Cumbria, Northumberland,
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NHS Foundation Trust

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Dr N Shaw
HM Coroner for County of Cumbria
Fairfield
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Dear Dr Shaw

Inquest into the death of Brenda Shields
Regulation 28 Report to Prevent Future Deaths Response

We write in response to your Regulation 28 Report dated 7 June 2023 following your investigation into the death of Brenda Shields. This response has been prepared by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust ("The Trust") and addresses the concerns as set out by HM Coroner.

By way of background context, we note that the Trust was not invited to be Interested Persons or to provide witnesses to give evidence on the issues central to the proceedings both in the mind of the family and HM Coroner.

The issues you raised at the time of the inquest and within your regulation 28 report were as follows:

(1) Brenda was discharged without any planned follow up. Her family were not involved in the discharge process despite assurances that they would be, her GP did not receive discharge notification from the Hadrian unit until 8 days after the event or from the Crisis team until 10 days after Brenda's death. Referrals promised from Hadrian unit to Drug/Alcohol services and Persistent Physical Symptoms Service were not made.

This concern suggests that Brenda's family were not involved in the discharge process from both the Hadrian Unit and the Crisis Team. By way of clarification, as is confirmed in the Serious Incident Investigation Report that was disclosed in these proceedings, Brenda attended a ward review meeting on 14 November 2022 with her husband and the plan in relation to Brenda's discharge from hospital was discussed. The plan for discharge included referring Brenda to the Community Treatment Team ('CTT'), the drug and alcohol team, the Persistent Physical Symptoms Service and for the Crisis Team to offer a 72-hour review. It is however, accepted that Brenda's family were not contacted as expected prior to the subsequent discharge from the Crisis Team.

In addition to the above, this concern also suggests that Brenda was discharged from the Hadrian Unit and the Crisis Team without any planned follow up. Again, by way of clarification and in accordance with the written evidence provided, immediately following discharge from the Hadrian Unit, Brenda was supported in the community by the Cumbria East Crisis Team, and she continued to be supported by this service until the date of her sad death (on which date she was also discharged from the service). The role of crisis services is to provide people with safe, effective, compassionate, high-quality care whilst they remain in mental health crisis. Where appropriate and as in this case, the crisis service offers home treatment intervention to allow people to be discharged from hospital earlier whilst still experiencing an acute phase of illness. The plan for discharge also included referrals into the other services referenced above and in particular, the referral to the CTT continued to be discussed with Brenda until the Crisis Team's final contact with Brenda, as the clinicians considered that Brenda would benefit from follow up from the CTT moving forward. In relation to the plan following discharge from the Crisis Team, the plan was documented as being for Brenda to engage with Recovery Steps, the local drug and alcohol service.

We further note the reference to referrals from the Hadrian Unit not being made. As HM Coroner is aware, a full Serious Incident Investigation ("SI") was completed in relation to Brenda's death. The SI was conducted in line with the NHS England Serious Incident Framework [2015]. The investigation was undertaken by an investigating officer who examined the care and treatment offered to service users by the Trust and establish whether it was timely, effective and in line with Trust policies and procedures.

The aim of the SI process is to identify any issues or concerns with care and treatment provision in an effort to improve standards and prevent the occurrence of incidents. The SI Report was disclosed as part of HM Coroner's investigation into Brenda's death and HM Coroner will be aware that the investigation identified the same points as highlighted in this concern as follows:

- *Making referrals to other services*
- *Involving other services in discharge planning; and*
- *Involving BS's family in discharge planning .*

As HM Coroner is aware, the Trust would ordinarily provide an overview of the SI Investigation, the learning from the investigation and the actions taken by the Trust during the inquest hearing. Sadly, the Trust were not invited to provide this evidence during the final inquest hearing however, to provide assurance, we have set out below the relevant learning points and actions taken to address these points prior to the inquest hearing below:

Findings of the Serious Incident Investigation

Whilst the investigation did not identify any significant findings considered to have impacted on care delivery and service, additional findings and learning were identified, some of which overlap with the areas of concern in your report. Although not central to the issues around Brenda's death, they are nevertheless important elements of learning from a Trust perspective:

a) Referrals to other services: The planned referrals agreed to the addictions service were not completed as expected on Brenda's discharge from Hadrian Ward. At the point of discharge there was a lack of clarification in responsibility of assuring onward referrals were made; and there was a delay in chasing up the referral to addictions by the crisis team during home-based treatment.

b) Involving family in discharge planning: Brenda's daughter's concerns were not adequately explored in terms of the decision to discharge from Crisis Team.

c) Involving other services in discharge planning: The crisis team did not liaise with the Persistent Physical Symptoms Service around Brenda's discharge from their service. Consideration should be given to follow up plans regarding physical health needs.

Action Plan

This learning was used to formulate an action plan and identified the following recommendations and actions to be implemented:

a) 'Referrals to other services' Actions/Recommendations:

The recommendations/actions implemented in relation to the learning identified at **'a'** above were as follows:

Actions/Recommendations:

"Discharge processes to be reviewed by Hadrian Ward to ensure onward referrals are communicated with receiving teams

The senior leads who attend MDT along with clinical staff will now capture onwards referrals and the acceptance of these referrals as evidence on the MDT proforma on Rio."

The Trust can confirm that the discharge processes have been reviewed and discussed with the staff on the Hadrian Unit during a Team meeting with minutes provided as evidence of this discussion. This meeting took place 5 April 2023. We are satisfied that processes are in place and that communication around these areas has improved.

