



Edward Jenner Court Pioneer Avenue Gloucester Business Park Brockworth Gloucester GL3 4AW

25 July 2023

Mr D.D.W Reid His Majesty's Senior Coroner Martins Way Stourport on Severn Worcestershire DY13 8UN

Dear Mr Reid

Ref: The Late Nigel David Harper -9131813

I am writing on behalf of **Executive**, Chief Executive, in response to your letter of 5 June 2023 containing the Regulation 28 Prevention of Future Deaths Report relating to this case.

On conclusion of the inquest, you established that there was a lack of understanding between Gloucestershire Health & Care NHS Foundation Trust and Herefordshire & Worcestershire Health & Care Trust regarding how each other's urgent care services are run; and that there was a lack of clarity concerning process for urgent referrals or requests. The Trust has now had opportunity to reflect on its practice and I am pleased that we have been able to identify improvements which will minimize the risk of a similar tragic event recurring in the future.

The learning from Mr Harper's death has focused on two key strands.

1. Improving understanding between both trusts regarding how their mental health urgent care services operate.

In terms of improving understanding between the two organisations, I can confirm that senior managers from both trust's urgent care mental health services have met to discuss this matter in detail and shared each other's Crisis Teams Operational Policies. These documents describe the purpose and scope of the individual services involved and include detail concerning referral and triage.

2. Strengthening the Standard Operating Procedure (SOP) of our Mental Health Liaison Team regarding inter trust referrals and transfers of care.

Our Mental Health Liaison Team has reviewed its SOP and made the following additions under the Discharge section of the document. I enclose a copy for your information and these changes can be seen on Page 17.

 Where referrals are made by the MHLT team to any service either within the trust, or externally, there will be a clearly defined agreement of what this service will provide and the timeframe of that intervention. Any referrals or requested contact must be followed up via a confirmed email immediately following contact being made (including a copy of the assessment, an outcome of referral made and agreed timeframe for that contact). A subsequent entry will be made on EPR. (*Electronic Patient Record*)

This document is currently in draft but will be ratified at the next Mental Health & Learning Disability Inpatient & Urgent Care Governance & Performance meeting on 7 August 2023. In the interim it is being shared with all members of the team via team meetings, and as such, we will be able to evidence that staff are aware of these important changes. Additionally, in six months' time, we will undertake a dip sample audit of Mental Health Liaison Team referrals to test our practice and ensure that learning has become embedded.

I would be grateful if you could share a copy of this response with Mr Harper's family and relay our deepest apology for the gaps in service provision that the inquest identified. We continue to reflect on the learning from his death and aim to improve the safety of patients through the changes made.

If I can be of further assistance, please let me know.

Yours sincerely

Medical Director



Deputy Medical Director