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Dorset HealthCare
University
NHS Foundation Trust

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[redacted]

Mrs Rachael Griffin
HM Senior Coroner
Bournemouth Coroner's Court
Town Hall
Bournemouth
BH1 6DY

14 September 2022

Dear Madam,

Re: Regulation 28: Prevention of Future Deaths - Miss Gaia Kima Pope-Sutherland Inquest

I write further to your Prevention of Future Deaths report dated 21st July 2022, issued in response to evidence heard during the inquest into the death of Miss Gaia Kima Pope – Sutherland (Gaia). The incredibly sad and distressing events surrounding Gaia's disappearance and untimely and tragic death have been the subject of a Trust Root Cause Analysis (RCA) investigation and a number of changes in practice have already been implemented, of which I understand you are aware. We, as a Trust, are committed to taking forward the further learning identified during the course of the inquest.

I appreciate you bringing the six additional specific issues of concern to our attention, and I hope that this response provides assurance as to the action we have initiated to address those issues.

I am also grateful to the court for providing clarification that the following specific concern relates to national bodies, as opposed to Dorset Healthcare University NHS Foundation Trust ("the Trust"), and therefore I will not comment further on this as part of my response:

> *Further I am concerned that there could be future deaths as a result of the lack of communication between neurology and psychiatric teams and request that there is consideration as to how to ensure effective lines of communication between the 2 disciplines.*

Please find below our response to the six concerns raised in respect of the Trust:

1) *As per paragraph 1(ix) above, the occurrence of sexual harassment or assault whilst an inpatient at one of DHUFT's inpatient units could have a detrimental effect on a person's mental health which could have fatal consequences. I request that consideration is given to a policy being put in place to provide guidance to staff as to how to deal with this situation.*

[redacted]

I note that in her letter to you dated 11th July 2022, [redacted], Service Director, outlined the following Trust action being taken in response to the evidence she gave during the course of the inquest. I reproduce the relevant paragraph of [redacted] letter below:

1. *To introduce a Trust procedure that deals with victims of sexual violence when they come onto wards, in terms of safeguarding them from future incidents / deterioration on the ward. In addition to consider specific guidance for staff as to how to support a patient following a sexual incident.*

   I can confirm that I have written to [redacted], Deputy Chief Nursing Officer, on 8th July 2022 to ask that he identify a member of the Sexual Safety working group to lead on drafting a procedure that deals with how to best support victims of previous sexual violence when they are admitted to an inpatient unit. The procedure will also cover what staff need to do upon a patient reporting a sexual assault or incident to them (both within an inpatient and a community setting). I have asked [redacted] to ensure that the procedure is finalised, approved and disseminated by 31st October 2022. I would therefore suggest that I update you on this matter by Friday 11th November 2022, if that is acceptable to you.

In addition to the above, the Trust also already works to the Bournemouth, Christchurch and Poole and Dorset Multi-Agency Safeguarding Adults Procedures, which detail definitions of sexual abuse and exploitation and how to raise a concern. That procedure includes an appendix on the roles and responsibilities of other agencies and includes details on the responsibilities of employees and managers in respect of harm, neglect and exploitation. We welcome your recommendation to strengthen these procedures with supplementary guidance specific to sexual harassment, assault and abuse, and believe the above forementioned actions, which are underway, address this point.

2) *As per paragraph 1(x) above, there is no specific policy in place within DHUFT around contact with the family or dealing with the Think Family approach. A lack of contact with family members, who know the patient best, could lead to information gaps, which could lead to future deaths. I request that consideration is given to a policy being created around contact both to, and from, a patient's family.*

In response to this concern, we will establish a working group led by [redacted], Interim Deputy Chief Nursing Officer, to develop a policy on Working with Families and Carers. The policy will cover expectations in respect of communication and engagement with and from families and carers that a patient wishes to involve in their care. The policy will also explain clearly what the Think Family safeguarding approach is and how staff can work within this approach when there are safeguarding concerns. The development of the policy will be a co-produced piece of work between professionals working in services and people with lived experience of using mental health services and of supporting someone living with a mental health condition. The working group will also include the Trust's Carers Development Lead, the Lead for Recovery and Social Inclusion, and a member of the Trust's Safeguarding team. The working group will ensure the development, ratification and circulation of the policy to staff by 31st January 2023.

3) *As per paragraph 1(xi) above, information could be lost on lengthy RiO records held by DHUFT if there is a significant number of records, and I therefore request that consideration is given to a guidance document dealing with how and what information should be flagged on RiO which could be provided to all staff at DHUFT. I would further*

[redacted]

request consideration is given to training staff on how to record information, so it is flagged on the record.

