Tees, Esk and Wear Valleys
NHS Foundation Trust

Office of the Chief Executive
West Park Hospital
Edward Pease Way
Darlington
Co Durham
DL2 2TS

Ms J Richards
HM Assistant Coroner
For County Durham and Darlington

9 February 2024

Dear Ms Richards,

Re: Response to Report to Prevent Future Deaths issued on 08.12.2023 in relation to Sarah Holmes

I am writing to you in response to the Prevention of Future Death (PFD) Report issued to Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV, or the Trust) on 08.12.2023 following the inquest touching the death of Sarah Holmes. I note that the PFD Report issued has been directed to both TEWV and Durham Constabulary, on the basis you have concerns in respect of both organisations. I have provided a response below in respect of concerns 5(1) and 5(2) of your PFD Report as it appears those are the matters where your concerns are directed to TEWV (with the second of those also being a matter for the Police to respond to). I set out below your concerns, as well as the response from TEWV in respect of each matter:

1. ***The escalation in risks that Sarah presented with which included highly dangerous and impulsive thoughts of harming herself were not appropriately reflected in a robust safety plan, and it was not thought appropriate to liaise with family and friends who may have provided an essential safety net when Sarah was alone, and at obvious risk of the impulsive thoughts of self harming returning, in the absence of any ongoing professional support. Although evidence was heard about further training and improvements that have been made in respect of safety planning and around issues of confidentiality, I remained concerned that such issues could arise again.***

The Trust acknowledges HM Assistant Coroner's concerns in respect of robust safety planning and this is a key priority across all Trust services.

To provide some context to our response in respect of Sarah's care, as confirmed at the inquest, the mental health worker(s) who assessed Sarah on 10 July 2022, acknowledged the varying methods of self harm that Sarah undertook in the days leading to her death, and took this into account as part of their assessment. It was heard that the plan for Sarah to return

home was very much made in collaboration with her. The mental health worker had considered the safety plan that Sarah had written with her community team and all options for treatment, including hospital admission were explored with Sarah. It was confirmed that, as would be expected by the Trust, the clinicians tried to go with the least restrictive options that would be the most beneficial for the patient. It is not accepted by the Trust that there was an absence of any ongoing professional support; a plan was in place for the crisis team to contact Sarah on the evening of 10 July 2022, and for her Care Co-ordinator to continue to engage and support after the weekend, on 11 July 2022.

At the time the plan was formulated, Sarah was reported to be no longer feeling distressed, was future planning, positive, bright, chatty and talking spontaneously. She wanted to resolve the issues around her benefits and move forward, and was not having ongoing suicidal thoughts. She remained calm and engaging, with plans to see a friend later that afternoon.

It is acknowledged that the mental health workers asked Sarah if they could contact her family or friends, and she asked that they didn't, as she did not want to worry her family when the crisis was felt to have passed. The inquest heard that the mental health workers felt they could not break confidentiality as there was not considered to be any immediate risk to Sarah, or others, and it was felt that Sarah had the capacity to make that decision. The mental health workers considered breaching confidentiality and weighed up the risk of Sarah going home without the support of a friend, against the risk of losing the strong therapeutic trusting relationship that Sarah had built up with services that would come with beaching her confidentiality. They felt that as Sarah had always worked with services, she would engage with the plan that she had collaboratively created on this occasion. The inquest heard how the mental health worker had reflected on this difficulty where patients have capacity to decline that family and friends are contacted, and has taken this on board in their future practice.

The Trust Serious Incident Investigation found that there was potentially a missed opportunity to contact Sarah's family or friends following the assessment, although this was a finding made with the benefit of hindsight.

Clinicians have a common law duty of confidentiality to patients such that personal information provided in confidence, such as between a patient and a healthcare professional, can only be disclosed with a legal authority or justification. Often, that legal authority will come from a patient's consent, but where that isn't forthcoming, clinicians have to consider whether or not there is sufficient justification to breach a patient's confidentiality. The Trust recognises the difficult position clinicians are faced with when considering this, particularly where the patient is considered to have capacity, and the risks are not felt to be sufficiently high at that moment in time, to justify a breach.

In addition, clinicians also have their professional codes to adhere to. For nursing staff, the relevant section on the Nursing and Midwifery code provides:

> *"5. Respect people's right to privacy and confidentiality*

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately. To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care

5.3 respect that a person's right to privacy and confidentiality continues after they have died

5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand."

The Trust has in place Common Sense Confidentiality guidance which considers how we work with carers where a service user states we cannot share information with their family / people close to them. This useful guidance is currently under review to provide further clarity to staff. In addition, discussions have already taken place at the Trust Fundamental Standards Group on 22 November 2023, to consider how this guidance can be further improved. Although plans are early in development, the intention is to create an updated guidance document to inform carers and support staff with decision making around confidentiality and information sharing. In addition, the Trust intends to develop a Trust-wide communication plan to disseminate the updated guidance. More information can be provided on this if required, as the information is collated and shared. However, in Sarah's case this guidance is not likely to have led to a different decision being made by the clinicians who clearly thought this through.

It is noted that HM Assistant Coroner has acknowledged that evidence was heard at the inquest about the implementation of training and improvements around safety planning and confidentiality. To reiterate, in accordance with the action plan developed as a result of the Trust investigation, the Trust has already;

- Re-shared the safety summary and plan information from the Intouch page on the Trust Intranet with all team members to improve the knowledge and quality of safety summaries and plans. A copy of the first page of the 3 sections covered has been provided, however, the full documents can be shared if required – particularly that which relates to 'Creating and Updating a Safety Plan'.
- A video providing a presentation on Safety Plans has been reshared with staff (https://vimeo.com/819417803/e915314e18?share=copy).

