North Cumbria Integrated Care
NHS Foundation Trust

26 June 2024

PRIVATE AND CONFIDENTIAL
Mr Robert Cohen
HM Assistant Coroner for Cumbria
Fairfield
Station Road
Cockermouth
Cumbria
CA13 9PT

Dear Mr Cohen,

Re: North Cumbria Integrated Care's Regulation 28 Response and Action Plan Concerning the Inquest into the death of Karen Thomason

I write following the inquest that you resumed on 02 May 2024 into the death of Karen Thomason. You concluded that Ms Thomason sadly died on 01 November 2023 at her home address in Carlisle, Cumbria. The medical cause of death was confirmed as:

1a Acute Ethanol Toxicity
1b
1c

A conclusion was recorded as Alcohol Related death.

During the inquest the evidence revealed matters, giving rise to concern and you felt future deaths may arise if the Trust did not take action. Therefore, as is your statutory duty, you reported the matters of concern and issued a Regulation 28 to the Trust. As you are aware, the Trust was not requested to be in attendance at the inquest. I was saddened to learn of the circumstances surrounding Ms Thomason's death and on behalf of the Trust, I wish to extend my sincere condolences to her family and friends.

I am grateful to you for raising your concerns to me. It is imperative to the Trust that safety issues are identified and rectified to ensure our services are safe and effective.

The Trust has undertaken a thorough review of Ms Thomason's care and the concerns raised within the Regulation 28 Report. A number of actions have been identified which will be implemented to address the concerns.

Please accept this letter as the Trust's formal response to the Regulation 28 Report, which incorporates the identification and embedding of all learning relevant to Ms Thomason's case, whether identified by the Regulation 28 Report or not.

Concern 1

There were errors in the completion of the hospital's safeguarding questions. The clinician answered 'no' to the question 'Is there a safeguarding concern?'. The clinician's evidence was that, in fact, she did have a safeguarding concern and explored it with Ms Thomason, but that she completed the electronic form in error. I am concerned that the form is regarded as a 'tick box' exercise rather than a vital safeguarding tool.

Safeguarding routine enquiries within Symphony (the Emergency Department's (ED) electronic patient record system) is an opportunity for staff to explore and record if there are any safeguarding or mental health concerns, whether the patient feels unsafe, and if there are any caring responsibilities (whether they care for someone or if anyone cares for the patient). The response to all safeguarding routine enquiries within Symphony during Ms Thomason's attendance to ED on 31/10/2023 was 'No'.

An ED Advanced Clinical Practitioner (ACP) took a history from Ms Thomason, which did include a safeguarding discussion. A safeguarding alert was also applied on Symphony, albeit this is visually quite subtle within the system. Ms Thomason was deemed to have capacity and was able to respond to questions of concern around her social and vulnerable state. During this discussion, social circumstances were explored, and Ms Thomason demonstrated her awareness of her alcohol related problems. She stated she was intending to get back in touch with alcohol support services (Recovery Steps), which she was previously known to. When asked about some bruising, Ms Thomason explained that this was a result of multiple episodes of falling. When asked specifically if anyone cared for her at home, which is part of the safeguarding routine enquiry questions within Symphony, Ms Thomason responded "no", but that a Housing Officer was keeping a close eye on her. Considering all of this information, the treating team felt there were no new safeguarding concerns; she was well known to all relevant services and relevant support was already in place for Ms Thomason.

The ACP's safeguarding discussion with Ms Thomason was recorded within the clinical assessment on Symphony, within a mandatory field ('clinical narrative'). This demonstrates evidence of good assessment and record keeping and provides the rationale for the decision to select 'no' safeguarding concerns. Clinical narrative option within symphony is there as a tool/place to free text and record discussions with patients.

While there is always the possibility of clicking the wrong box in error, we found on this occasion the ACP had explored the social background thoroughly and clicked "no" safeguarding concerns.