In relation to the second recommendation, the Trust has reviewed completed MDT audits and they have shown good compliance with capturing onward referrals and the acceptance of referrals as evidence on the MDT Proforma on the Trust's electronics records system. This is now audited monthly. The compliance figures are January 2023 93%, February 93%, March 2023 95%, April 87%, May 88% and June 95%. Senior leads now attend MDTs 7 days a week to ensure that senior leadership is now offered at all MDTs.

b) 'Involving family in discharge planning' Actions/ Recommendations:

The recommendations/actions implemented in relation to the learning identified at **'b'** above were as follows:

Actions/Recommendations:

"For the team to continue monitoring and assurance of care giver inclusion in safety planning and discharge planning.

An Audit will be undertaken to understand compliance as well as continued carer awareness training to be offered to all staff."

Carer inclusion is reviewed at the daily MDT. This is to ensure that the triangle of care is maintained and to confirm that care givers are supported and understand the service user's needs, thus supporting care givers in safety planning, care planning and discharge planning. Carer contact is still offered to those where no consent has been given using common sense confidentiality principles to support the care giver and assess and offer support. The last audit to ascertain if care givers' views had been included was in May 2023. This is due to be repeated in August. May's audit indicates an improvement in carers

being involved in safety/discharge planning. A supervisory check at time of writing of 5 recent discharges confirms that care giver views were included in 100% of cases.

Carer leads continue to roll out carer awareness training. This is at 80% across the service currently. A further 8 staff have had Carer Awareness and Getting to Know You training over the past 4 months. Carer leads also offer 1:1 Training for new staff working within CRHT.

c) 'Involving other services in discharge planning' Actions/Recommendations:

The recommendations/actions implemented in relation to the learning identified at **'c'** above were as follows:

Actions/Recommendations:

"An Audit will be completed to monitor compliance with discussion and documentation of physical health within MDT."

The Monthly MDT audit captures if discussions around Physical Health monitoring are taking place during the MDT process. A weekly report for the crisis team shows the completion of the Physical Health checks, which is then used to feedback to Senior leads around outstanding actions during MDT meetings. Twice weekly caseload audits also take place where the pathway coordinator adds a progress note to reflect any missing documentation/actions including Physical health checks. The monthly audits completed in January, February and March identified 100% compliance in the completion of physical health checks and the documentation of these within the MDT meeting.

(2) Inadequate weight seems to have been given to Brenda's alcohol problems and her assurances that all was and would continue to be well were accepted at face value despite her recent history, her family find it hard to understand how she could be graded low risk on the day she died.

The Serious Incident Investigation Report identified that the clinicians involved in Brenda's care considered her alcohol use throughout the care and treatment provided and the plan following discharge from crisis services was for Brenda to engage with Recovery Steps, the local drug and alcohol service, which was considered to be appropriate in light of the presenting risks. Whilst the most recent planned referral had not been made prior to her death as outlined above, it should be noted that professionals had promoted engagement with addictions services throughout Brenda's history. The nature of this service is that engagement with drug and alcohol services is entirely voluntarily, and Brenda did often decline referrals to drug and alcohol services throughout her care and treatment with the Crisis Team.

In relation to the risk assessment conducted on the day Brenda was discharged, the Serious Incident Investigation Report found that the FACE risk assessment contained all of the relevant risks and scoring was appropriate for the presenting risks.

It is difficult to predict suicidality entirely on an empirical basis. Studies have examined the range of tools currently in place across mental health services and their effectiveness in respect of patients rated as "low risk" of suicide during what is later identified as their final contact with mental health services prior to taking their own life. Statistics presented by the National Confidential Inquiry into Suicide and Safety in Mental Health in 2006 looking at preventable suicide do indicate that 86% of patients who had been in recent contact with mental health services at their final contact, suicide risk was rated to be low or absent. Consequently, the Trust is in the process of reviewing its approach to risk assessment with the intention of moving away from quantification of risk to that of a more narrative approach in line with recommendations made by NICE in their Self Harm: assessment, management and preventing recurrence [NG225] guidance of 2022.

(3) I refer you to the PFD report I issued referring to Charlotte Grace on 29/10/19. Assurances were given in response to that report which again focused on discharge without family/carer involvement which is surely paramount. I note actions mentioned in the incident report in this case but am still concerned that similar events may occur in future.

This concern relates to a Regulation 28 report regarding an unrelated individual in 2019 on account of the fact that there are alleged overlapping issues regarding involvement of family and carers in discharge decisions. Firstly, it is important to note that the 2019 report related to care provided by a different NHS Trust, CNTW responding to the Regulation 28 report only as a result of taking over that service at the time the report was issued. Secondly, appropriately involving families and carers is fundamental in all of the services that we provide, and the Trust strives to continually learn lessons as to how to build and improve on this involvement. That said, the implications of not involving family and carers to the fullest extent will vary on a case-by-case basis. We note that the extent to which the issues with family involvement in this case were not explored in evidence due to the absence of any Trust witnesses however, the written evidence from the SI investigation concluded that the findings/learning identified in this investigation were not considered to be causative or contributory to Brenda's death, particularly as carers' views had been sought at a number of points during Brenda's care and treatment and the Getting To Know You documentation had been completed.

In any event, the detail above sets out the work that has been carried out by the Trust in response to this case and more broadly regarding involvement of families and carers. This work is supported by the Trust Together: Service User and Carer involvement Strategy which sets out that service users and carers should be at the heart of everything we do and getting this right is the single most important thing we can do as an organisation.

We hope that the information provided offers you the necessary assurances that the Trust have invested time, effort and resource into investigating the issues you have highlighted with a view to improving patient care and safety and reducing the risk of any adverse incidents or outcome in the future.

Yours Sincerely

Executive Medical Director / Deputy Chief Executive