Essex Partnership University
NHS Foundation Trust

28 March 2024

Private and Confidential

Ms Sonia Hayes
HM Area Coroner for Essex Coroner's Office
Seax House Victoria Road
Essex
South Chelmsford
CM1 1QH

Chief Executive Office
The Lodge
Lodge Approach
Wickford
SS11 7XX
[redacted]
[redacted]

Dear Ms Hayes,

Georgia Gypsy Catherine Dehaney-Perkins (RIP)

I write to set out the Trust's formal response to the report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 5th February 2024 in respect of the above, which was issued following the inquest into the death of Ms Dehaney-Perkins.

I would like to begin by extending my deepest condolences to Ms Dehaney-Perkins' family. The Trust sympathises with their very sad loss.

The matters of concern as noted within the Regulation 28 Report have been carefully reviewed and noted. I will now respond in full to these concerns in the hope that this provides both yourself and Ms Dehaney-Perkins' family with comprehensive assurance of changes that have been made at the Trust to address the concerns you have raised.

Concern 1) On 28 August Ms Dehaney-Perkins was agitated and distressed on return to the ward from leave and had consumed alcohol that was known to increase her risk of self-harm. Ms Dehaney-Perkins tied a ligature to this assisted toilet bar and hanged herself. Staff found Ms Dehaney-Perkins and removed the ligature.

a) Ms Dehaney-Perkins was admitted to a room with an assisted bathroom (this was not a requirement for her) with a fault in the anti-ligature safety mechanism meant that the safety feature could not be implemented.
b) There was no risk assessment about the suitability of this room for Ms Dehaney-Perkins a patient with a self-harming history at the time of the admission.
c) The fixed-point ligature was not appropriately updated in the risk assessment and was not discussed at a discharge planning meeting.
d) The Trust Datix Report was incomplete

Response: All patients have a risk assessment completed within four hours of admission to the ward. This is monitored through the clinical dashboard daily by the Nurse in Charge. On admission the Nurse in Charge will delegate duties to ensure that all admission tasks are completed. Prompts have been added to the ward diary to remind staff to check that all tasks including risk assessments have been completed.

Cherrydown Ward has two assisted bathrooms which have reduced ligature handrails. To reduce the risk of patients allocated to those rooms, the risks are documented in individual risk assessments and care plans. If a patient is at significant risk of self-harm the ward would attempt to relocate patients to ensure that any high risk patients are not allocated the assisted bathroom bedrooms. This will also be discussed in 1:1 support supervision and the monthly meetings with all qualified staff to ensure that this is taking place. Documentation will be audited at the 1:1 support supervision's with those staff that have patients allocated the assisted bathroom bedrooms.

There is a prompt on the handover sheet to ensure that the Nurse In-Charge checks the handrails mechanism remains in a locked and upright position. This is checked and signed for every shift. Regular audit and assurance are completed by the Ward Manager and Ward Clerk to check that this is being completed. Regular inspections of all room fixtures including handrails are done as part of Ligature audits to ensure compliance with EPUT safety protocols.

Thorough risk assessments are being carried out using EPUT risk assessment tools including suitability of rooms for all patients on admission. There is collaboration with mental health professionals, including psychiatrists, psychologists, community mental health nurses, GP's and social workers to gather comprehensive information regarding the patient's history of self –harm and associated risk factors.

The General Workplace Risk Assessment has been updated to include the fixed-point ligature. Multi-disciplinary team discussions are being undertaken to develop and to review individualised care plans and risk assessments as part of discharge planning.

The Matron has made urgent contact with the risk management team in relation to the Datix Report for this matter – the datix report was approved by the Patient Incident Team on 26th March 2024. A further review of the process is being undertaken to improve sign off where there is a patient safety incident.

Concern 2) Medication was appropriately withheld on 28 August when Ms Dehaney-Perkins returned to the ward intoxicated due to potential interaction with alcohol that can cause increased sedation,

Response: The Trust notes the above finding by HM Area Coroner.

Concern 3) Arrhythmia and fatality

a) This risk of consuming alcohol with her specific medication was not discussed with the Ms Dehaney-Perkins or family.
b) Not all incidents of consumption of alcohol on return from leave were recorded and risk assessments were not updated.
c) Ms Dehaney-Perkins had agreed to mitigations of medication management by her family that were not recorded on the care plan on discharge on 2 September. Ms Dehaney-Perkins demanded control of her medication on 4 September against concerns of her family who were forced to return medication.

Response: If a patient is identified as at high risk of alcohol misuse they are referred to the Drug and alcohol service. It is also discussed with the patient advising them of the risks of using alcohol whilst on medication. Where consent is given family are invited to ward reviews and discharge planning meetings and discussion around medication, risks and compliance is part of those meetings. This is documented in the patients' notes.

A risk assessment is completed prior to a patient going on leave. Upon the patient returning from leave one to one engagement is offered to the patient, if any incident has occurred whilst the patient has been on leave this is reported via Datix and the risk assessment is updated accordingly. The incident is also documented within the patients' notes and information is shared with all health professionals involved in the care of the patient during handover, Multidisciplinary Team meetings and ward reviews.

In order to strengthen safety measures in relation to this concern the wards now have in place that post each discharge meeting, discharge plans are shared with all health professionals and family/carers (with consent) involved in the care of the patient. A prompt is now written in the diary to remind staff to check the discharge plan that has been agreed for that patient including medication plans.

Concern 4) The Home First Treatment Team attended a scheduled appointment on 4 September and Ms Dehaney-Perkins appeared stable and updated the risk assessment that the risk of self-harm remained significant when alcohol was consumed. No action was taken following a call raising some queries and concerns from family that evening that Ms Dehaney-Perkins had left her home with her medication.

Response: The Home First Team will support patients and carers when they contact the team raising concerns around risk. The patient will be contacted by a member of the team who will explore the concern and manage it accordingly.

Where it is clear that there is an imminent risk to the person or to others, the Home First Team may consider requesting urgent police assistance to support with keeping the patient safe.

Where there is no imminent risk indicated, and the Home First Team are unable to make contact, the team will feed back to the carer to inform them that no contact has been made, however every effort has been made to contact the patient. Where this person is known to EPUT services the relevant team will be notified to provide follow up for the patient.

If the carer has identified risk that is deemed to require further assessment / intervention, the Home First Team may consider whether a home visit is warranted and “cold call” the individual. This would be also with the assistance of the Crisis 24 Team where appropriate. All staff have been reminded about ensuring that they work according to trust policy and this has been discussed in the business meetings. Assessments and clinical notes are reviewed with individuals during their one to one supervision to focus on the quality of their record keeping including risk assessments.

I hope that I have provided reassurances around the steps that we have taken to address the issues of concern contained within your report. We appreciate that there is an acute need to embed and effect change, hence we will monitor the above provisions to ensure these are contributing to our overall aim of keeping patents safe and delivering therapeutic care.

Please do let me know if you require any further information at this stage, including copies of any of the documents referred to above.

We will await your direction before sharing a copy of this reply with the family / the CQC as required.

Yours sincerely,

[redacted]
Chief Executive