Essex Partnership University
NHS Foundation Trust

7 July 2023

Private and Confidential
Ms Sonia Hayes
Area Coroner
Coroner's Office
Seax House
Victoria Road South
Chelmsford
CM1 1QH

Chief Executive Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

[redacted]

[redacted]

Dear Ms Hayes,

I am writing to set out the Trust's formal response to the report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 7 May 2023, which was issued following the inquest into the death of Mrs Bency Joseph. The Trust has provided a response in acknowledgement of your concerns.

I would like to begin by extending my deepest condolences to Mrs Joseph's family. This has been an extremely difficult time for them and I hope that my response provides Mrs Joseph's family, and yourself, with assurance that the Trust takes their loss seriously and is taking action to address the concerns raised in your report.

1. Essex Partnership NHS Foundation Trust Mental Health Liaison Psychiatrist assessed Bency Joseph as suffering from a first episode psychosis when she attended hospital on 23 May as an emergency and there was a delay in prescribing and administering therapeutic medication required for a first episode of psychosis with delusions.

    a. [redacted] Lorazepam was prescribed and administered on 25 May 2022 at hospital and evidence was that this was sub-therapeutic. One dose of medication was administered and Bency Joseph was discharged under the care of the Home Treatment Team.

    b. On 26 May the Home Treatment Team found that Bency Joseph did not have capacity, had deteriorated and prescribed urgent medication to be provided on the same day. The medication was not provided.

    c. It is unclear if the urgent prescription was received and processed.

    d. The family's concerns and attempts to escalate the failure to provide the medication were not actioned by the Trust and the death occurred in the early morning of 27 May as the family were making arrangements to take Bency Joseph back to accident and emergency due to the omission to provide medication and further deterioration.

I note the above concern states that Mrs Joseph was assessed by a Psychiatrist. I can also confirm that Mrs Joseph was assessed by a Mental Health Nurse in the Mental Health Liaison Team on 24 May 2022.

In relation to access to medications, staff within the Home Treatment Teams (HTT) and Mental Health Liaison Teams (MHLT), have access to Patient Group Direction (PGD) medications which they can provide to patients on assessment, if required. The current PGDs available to staff for supply/administration are:

- Lorazepam [redacted] when needed for anxiety, every four to six hours
- Zopiclone [redacted] at night when needed for sleep
- Promethazine [redacted] when required for anxiety

Nurses are required to undertake training for working with PGDs generally available as e-learning via the Trust online training portal addressing legal and accountability issues. Competencies are assessed by team managers during supervision, medicines management face-to-face and online training. Authorisation to work within a PGD has to be renewed every two years or if the document is updated ahead of this timeframe.

As patients are often referred to MHLT and HTT with varying symptoms. The Trust is currently considering the need to expand the number and types of medications available for nurses to use via PGD. In order to inform these considerations, the Trust's Director of Pharmacy and Service Managers for urgent care pathways are collaboratively reviewing the medication needs for the services.

Within urgent care services where patients may access the services out of hours, quick initiation of medication is sometimes required. In Mrs Joseph's case, the medication had been requested by the Psychiatrist in the HTT on 26 May to the Trust's pharmacy team at 15:30hours when he reviewed the patient. The Trust's pharmacy team operates 09:00hours to 17:30hours and it may take several hours for a request to be processed, which then requires delivery from the central pharmacy department to the requesting site.

Doctors and Nurse Prescribers are aware of the need to utilise FP10 prescriptions and signpost patients and relatives to their local pharmacy to obtain medications without delay if it's safe to do so.

As part of care provided by the HTT, there are occasions where medication may need to be supplied by the Trust's pharmacy department; an example being on occasions where the HTT are administering and monitoring the medications in the home environment to support concordance or where the medicines involved are "hospital only". In these circumstances robust planning takes place to ensure that a timely supply is possible.

Resources are being developed for urgent care services across the organisation to re-enforce the expectation that an FP10 should be used initially for patients who require urgent medications to manage their symptoms. We aim to have the resources available by the end of July 2023. Supply via PGD would be used where there is an urgent need and no access to a

Doctor or Nurse Prescriber to complete an FP10, and where the medication is available by this route with a competent Nurse to supply.

2. The Trust investigation did not:

    a. Inform or involve the Trust Senior Pharmacist who was unaware of the death and had no opportunity to be involved in the internal investigation.

    b. Involve the Family of the deceased

    c. Lost an opportunity to understand concerns that the Family had been trying to access additional urgent medication prescribed on 26 May 2022 without success and had been telephoning the Trust to raise an alert.

Following notification of Mrs Joseph's death, the Trust's Clinical Review Group reviewed details of the incident on 14 June 2022 and requested that a Clinical Review be completed. The Group directed that the scope of the review should be from Mrs Joseph's first contact with the Trust until her death and that any questions from the family should also be answered. At that point in time, it was not evident that involvement from the Trust's Director of Pharmacy would be required, however the Trust acknowledges that when the report was reviewed by the Clinical Review Group, the Group should have picked up on this point and requested input prior to final approval of the report. This learning has been shared with the Chair of the Clinical Review Group.

The Trust wrote to Mr Joseph on 18 July 2022 to advise him that a Family Liaison Officer (FLO) had been allocated to support him throughout the review process; the letter provided the name and contact details of the FLO. The FLO contacted Mr Joseph to explain the review process and enquire as to whether Mr Joseph had any questions he would like addressed within the report. Unfortunately, despite further contacts on 3 October 2022 and 19 November 2022, Mr Joseph did not provide any questions and therefore the report was completed without any questions from the family. This is not an unusual occurrence; we are mindful of not imposing on families during their time of grief. In such cases the FLO provides reassurance that whilst the review process will continue, any questions can be addressed following completion of the report and the Trust does not put a timeframe on engaging with families post report approval. Mr Joseph was in contact with the FLO following Mrs Joseph's inquest and the Trust has recently responded to this.

I hope that I have provided you with robust assurance that the Trust has taken steps to address the issues of concern in your report, that we are continuing to take action to strengthen the care provided to our patients, and that patient safety is the Trust's top priority.

Yours sincerely,

Deputy CEO