Herefordshire and Worcestershire
Health and Care
NHS Trust

Chief Executives Office
2 Kings Court
Charles Hastings Way
Worcester
WR5 1JR

[redacted]

[redacted]

[redacted]

27 July 2023

Mr D D W Reid
HM Senior Coroner
Worcestershire Coroner's Court

[redacted]

Dear Mr Reid,

Re: The Late Nigel David Harper - [redacted]
Regulation 28 report to prevent future deaths - response

Thank you for forwarding on your Regulation 28 report. I have read your report carefully and attempted to address your concerns that you have raised as a result of the coronial inquiry regarding the death of Nigel Harper.

In your report, you highlighted the following points of concern:-

Concern

You concluded that the events in Mr Harper's case arose out of the lack of understanding between two NHS Trusts concerned (Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT) and Gloucestershire Health and Care NHS Trust (GHCT) as to how each other's mental health services operate – otherwise agreements would have been made for Mr Harper's mental health to be assessed urgently, as was intended. You were concerned that staff at HWHCT and GHCT do not understand how to make urgent mental health referrals or requests for urgent mental health assessments to each other, and there remains a risk that other deaths may occur in similar circumstances in the future.

Firstly, I think it is important to address why this missed opportunity occurred in the first place. Fundamentally, it would appear there was a genuine breakdown in communication between the two organisations. The clinician in the GHCT Mental Health Liaison Team made contact with HWHCT Crisis Resolution Team (CRT) to discuss a patient that they had assessed in their local emergency department. I gather that GHCT assumed this conversation constituted an urgent referral, although this was not the reciprocal interpretation, with HWHCT staff believing that it was for information only initially, awaiting confirmation of the final discharge plan once the GHCT clinician had confirmed with the patient and his family.

I wish to reassure you that as a Trust, we have very much reflected upon this missed opportunity. HWHCT raised a Ulysses report regarding the care and treatment received, latterly escalating this to a serious incident review. An investigating officer was identified within the Division, who was responsible for undertaking a detailed investigation using root cause analysis methodology. In addition, the staff involved have been given the opportunity to reflect on the incident via a psychology-led debrief and will have been able to discuss any further issues or concerns in individual supervision.

On receipt of the joint Regulation 28, [redacted], Operational Lead for Urgent Care (HWHCT) met with [redacted], Deputy Director for Urgent Care Mental Health (GHCT) and [redacted], Solicitor (HWHCT). The purpose of this meeting was to take a detailed examination of the circumstances surrounding the communication between both organisations and to work collaboratively on a suitable solution. As a result, changes to local policy have been made (outlined below) and communicated to those staff in the affected services by email dated 18 July 2023.

In an attempt to prevent reoccurrence, we have reviewed/amended our CRT Operational Policy to include a specific section on inter-Trust referrals and transfers of care. In summary, if a patient presented in crisis to out-of-County emergency services/organisations our standard operating procedure has been updated to address this situation, as below:-

> Following an assessment, it may be that the patient requires ongoing care and treatment under HWHCT. In these circumstances both providers share responsibility for ensuring that the patient's referral/transfer of care is seamless and that access to service provision is initiated on the basis of clinical urgency. This process should start with a telephone conversation between the external organisation and staff from HWHCT, seeking to clarify and agree the following:
>
> - The exact nature/purpose of the call (i.e. referral or information only)
> - The degree of urgency and response required (in keeping with NHSE MH Access Standards 2021);
> - Very urgent: contact with patient within 4hrs (CRT)
> - Urgent: contact with patient within 24hrs (CRT/Home Treatment Team (HTT))
> - Routine: contact with patient within 72hrs (HTT)
>
> Once the appropriate response has been mutually agreed, HWHCT will document the outcome of the discussion on Carenotes, our electronic patient record system. In addition, the referrer will provide a comprehensive/documented assessment (to include formulation of risk and management plan) to the receiving service at their earliest convenience.

For completeness I have included an updated version of our standard operating procedure.

I hope this reassures you that the Trust has learnt from your concern and have ensured we have reviewed this missed opportunity. We now believe there is a robust system in place to ensure that such a situation cannot occur in future.

I hope that the information above adequately addresses your concerns.

I do not have any submissions to make in respect of publication of this response. I would be grateful if you could kindly send a copy of my response to those to whom you copied your Regulation 28 report.

Yours sincerely

[redacted]

[redacted]

Chief Executive

Enc.