In response to this concern, the Trust will develop a guidance document on viewing, adding and removing alerts on RiO and upload this to the Trust intranet by 30th September 2022. The existing RiO e-learning and classroom-based learning courses, which are a mandatory requirement for new staff who will be using RiO as part of their role, will also be updated to orientate staff to the existence of the guidance and to demonstrate how and when to use the alerts system on RiO. This will be updated by 31st October 2022. This training will also be available as a standalone e-learning module, which will be available to all existing RiO users in the Trust. The e-learning module will be promoted to staff via email and via dissemination at the CMHT Team Leaders workshop. This will be available and disseminated by 31st October 2022. This work will be led by our Clinical Systems Team and Patient Safety Team in partnership.

Please note we have focused our action on the alerts system on RiO. As outlined in the evidence given to you by [redacted], there is also a separate function on RiO of flagging a progress note as a significant event so that it informs the risk assessment. We have not identified any further actions for this function, as this already forms part of our RiO training programme.

4) *As per paragraph 1(xii) above, I would request that consideration is given to providing training to all staff on the access to Community Mental Health services which could also cover the processes regarding discharge planning from the care of the mental health teams.*

I and my team note your concerns that you considered there to be "*some ambiguity and inconsistency during the evidence regarding the content of the Integrated Community Mental Health Teams (CMHT's) operational policy, and the understanding and application of* it" The Trust team has considered carefully your recommendation that training be provided to all staff on access to Community Mental Health Services, including the process for discharge planning.

It is our view that there is not a misunderstanding or ambiguity amongst staff with regards to accessing CMHT's or in respect of discharge from the service, but that clinical judgement is used by staff. It is our belief that the issues that arose during the evidence of Trust witnesses reflect a national problem that was described in the evidence provided by [redacted] As you may know, CMHT's were commissioned some thirty years ago, to work with a population of people with what was previously clinically defined as "Serious Mental Illness". The service was primarily set up, and resourced, as a specialist, secondary care mental health service for people with severe and enduring mental illnesses such as schizophrenia, bipolar, and treatment resistant severe depression. The threshold for the service was therefore set many years ago and was designed for people who had significant mental health needs. We fully recognise that in 2022, this model is not well placed to meet the wider mental health and wellbeing needs of our patient population. What is now needed is a mental health and wellbeing system that offers a range of support from varying organisations that can provide advice, guidance, information, signposting, education, support, care and treatment that meets a broader range of needs. Some of those needs fall into what we would recognise as a diagnosable mental illness, that will benefit from an evidenced based, clinical treatment, and many of those needs benefit from a non-medical or non-clinical model of support and care. Dorset is not alone in trying to transform its community mental health services. It is in this context that access to CMHT's has increasingly come under scrutiny, as our local population look for a service to meet the full range of needs that come under the broad umbrella of mental health. Not all of these services exist, and for those that do, they are currently not well coordinated as a system, but considerable effort is being made to integrate and meet wider need.

[redacted]

In respect of the care provided to Gaia, the Trust remains of the view set out in the RCA report (and reiterated by Trust witnesses), that Gaia did not meet the eligibility criteria for CMHT care on the occasions she was discharged from CMHT care in December 2016 and March 2017, and also at the point she was assessed under the Mental Health Act ("MHA") in October 2017. That is not to diminish the difficulties Gaia faced, or her level of distress. We do not dispute that the failure to refer Gaia to Steps to Wellbeing ("STWB") for her Post Traumatic Stress Disorder in December 2016 was a missed opportunity. There were also missed opportunities in terms of the assessment and onward plan of care following the MHA assessment in October 2017, which are acknowledged by the Trust and formed part of the jury's conclusions. The Trust has taken action to address these issues as detailed in [redacted] witness statement of 16 June 2022, and as set out in the evidence she gave to you, namely through:

(i) the CMHT/STWB interface/screening meetings and updated SOP; and
(ii) the updated SOP for Flow of Information following MHA Assessments

For these reasons and the transformation work being carried out as described in this letter, the Trust does not consider that implementing an action to train Trust staff on the access to CMHT's would resolve the issues raised.

It is our belief that the issues highlighted will be addressed through the transformation work that the Trust is closely engaged with, which was touched upon in the evidence of [redacted]. The NHS Long Term Plan and the Commissioning Framework for Community Mental Health sets out a new vision of mental health support provided by health, social care and voluntary, community and social enterprise (VCSE) organisations, beyond the model of CMHT care. In Dorset, the multi-agency, coproduced project to deliver this vision is known as the Mental Health Integrated Community Care (MHICC) programme. The programme has reached the stage where it is co-designing a new operational model of care, to begin implementation in 2023 / 2024.

