Dudley Integrated Health and Care NHS Trust

Brierley Hill Health & Social Care Centre
Venture Way
Brierley Hill
DY5 1RU

Date: 11th April 2024

[redacted]

[redacted]

Mr Adam Hodson
Assistant Coroner for Birmingham and Solihull

Dear Mr Hodson

Re: Regulation 28 report, prevention of future death pertaining to Thomas Loxton, deceased

Firstly, on behalf of Dudley Integrated Health and Care NHS Trust, may I extend our most sincere condolences to the family of Thomas Loxton.

During the course of the inquest the evidence revealed matters giving rise to concerns in such a way that there is a risk that future deaths will occur unless action is taken. In response to your regulation 28 report to prevent future deaths we have outlined below the actions Dudley Integrated Health and Care NHS Trust has taken to address the matters of concern that affected our organisation.

1. *In the inquest, there was evidence that Thomas' family received letters from clinicians from Dudley Integrated Health and Care NHS Trust (DIH) requesting that Thomas made contact with them, which were sent after his death, causing obvious distress to his family. It is not difficult to see that this type of administrative error could lead to significant distress to families who are already vulnerable by virtue of their bereavement, and which could give rise to a risk of death. An RCA carried out by DIH identified that action was to be taken - namely that DIH should work with colleagues at Black Country Healthcare NHS Foundation Trust (BCH) to establish and embed the process for notifying of patient deaths. However, this does not appear to be an action that has been identified in BCH's RCA report, and I am concerned by the apparent lack of collaborative working to ensure this process is carried out.*

Building on the collaborative working arrangements we already have in place between DIH & BCH, with immediate effect, we have implemented a more enhanced process in both organisations to try to minimise any opportunities for delay and the impact this might have on families, as well as identified some broader actions to help develop further improvements:

- On being informed about the unexpected death of an adult patient known to any DIHC service, we are now routinely contacting BCH to enquire as to whether they were aware of the death and what involvement (if any) they had with the patient. We recognise that there will be instances where there has been no involvement from BCH but as typically individuals will likely to have been in contact with secondary care MH services, and the overall numbers will be relatively small, the benefit has been acknowledged as outweighing those few instances where it is unnecessary

- To further support this, BCH are now reviewing their notes in more detail to help identify any interaction with other organisations; where there is any doubt as to whether DIHC had been involved in the care then they are routinely contacting DIH to confirm.

- In addition, we recognise that a patient's GP will often be best placed to receive death notifications, reflective of their role as being at the heart of individual patient care. However, it is not always possible for each GP to be able to easily recognise all of the relevant organisations which would require being informed.
  Both DIH & BCH have therefore raised this issue with our local Black Country ICB to explore how we might be able to better manage this with our primary care colleagues.
  Within DIH, we have also engaged with our own GPs – we manage two GP practices in Dudley – to help identify any further opportunities for improvement.

- We have also identified that the full implementation of local medical examiner services also provides an excellent opportunity to improve the death notification process for all organisations and so are also exploring this with the relevant colleagues.

- We fully recognise how challenging it is for families when a loved one is lost and would never want to create any additional distress caused by making contact after a patient has died. We believe that, alongside the actions described above, the systems we already have in place to support families at such a difficult time should provide a robust safety net to these individuals, especially given their vulnerability at such a difficult time. As a provider of mental health services, we have the skills and expertise to provide the necessary professional support as required, as well as work with our colleagues at BCH where we identify that more intensive support might be necessary.

2. *Secondly, the evidence on behalf of DIH was that the above action to be taken remains outstanding and has a target completion date that arises after the conclusion of this inquest. I am concerned that if this target is pushed back and/or is not met, for whatever reason, there is a risk that future deaths will occur. Upon conclusion of the inquest, I am Functus Officio, with no power to request updates from the Trust to check and ensure that the targets have been met and changes have been made. Whilst I am grateful for the efforts of reassurance provided by representatives of the Trust at the inquest, I am reluctant to dismiss my concerns, particularly where actions remain outstanding, and I have opportunity to take action now to ensure that the risk of future deaths is reduced.*

The actions described above have already been implemented, and so hopefully help demonstrate the joint commitment from both ourselves and BCH to addressing the relevant actions.

In addition, we are both ensuring that these immediate changes are now being appropriately reflected in the relevant procedural documents within each organisation.

Finally, following a decision by our commissioners regarding the future delivery of the clinical model of care for Dudley, DIH is currently in the process of transferring all of its services to other provider organisations.

For our mental health services, this will result in a transfer over to BCH from 1st July 2024 which we see as a further opportunity to establish and improve robust systems and death notification processes as part of bringing our services together.

I hope this provides you with assurance that the Trust has taken the concerns raised in your regulation 28 response very seriously and will continue to take action to reduce the likelihood of a similar incident from reoccurring. We hope that the actions highlighted above will make a difference and we will review changes made at regular intervals to ensure that they are embedded whilst sharing the outcome and lessons learnt with all affected staff.

Yours sincerely

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Chief Executive