk assessment within the inpatient setting is inherent to this role and one that our nursing staff are fully capable and supported to conduct given their clinical knowledge and expertise.

   The decision to allow Tracy to cover her self-harm wounds with a bandage whilst out on leave due to her expressed concern and embarrassment was a reasonable, compassionate and considered decision to make at the time albeit with hindsight one which is no doubt regretted by the staff member. This was not the root cause of this tragic event; we would not seek to hold an individual staff member to account for this tragedy. This is in line with the Trust's commitment to fully embed and apply a Just Culture Framework to incidents to aid learning, and more broadly to support staff to feel comfortable to raise concerns without fear of blame or recrimination. This is in line with the new NHSEI Patient Safety Framework which advocates a human factors/systems-based approach to improving safety and is fundamental to the Trust's cultural improvement strategy.

4. **Part of the Risk Assessment for giving a bandage to Tracy was that she was to hand the bandage back on her return to the ward. Tracy did not return the bandage and was not asked to return the bandage. That Tracy had been given a bandage was overlooked on her return.**

   This is a regretful omission which was human error.

5. **Following Tracy ligaturing with the bandage on the evening of 1 June 2021, there was no investigation as to where she obtained the bandage, despite there being a bold, red instruction in the SBAR records that Tracy was not to be given a bandage due to ligature risk. By the date of the inquest some witnesses were still unaware as to how Tracy had come by the bandage she had ligatured with. Some witnesses were still unaware as to what Tracy had used as a ligature.**

On discussion with the Matron for the ward the article used was a dressing gown cord not a bandage, it is not clear however who this cord belonged too or if it was in fact Tracy's own. Tracy would secrete objects in her room to self-harm with, this was a symptom of her illness, it may be that she had obtained this cord from another patient or indeed hidden it on admission to the ward. The fact that some staff were not aware of this incident or what was used is of concern. The Lead Nurse and Matron for the area will ensure that all incidents are shared through the ward safety huddles and handovers, this will be monitored through the unannounced attendance of huddles and handovers by the Lead Nurse or Matron to embed and role model good practice.

6. **Following Tracy ligaturing on 1 June 2021, there was a review meeting and then a Multi Disciplinary Team Meeting. She had a meeting with the Psychologist later that day. No evidence was heard that there was a review of her hourly observations.**

   Tracy was an informal patient working towards discharge; within ward reviews, therapy and 1:1 sessions there were regular discussions, which are documented, with Tracy regarding the treatment approach of the ward which was to support and enable her to a successful discharge, and not to foster dependence on ward staff. Increasing observations would have been a retrograde step and may have increased Tracy's sense of being stuck or indeed failing in her goal to be discharged to new accommodation; she was at this time both "happy and anxious" about moving on from the ward. To enable her to do this the team utilised clinical judgement and their knowledge of Tracy by validating her concerns, being responsive to her needs whilst at the same time promoting independence and self-regulation.

7. **Written records did not specify correct dates and times as to events, for instance the Event Date/Time of the ligaturing incident on 1 June 2021 at 20:53 hours is recorded in the Clinical Notes as "02 Jun 2021 06:49". Tracy's date of death is recorded as 5 June 2021 and her date of birth in the SBAR records is recorded as 1 May 1981, when it is the 1 June 1981.**

   The issue of contemporaneous record keeping of a high standard is a priority for the Trust and we have commissioned an external law firm to provide training to staff on this subject. This will be underway within the next 6-8 weeks.

8. **Certain events are not included in the records, for example that a bandage had been given to Tracy on 1 June 2021 on her going off ward, contrary to the instruction contained in the SBAR records and of 121 Talk times with Tracy. Evidence was heard that steps are being taken to improve record keeping. However this matter has been raised with NSFT previously and evidence from one witness at the inquest was that not "every discussion" with a service user is recorded in the Clinical Record and that entries are made by one allocated person on a shift who will be told orally what to put by members of staff. This witness had had a 30 to 40 minute one to one meeting with Tracy the day prior to her ligaturing on 1 June and talk time with Tracy on the day following her ligaturing on 1 June, details of which may have been helpful to other staff and regarded of some importance to Tracy's care.**

   On discussion of this point with both the Matron and Lead Nurse for the area the allocation of one person to update records is not common practice. This has been discussed with the ward teams and reiterated that this is not good practice.

