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

Private and Confidential
Ms J Richards
HM Assistant Coroner for County Durham and Darlington
HM Coroners Office
PO Box 282
Bishop Auckland
Co Durham
DL14 4FY

23 February 2024

Private and Confidential

Dear Ms Richards,

Re: Report to Prevent Future Deaths issued on in relation to Linda Banks

I am writing to you in response to the Report to Prevent Future Deaths (PFD) served on Tees, Esk and Wear Valleys NHS Foundation Trust on 19 December 2023 regarding the death of Linda Banks. For ease of reference I have addressed concerns 2 and 3 separately to concern 1:

Concern 1: A thematic review completed in November 2021 had identified a number of significant issues in the functioning of mental health services, and many of the same issues were also identified in the serious incident review into Linda's care and treatment, from February 2022 until her death. It is apparent that any actions taken as a result of the thematic review were not effective in implementing change and that the action plan was still a "work in progress" at the Pre Hearing Review Hearings which took place in this case in 2023.

As advised at the inquest, the action plan for the thematic review was reviewed and incorporated into a larger overarching improvement plan for the Durham and Darlington Crisis Team following a restructure of its operational management and governance processes and arrangements in April 2022. This meant that whilst all the points had been actioned, some work was still being carried out at the time of the Pre-Inquest Review Hearings to continue to refine and improve the Crisis Team and ensure any changes were fully embedded. As heard at the inquest and set out in the statement of Thomas Hurst, all actions have been addressed, with a plan for outstanding training to be completed, however if you wish for further clarity on any particular action please let me know.

Concern 2: The Serious Incident Investigation into the care received by Linda was not completed until the end of January 2023, some 9 months after the death. This is neither timely nor responsive. Despite reassurances given that the Trust are working to

eradicate such delays, in response to a series of previous PFD reports issued by the Coroners of Durham and Darlington, there are still cases coming to the attention of the Coronial service where the Serious Incident Investigations are significantly delayed in excess of the 60 day NHS framework.

Concern 3: As previously reported the concern in relation to the delays in such investigations and any subsequent necessary action required, is twofold. Firstly, the quality of the investigation is severely compromised as the evidence is not captured when memories are fresh. Secondly, because any lessons to be learnt and improvements to be made to improve patient safety cannot be implemented promptly.

We have taken your concerns regarding the timing of Serious Incident Investigations (SII) very seriously and as you state, I have updated you on the Trust's progress in relation to this on a number of occasions, including regularly providing you with a list of SII that remain outstanding. We have made every effort to be transparent with you and to confirm the clear timelines for completion for internal quality assurance.

It was therefore disappointing to receive a further PFD on this matter. I was further confused that the PFD in this case appears to have been issued in relation to you being advised on another unrelated matter that an SII would not be completed until January 2024, when the death occurred in October, and not due to any outstanding concerns in relation to the evidence heard at this inquest.

The Patient Safety Incident Response Framework (PSIRF) will replace the current Serious Incident Framework 2015. This represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. This is a key part of the national NHS Patient Safety Strategy, which recognises that new ways of learning are required to drive change and improve standards.

PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

Compassionate engagement and involvement of those affected by patient safety incidents.
Application of a range of system-based approaches to learning from patient safety incidents.
Considered and proportionate responses to patient safety incidents.
Supportive oversight focused on strengthening response system function and improvement.

The Trust fully transitioned to the new PSIRF arrangements in January 2024, following months of developing a new set of systems and processes, including the implementation of "InPhase" which is the new mechanism for incident reporting.

Under both the 2015 Framework and PSIRF, following the notification of a death, the death is reviewed by the Trust as part of a multidisciplinary huddle. This identifies the most appropriate and proportionate response which under PSIRF includes a wide range of options, such as, but not limited to, a Multi-Disciplinary After-Action Review, a Mortality Review or a Patient Safety Incident Investigation (PSII). We have always undertaken Early Learning Processes in lieu of any further investigation to identify any issues or themes in the period immediately after we are aware of the death. PSIRF has offered a range of options and these systems and processes will further improve the Trust's ability to identify themes early in patient safety incidents and respond in a timely manner, taking actions that are SMART (Specific, Measurable, Assignable, Realistic and Time-related).

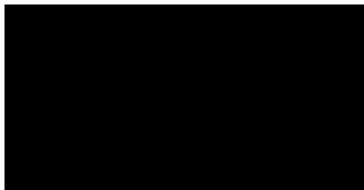
It is important to note, that PSIRF does not incorporate any specific timescales for completion of PSII reports, recognising each case is individual, however the Trust are aiming to complete these in a timely manner. I continue to have direct oversight of all incident reports, as does

the Chief Nurse, who keeps our Quality Assurance Committee and our Board fully briefed on the progress of the remaining cases which fell within the old Serious Incident Framework, in addition to the responses to new incidents under PSIRF. NHS England, the North East and North Cumbria Integrated Care System and the Care Quality Commission also remain fully sighted on these issues. We also continue to have weekly sitrep / report out meetings to ensure we are sighted on the progress of each review and can provide any additional support to reviewers that may be needed. Any patient safety incident that occurred before the implementation of PSIRF will have a review under the 2015 framework, these reviews are all progressing.

I have taken the opportunity to share an updated version of the list of the serious incident reviews that I have previously shared with you to be open and transparent and to demonstrate progress. You will see from this that the only case remaining open and ongoing is a complex homicide review being undertaken by an external agency.

In light of the above, we hope that you are assured that timely investigations remain a priority for us and we are focused on processes to ensure early memory capture of evidence in addition to identifying and implementing learning promptly. Given the changes around PSIRF, our Chief Nurse would be more than willing to come and talk to you about the new processes, as we have done with other Coroners in the area.

Yours Sincerely



Chief Executive