One of the key areas the MHICC is working to address is providing better mental health support and care at a primary care level (beyond STWB, which offers psychological treatment for a specific range of conditions). The transformation programme is looking at how we can implement a new model of care, so that we can provide open access to mental health services at a primary care level to meet someone's needs, without eligibility criteria or thresholds. We have tested a virtual multi-disciplinary team in Poole between GP's, social care, STWB, the VCSE sector and CMHT's, and you may be pleased to note that we are working together to discuss the needs of patients and how best those are met in a coordinated way. We are also piloting a Peer Specialist (person with lived experience of mental health) working in a GP surgery in North Dorset, offering support to anyone who wishes to see a professional about mental health need, with support and supervision from the GP, STWB and CMHT. If successful, these are some of the ideas that may be rolled out across primary care, to meet patient mental health need.

The Trust believes that the transformation programme will be the most effective approach to addressing the concerns raised in respect of CMHT care and the wider issues of access to mental health support, as opposed to implementing training on the existing CMHT model for staff. The Trust would be happy to keep you updated and provide information about the MHICC transformation programme if you would welcome that.

5) *As per paragraph 1(xiii) above, when a Mental Health Act assessment is undertaken, there is a possibility that information may not be fed back to the GP in the best way or in a timely manner, if it is not fed back by those from the Mental Health team, and I therefore request that consideration is given to the DHUFT representatives forwarding information, directly to the GP, rather than through the discharging team at the acute hospital. This may include their RiO record notes, or their assessment notes.*

[redacted]

This requirement has been considered by [redacted] Deputy Chief Medical Officer. You heard during the course of the inquest (and as part of Dorset Council's evidence) that relevant information and a report following the assessment will be provided to the GP by the Approved Mental Health Professional (AMHP), who is part of and coordinates the assessing team. Dr [redacted] has met with his clinical colleagues and it has been agreed that (in addition to this information provided by the AMHP):

i) A RIO template will be designed to enable a section 12 Doctor to complete and set out key summary patient information following a MHA Assessment conducted in an acute hospital setting;
ii) All doctors undertaking Section 12 work will be written to, to advise them of the template and provide them with guidance on how to use it.
iii) The completed template will be sent to the patient's GP following a MHA assessment taking place in an acute hospital setting; and
iv) A blank copy of the template, and details regarding the requirement for its use, will be added to the SOP for Flow of Information following a Mental Health Act Assessment.

The Trust has agreed with your helpful recommendation and will formally amend the SOP to remove the paragraph previously inserted at section 3.2 during the course of the inquest, which outlined the following requirement:

3.2 In addition and specific to MHA assessments undertaken in an acute hospital setting (e.g. Poole Hospital, Royal Bournemouth Hospital, Dorset County Hospital), the Doctor(s) taking part in the MHA assessment must provide a written or electronic copy of the outcome of their assessment to the acute hospital ward Doctor responsible for the person's care whilst in the acute hospital, so that this information can be reflected accurately in the acute hospital discharge summary. This will ensure a comprehensive discharge summary detailing the physical and mental health care and assessments a person received whilst in the acute hospital.

This will be replaced with suitable wording to reflect the need to write to the GP directly using the new RiO template following a Mental Health Act assessment taking place in an acute hospital setting. This template will be developed and made live in the RiO system by 31st January 2023, and the SOP updated by this date and issued to staff.

6) As per paragraph 1(xiv) above, in respect of the feeding back of information to the GP by the AMHP which is detailed at paragraph 2.10 of the Standard Operating Procedure for the flow of information following Mental Health Act assessments, I would request that consideration is given by Dorset County Council, BCP Council and DHUFT to reducing this timeframe from 7 days to 72 hours. Although this is a decision for Dorset County Council and BCP Council, the document is a DHUFT document and so will require their consideration too.

[redacted] has written to Dorset Council and BCP Council on 27th August, 31st August and 9th September 2022 in respect of this matter. BCP have confirmed they are in agreement with the 72 hour timescale and tell us that they already work to this, and the Trust awaits Dorset Council's response. I can confirm that the Trust supports the recommendation to reduce the timeframe in question from 7 days to 72 hours and we will update the SOP accordingly, upon Dorset Council's agreement. I am grateful for your acknowledgement that this is a decision for the two councils in question, as opposed to the Trust.

I hope that in respect of the concerns raised, the actions I have detailed above addresses those matters. I plan to provide a further written update to you regarding the progress of these

[redacted]

action by 31st May 2023. Once again, I am again grateful for you bringing these issues to my attention.

Yours sincerely

[redacted]

[redacted]
Acting Chief Executive

[redacted]