   There have been some ICT barriers to agency staff accessing the electronic patient record historically however this is being corrected to ensure that all staff have access and are aware of the expectation to record contemporaneous notes individually and comprehensively, see response to question 7.

9. **On Tracy being found on the 2 June 2021 with a ligature around her neck, emergency lifesaving equipment was not brought immediately to Tracy's room. Monitoring equipment was obtained by a member of staff who gave evidence they were unaware Tracy was not breathing. On return to Tracy's room the emergency "crash bag" was then requested and obtained.**

Training and ward-based simulations have been restricted through the pandemic however these are being reinstated, the Trust is currently 85% (the Trust target is 90% allowing for sickness, maternity leave and new starters) compliant with basic life support training for the relevant staff groups, this includes ensuring that clear instructions are given by the resuscitation leader in such a scenario. The trajectory to achieving 90% compliance in this subject is September 2022. The Trust has recently revised and improved the induction of new starters which means that all staff will receive all the necessary safety training in their first week of employment, this programme commences on 4th July 2022.

10. A draft Patient Safety Incident Investigation Report (PSII) has been prepared. Evidence was heard that this is now used rather than a Serious Incident Requiring Investigation Report and has the advantage of being "more timely" and providing more learning. The report was still in draft form at the date of the inquest (nine months following Tracy's death) and the draft was only available to me on the morning of the first day of the inquest, despite assurances at Pre Inquest Review Hearings that it would be available prior to the inquest.

It is always regrettable when reviews are delayed however this occurs for many reasons and does not prohibit early learning safety actions from being implemented on initial screening of an incident. In this case a patient safety alert was sent to all ward areas to highlight the necessity to consider all forms of potential ligature paraphernalia and the ward in question undertook a review of incident antecedents to look for trends or themes which they could mitigate against to prevent further incidents amongst patients.

The Trust always would wish to engage with family members and significant others in these circumstances to ensure that any questions they have are included in the terms of reference for a review, with this in mind the new review framework advises a period of 90 days to complete a review which is an extension on the previous framework of 30 days (60 days previously). The Trust received questions from Tracy's family via your office in September 2021, at which point we had already hit the 90 day target, in October 2021 the author visited the family and again in November 2021 to ensure their questions were fully explored, this was good practice and responsive to the family's needs.

The sign off process for a draft report has four or in some cases five stages; firstly, it is seen and agreed by the family, and/or significant others, then the leadership team of the area where the incident happened, then it goes to a Clinical sign off panel for quality checking against the Royal College of Psychiatrists SIRAN standards and scrutiny of the efficacy of recommendation. If a non-complex case this is the final stage before being formally issued. In a complex case such as Tracy's the review must be signed off by the Chief Nurse and Chief Medical Officer, this is the fifth stage.

This review was delayed at the leadership sign off stage due to a restructure of senior leads over the Christmas and New Year period. Following a meeting between the family and the newly appointed Lead Nurse further amendments were made, the leadership team signed the draft off in early March 2022, the Clinical panel held on 24th March 2022 advised some amendments which took it to a further panel on 30th March 2022. Following this at review by the Chief Nurse and Chief Medical Officer ratification was halted due to further amendments being advised just prior to the inquest. Hence why the report remained a draft and was in various version formats. To address the risk of version control issues in the future which causes distress and undue confusion no drafts will be shared with any party in hard copy format as of now, the final ratified version will of course be available to all relevent parties.