- Reflective practice sessions have now taken place to discuss the learning from this incident. There has also been discussion in huddles regarding safety planning and also on using the 'need to know' section to ensure core information is included in the safety plan. There has also been individual practitioner reflection around discussing risks with families, maintaining the trust in a therapeutic relationship and the circumstances where confidence has to be broken, to mitigate risk.
- Literature is being developed and disseminated across the Trust in relation to key learning from the patient's journey. In addition, the Patient Safety Team will be undertaking Teams meetings to discuss the same.
- Supervision sessions are carried out monthly to evidence that learning has been embedded.
- Carer awareness training has been carried out.
- Consent and confidentiality has been discussed in Team meetings and supervision.

Separately to the learning identified as a result of the Trust investigation, HM Assistant Coroner is aware that the Trust has ongoing assurance around assessment and management of risk via the Quality Assurance Schedule (QAS). Senior Clinical Staff complete monthly audits to monitor the quality of narrative risk assessment and risk formulations and safety plans being produced by staff, the audits also consider evidence of co production with the service user and involvement of families / carers. The findings from these audits are then discussed and scrutinised at the Specialty Governance Group to identify whether any further action is required. Anything that remains a concern following the monthly audit is added to team meeting agendas for discussion to ensure that improvements can be implemented on a rolling basis. These actions also inform the overarching Adult Mental Health Action Plan which is reviewed and implemented by the governance action planning sub-group. The Quality Assurance Schedule is monitored by the Trust's Fundamental Standards Group and reports into the Care Group Board and Executive Board to ensure monitoring through the Trust's governance structures. NHS England, the ICS, the CQC and our partners see the audit results at the Quality Board which is a part of mandated support and focusses on the quality of care at TEWV. These results are showing an improving picture and identify the teams that require more support to improve.

2. ***There remains no policy in place between Mental Health Services and the Police as to the appropriate agency to undertake welfare checks and in particular there is no formal procedure to escalate matters when Mental Health professionals are concerned that life or limb is at risk and the Police do not agree and decline to assist. The College of Policing authorised guide to professional practice is clear that forces should ensure they have a policy on mental health and that although certain issues are required to be subject to local operating protocols with mental health, ambulance and other providers, there are other issues that should be determined by policy which would also ensure that services which operate across multiple health commissioners and providers to establish basic minimum requirements to determine police contribution to any local agreement with other providers.***

At the time of Sarah's involvement with services, there was no specific policy in place between TEWV and Durham Constabulary as to the appropriate agency to undertake welfare checks, however, the agencies have worked together to develop an Interim Policy pending implementation of 'Right Care, Right Person' (RCRP). This Interim Policy will be entitled 'Interim Concern for Safety Escalation Policy' and has been collaboratively created between Durham Constabulary and the Trust. The Interim Policy *'provides a process to support decision making in relation to Police attendance at concern for safety incidents'*. The aim of the Interim Policy is to provide *'a framework for escalating incidents of concern for safety and welfare checks, in which a decision is made for Police not to attend and partner agencies disagree*'.

The position remains that only the Police have the power to force entry into a property under section 17 Police and Criminal Evidence Act 1984 (PACE) in circumstances to save life or limb, or prevent serious damage to property. TEWV staff are encouraged to always use their best endeavours to make enquiries by telephone and in person to establish the wellbeing of a patient where concerns have been raised.

I can reiterate the position that was explained at the inquest, that TEWV is currently working very closely with Durham Constabulary (along with other relevant stakeholders) with regard to the introduction of 'Right Care, Right Person' (RCRP). This will supersede the Interim Policy that has been developed and provide a more detailed Policy and framework for TEWV, Durham Constabulary and other partner organisations to work within in carrying out welfare checks. The Trust has attended an event in October and December 2023 with Durham Constabulary to establish work streams to implement the model, and is actively working with all partner agencies to progress this.

With regards to the concerns around escalation, the Interim Policy confirms that if there is a situation whereby Police and mental health services disagree on which agency should take primacy for the concern of welfare report, the Interim Policy will be triggered. It sets out the roles and responsibilities of each level of Police command and details of who concerns should be escalated to within each organisation where such disagreements arise. The Interim Policy also includes an out of hours provision.

In addition, prior to the implementation of the Interim Policy, the Trust committed to preparing a patient safety briefing regarding actions to be taken when a dispute arises with partner agencies. This has been completed and circulated to all clinical teams. I understand a copy was also provided to HM Assistant Coroner. The briefing provides a clear message to staff in respect of communication and escalation in circumstances where it is apparent that *'opinions of the level and immediacy of risk posted to an individual differs between organisations and that this may result in a delay in response'*. Pending the introduction of RCRP, this provides staff with practical and appropriate guidance to so far as possible, manage patients in a safe and consistent manner.

I trust that this provides assurance that these concerns have been taken very seriously by the Trust and we will continue to strive to improve the service that we offer.

Our Chief Nurse, Medical Director and I have made repeated offers to meet with the Coroners in the Durham and Darlington jurisdiction and all offers have been declined. We do meet with other Coroners, and we are aware of some of our partners who meet with Coroners in this jurisdiction. I would like to repeat our sincere offer to meet at your convenience and discuss the developments at TEWV and how we are working with our partners and the people who use our services to improve care.

Yours sincerely

Brent

[redacted]
Chief Executive