NHS
Sussex Partnership
NHS Foundation Trust

Office of the Chair & Chief Executive
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Thursday 22 June 2023

Dear Ms Schofield

Inquest into the Death of Caroline Forte, Regulation 28: Report to Prevent Future Deaths

I write in response to your Regulation 28 Report dated 27 April 2023, addressed to my predecessor,

I was so sorry to read the details of the circumstances leading to Caroline's death and I extend my sincerest condolences to her family.

I acknowledge and understand the concerns that you have raised and want to assure you that, following the Inquest, the Trust took immediate steps to seek to learn from the Inquest's findings and make improvements, not just specifically relating to Amberley ward but trust-wide.

To do that, the Trust set up a working Group, of senior clinicians, to identify what action was needed to prevent recurrence of the contributory factors identified in Caroline's Inquest. That working Group was led by the Trust's Deputy Chief Nurse (Quality, Safety & Improvement) and met fortnightly to formulate the necessary improvements and enable trust-wide implementation. Additionally, in parallel, the Trust's Legal Director led a piece of work to create new leave documentation, process and policy. I will describe the outcomes of the improvements in turn, utilising and thus responding to each of the seven concerns you raise in your Regulation 28 Report:

a) **The daily care log was not completed so it was not possible to ascertain who was the last person to see Caroline leave the ward**

During the aforementioned improvement works, it was recognised that the existing 'log' did not sufficiently enable staff to be prompted and to capture all relevant information, and needed improving in a number of areas. So, new documentation has now been created, in the form of a new '*Record of patient leaving ward*' document, a copy of which I attach. This will be introduced on the Trust's wards from 1 July, with local training being provided to staff to ensure the importance of it's consistent use is fully understood. As with any new documentation there will then be a review of the new documentation's efficacy; this will be done in 3 months' time and the findings reported through the Trust's Acute Care Forum. That Forum is a meeting of trust-wide clinicians as well as service users, and the new documentation was collaboratively formulated within that Forum to seek to ensure that it would best meet the needs of staff, patients and families/carers.

b) There was no record to show which nurse carried out a risk assessment before she left

The new '*Record of patient leaving ward*' document requires a Registered Nurse (or another registered professional, such as Medic or OT) to sign the patient out. Moreover, and specifically, the new document makes it clear that, by signing the form, the nurse/medic/OT has collaboratively considered the patient's leave safety plan with them and any relevant family/carer/friend etc and, furthermore, that the leave safety-plan has been collaboratively re-affirmed by all.

c) There was no overnight care plan

As referred to above, completion of the new '*Record of patient leaving ward*' document requires consideration of the leave safety plan which, if a patient were going on overnight leave, would require consideration of the overnight care plan and would thus identify if it were missing. Overnight care plans are used by Amberley ward, as a local initiative, and the ward Matron is now doing monthly spot checks to confirm that these are being completed and uploaded for patients going on overnight leave. Further, the Trust has an ongoing trust-wide audit programme whereby it is qualitatively auditing in-

patient records to ensure care plans are appropriately completed. This audit, once complete, will be presented to and monitored by the Trust's Effectiveness Committee, to ensure care plans are of an appropriate standard trust-wide.

d) The "My care and safety plan" had not been updated with regards to "My family will do" section

As referred to above, completion of the new '*Record of patient leaving ward*' document requires collaborative consideration of the leave safety plan with, not only the patient, but also any relevant family/carer/friend etc. So, any lack of detail in the 'My care and safety plan' would be identified before a patient were permitted to leave the ward.

e) The family were not provided with a copy of the Section 17 leave form

When the new '*Record of patient leaving ward*' document is completed there is now a specific prompt to ensure that the patient (if detained) has a copy of the s.17 leave form then there is the aforementioned collaborative consideration of the leave safety plan with the patient and the family/carer/friend etc. This will enable family/carer/friend etc to have knowledge of the contents of both the s.17 leave form and the safety plan. That collaborative conversation would enable further documents to be copied and provided, as appropriate.

f) At the time of this leave the family were unaware that Caroline had self-harmed in the hospital by tying a ligature. Therefore, the family told the Inquest that they therefore had no strategies in place to minimise the risks of such an event. Similarly, there was no communication with the hospital as to how to minimise Caroline's risk.

As indicated above, safety planning ought to be a collaborative process and I was truly saddened to hear that Caroline's family were left without strategies to support them to minimise Caroline's risks. Amberley ward have, of course, reflected, at length, on the sequence of events that led to Caroline's death. The Matron is overseeing monthly audits to check that family have either participated in ward

reviews, or been contacted after, to be given an update. The ward's aim is to invite a relevant family member to their loved ones' MDT review meetings, so the family member can participate in the review and have an opportunity to give their own views. If they have not been able to attend then a call to the relevant family member is made after the meeting to ensure they are aware of the plan. Additionally, the ward is considering employing a "Carers Lead", who would provide a primary point of contact for all family members. Further, the aforementioned trust-wide care plan and risk assessment auditing includes qualitatively auditing to ensure meaningful, appropriate family/carer engagement, as part of the Trust's ongoing 2023/4 improvement plan. The new '*Record of patient leaving ward*' document will also ensure a further collaborative conversation takes place and the leave safety plan is re-affirmed before the patient leaves the hospital.

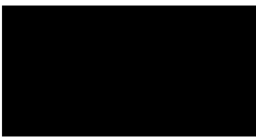
g) Senior Officers from the ward showed a lack of knowledge of the Trust’s own Section 17 leave policy and Safe and Effective Assessment & Management of Clinical risk: Risk Management Police and Procedure.

The s.17 leave policy is being updated, so that it incorporates the new form, as well as some other modifications. Once ratified, there will be corresponding training which is delivered by the Trust's Mental Health Act team which is overseen by the Trust's Legal Director. Regarding, the ward's understanding of the Safe and Effective Assessment & Management of Clinical risk: Risk Management policy, I understand that this specifically centred on the aforementioned assessment of risk prior to s.17 leave and corresponding sharing of information within the ward and with the family. The Amberley ward Matron led the ward's discussions about the improvements needed following the Inquest which, in addition to those already mentioned, has involved on-going monitoring of the quality of concise and precise handover of information (both verbal and written) from shift to shift, and to MDT, during MDT daily handovers. Additionally, the Matron has been working with the Trust's lead trainer for clinical risk and the Trust's suicide prevention lead, to fully understand early indicators of risk to ensure his ward is capturing and fully understanding these warning signs. The Matron has also been actively involved in the formulation of the new '*Record of patient leaving ward*' document which Amberley ward will be using from the trust-wide implementation date of 1 July.

By way of further assurance, and for completeness, I have also enclosed the Patient Safety Learning briefing that the Trust circulated, following the Inquest, to all its acute care teams, for learning from the matters that arose in the Inquest.

I hope that the aforementioned actions are of assurance to you. We believe that these actions will lead to a substantial improvement in the experience of patients and the families/carers/friends who support them when they are on leave from our hospitals. As indicated, we will be monitoring the effectiveness of these improvements to ensure they meet the needs of our patients and their families/carers/friends and will write to you with an update in 6 months' time. In the meantime, if you have any questions regarding the content of this response or if I can further assist please do not hesitate to contact me.

Yours sincerely,



Chief Executive Officer

Sussex Partnership NHS Foundation Trust