Whilst accepting that the review was heavily delayed, we would always err to include the family, and significant others throughout the process prior to final ratification, this has to be done in the family's timescale. The purpose of the internal review is to facilitate learning and improvement it is not a process to hold to account, ascertain cause of death or answer to a complaint, civil or legal process. This is a very clear and appreciated direction under the new framework made by NHSEI.

11. The PSII Report contains many inaccuracies including Tracy's date of death, stating it to be 5 June 2021. The report refers to Tracy ligaturing again at 21:00 on 3rd June 2021. The correct

date is the 2 June 2021.

The draft version shared with your office prior to inquest was correct, the earlier version shared with the family is not, for this I apologise fully, see response to question 10 regarding version control.

12. **The PSII report refers to the notes of the incident on 1 June 2021 that Tracy ligatured with a bandage but goes on to say that in interviews a cord from her dressing gown was used. Confusion remained as between the events on the 1 June 2021 and the 2 June 2021. The report refers to the view of the MDT meeting on 2 June was to keep Tracy on hourly observations. There is no reference in the Clinical Notes to observations being discussed. Witnesses asked about observations at the inquest could not recall observations being discussed or that they were not discussed.**

    See responses in questions 5 and 6.

13. **The PSII did not involve interviews with members of staff who had involvement with Tracy in the hours and days prior to her death, including staff who gave the bandage to Tracy and a Nurse who had regular involvement with Tracy's care and who knew her well.**

    The staff who were not spoken to were agency staff who are not compelled to comply with Trust reviews despite the obvious ethical and professional drivers to do so. In this review one agency staff member approached did make himself available however a female staff member did not. However, the review panel were content that the staff who did engage knew Tracy well and were able to give a consistent account of events as they knew them, this included a range of professionals: nursing, occupational therapy, psychology, and psychiatry.

14. **The PSII stated that statements of members of staff "for the Coroner" were reviewed. However, many of these statements contained inaccurate dates and times including the date of death.**

    See response to question 7.

15. **The PSII does not make findings with regard to areas of concern raised at the inquest such as with regard to Tracy being given a bandage on the morning of 1 June 2021 despite there being a bold red note contained in the records that Tracy should not be given a bandage, that this was not discussed with any other senior member of staff, no record was made of the decision and the rationale for the decision, nor that the bandage was not returned on Tracy's return. The PSII does not include reference to inaccurate record keeping and full records of important events not being kept.**

    It transpires the SBAR was a document not uploaded onto the electronic record. This led to the author nor being aware of the SBAR and reporting on what was in the electronic record only, this was a gap in attention to detail. This aspect regarding the risk posed by the bandage should have been included in the review and was an omission, the author of the review has reflected on this and will ensure this is not repeated.

    Equally within the review panel oversight role and the review sign off processes it is the responsibility of those senior staff who form those panels to ensure all information is accurately recorded, analysed and appropriate conclusions met which address all safety concerns.

    The SBAR tool is now routinely uploaded onto the electronic record.

16. **The first draft of the PSII Report contains a sentence "However, staff noted there was a lack of clinical or management leadership supervision on the ward at the time and they were often left to "firefight" with patients who they perceived carried a greater level of acute risk than**

Tracy." This view of staff was not included in the final draft Report.

See responses to questions 1 and 10.

In respect of the care and treatment provided to Tracy by the Trust, the gaps in good practice highlighted as part of the internal review and further expanded during the inquest demonstrate this fell below expectations.

We would all wish for the best quality care and treatment for our loved ones and despite the teams combined knowledge of Tracy, their clinical expertise and genuine desire for Tracy to succeed in her recovery this was not to be. For this I again fully apologise and express my condolences to Tracy's family.

In completing this response to you, it is also clear that there were gaps in the governance and attention to detail of the review process which has caused unnecessary distress to the family of Tracy and raised your concerns regarding the quality of the review. I hope that the steps the Trust has taken and continues to take to address these provides you with sufficient assurance regarding our sincerity to improve and address the shortfalls.

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer