NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

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[redacted]

Mr David Lewis
Assistant Coroner for Liverpool and Wirral
HM Coroner Court,
Gerard Majella Courthouse
Boundary Street
Liverpool
L5 2QD

15 November 2022

Dear Sir,

Response to Regulation 28 Report to Prevent Future Deaths

Thank you for your letter dated 30 September 2022, following the conclusion of the inquest into the death of Katharine Mary Tyrer. I have reviewed the concerns fully and our responses and actions that we are undertaking to these are detailed within this letter.

1. The ward layout did not lend itself to easy observation of patients. The Court's expert considered it 'wholly inadequate'. The jury felt that this contributed more than minimally to Katharine's death.

A number of rooms (including Katharine's room, 23) were remote from the nursing station and largely out of sight unless visited for a specific purpose. Whilst I am aware that some changes have been made since 2018, I am concerned that the current layout continues to place vulnerable patients, who might take their own lives, at risk.

It is appreciated that the Trust might not be in a position to create a ward which eliminates all of the layout issues. However, mitigation measures might be appropriate if the present facilities are to be used on an ongoing basis in an unmodified form. I am concerned that the limitations presented by the current

layout may mean that staffing levels need to be adjusted to allow for greater levels of informal observation, oversight and monitoring.

At the time of the incident the ward was a 24-bed facility and was appropriately staffed according to the number of beds. Immediately post incident several improvement actions were taken in respect of the location of the ligature knife and nurse stations situated within the ward (including corridor areas) to support appropriate observations.

The Trust is aware of the limitations of the existing ward environment in respect of the age of the Springview building and the ability to observe all areas and as such the staffing levels are adjusted according to the ward environment, acuity and patient needs.

In response to the above I can confirm that the ward was reconfigured in October 2021 when it has become a 20-bed facility. As a result, the new ward layout assists with observation and oversight. The layout of the ward is in line with the existing estate available. For any new build developments or full refurbishments, the Trust is aware of and would plan the specifications in accordance with the Health Building Note 03-01 (Adult Acute Mental Health Units). This best practice guidance concurs with the Care Quality Commission (CQC) regulatory framework (regulation 15).

2. The argument with her husband was a trigger event for Katharine. She was seen briefly by some ward staff between her return to the ward at around 10:25 and 11:00, but left completely unattended between 11:00-12:00. The jury felt that there was a missed opportunity at this time to affect the outcome and that the assessment of the risk that Katharine posed to herself had been inadequate.

The evidence indicated that ward staff (seemingly regardless of their level of experience and seniority) who attend a patient in a situation like this are left to determine what (if any) action to take based upon their clinical judgement. In particular, it is left to the individual to decide whether escalation to a senior clinician would be appropriate and whether observations or monitoring (or even simply staying with the patient) should be increased for a period of time.

I was told that it would not be unworkable in any scenario such as this (involving knowledge of a trigger event in the case of an impulsive patient with a known history of suicide attempts and self-harm) for there to be a procedure which called for an automatic review by the senior clinician on the ward at the time. However, that is not the current situation. I am concerned that, in the absence of a clear protocol, relatively junior staff (who may not be able to effect an adequate risk assessment) may not be equipped to determine how best to address the short-term risk.

Having considered the concerns outlined with regards to observation of our patients, we have reviewed our policies, procedures, and best practice approaches. With

specific regards to the Supportive Observation & Engagement Policy (CP25) we have further reviewed Issue 12 (Implemented 30 August 2022) and note that in the zonal section of the policy (Appendix 1) it does articulate the need to escalate changes in behaviour to a more senior member of staff in addition to peer independent peer review.

As learning from this incident and your feedback above, the policy has been further strengthened with regards to trigger events and the requirement for an automatic review to be undertaken when a non-registered member of staff identifies any issue which could be classed as a trigger event. This practice is currently taking place but is not explicit within CP25 for all events. As such the Supportive Observation & Engagement Policy (CP25) has been updated and will be reviewed through the Trust governance processes on the 15th December 2022

In addition to the update of the policy, further training is being provided to all in-patient staff as part of a Quality Improvement approach. With effect from December 2022 face to face clinical risk training using a formulation approach will be delivered linking the 5 p's model (predisposition to risk, precipitating factors for risk, perpetuating factors for risk preventative factors for risk) with the practical application of SystmOne (electronic patient record system).

This new training programme will supplement and strengthen the existing essential Mental Health Risk Assessment & Formulation e-learning and is intended to increase staff knowledge and skills and improve standards of patient care. Following on from this programme the impact/effectiveness will be audited by Modern Matrons.

We hope the additional measures that the trust has adopted as subsequent learning following this incident and inquest provides assurance that we have improved mental health care for our patients.

Should you require any further information, please do not hesitate to contact me.

Yours sincerely,

[redacted]

Chief Executive