To further explain and expand, clicking "yes" opens up an additional list of questions related to safeguarding for exploration and completion. These additional questions include further consideration of patient behaviour, their explanations of any injuries and whether the explanation and history provided gives cause for concern or is inconsistent with the presentation. Ms Thomason was considered to be sufficiently alert and orientated and with capacity and therefore these would have been unlikely to yield anything additional.

The clinician's statements coupled with the symphony record for this patient provides evidence that on this occasion the safeguarding of Ms Thomason was taken incredibly seriously. The ACP clinician has demonstrated that they had a full safety and welfare conversation with Ms Thomason. We do not believe the safeguarding box was checked in error on this occasion.

We do recognise however, that it is possible that our clinicians are limited by the question on our electronic ED system. The question is rigid in its current format and doesn't allow clinicians to distinguish between historic safeguarding concerns and new concerns for immediate action during an ED attendance.

RECOMMENDATION 1: ***change the symphony safeguarding question. Consider "are there any new safeguarding concerns?"*** **"Is there an existing safeguarding concern that is under control?" Is there something new today that needs action today to deal with something different or unusual today?**

Concern 2

There is evidence that Cumbria Housing staff had asked to be notified of the discharge of a vulnerable patient so that they could provide support to her but that they received no communications on several occasions. I am concerned that this may mean that other patients are discharged without appropriate support being alerted to their needs.

Unfortunately, the ED Team were not made aware at any stage during Ms Thomason's ED attendance, of any ask or requirement to notify the Housing Officer of Ms Thomason discharge or that the Housing Officer had any concerns, either by the Housing Officer themselves, the Ambulance Service, or Ms Thomason. This was not conveyed verbally nor was it documented in the Ambulance records that were shared with ED on Ms Thomason's arrival into the department.

Ambulance records show that Housing Officers had been keeping an eye on Ms Thomason and that the Housing Staff had called the ambulance. The records also show that the Housing Officer had completed an adult safeguarding referral. Paramedics recorded that Ms Thomason had capacity and they did not complete a vulnerable adult notification. There was no copy of any safeguarding referral or any document accompanying Ms Thomason alluding to any concerns or adult social care or housing officer contacts.

Ms Thomason in her discussion with the ACP clearly articulated that the housing officer had been supporting her and keeping an eye on her and this was therefore recorded within the ED Symphony record as a positive safeguarding element of support.

Ms Thomason was deemed sufficiently recovered to book her own taxi and make her own way home. Every patient who leaves the emergency department after the medical decision has been made for discharge will have a conversation with staff about how they're going to get home and with whom, however these are not mandated fields within the current Symphony system. We can however evidence this to a degree through our routine practise of arranging transport and taxis for multiple patients who struggle to arrange this for themselves on a daily basis.

We do recognise however that this case highlights how vulnerable adults such as Ms Thomason could be better supported and safeguarded in particular when leaving the department and even in the knowledge of them being known to support services. Notwithstanding that even if people have what we regard as risky behaviours or unsafe lifestyles they do have the capacity and choice (freedom of liberty) to do as they wish.

RECOMMENDATION 2: Update Symphony to include discharge discussions for all patients. Include an ask "is there anything we can do or anyone we can notify before you go home?" Explore the "discharge screen" options on symphony to include a vulnerable adult question set.

RECOMMENDATION 3: Re-launch our public messaging within the ED and promoting and encouraging patients to let us know if they feel vulnerable, feel unsafe, don't feel safe to leave.

Concern 3

The evidence I received places an emphasis on the fact that Ms Thomason had capacity and indicated that she felt safe. It is certainly correct that this meant that there could be no question of her being held in hospital. It is also correct that her view of her situation was of relevance. However, it does not mean that obvious vulnerability or safeguarding concerns could not be addressed. Regardless of what Ms Thomason said, her vulnerability was obvious. I am concerned that the concepts of 'having capacity' and 'not being vulnerable' are being elided.

We recorded that Ms Thomason told us she had support and that the Housing Officers were already checking on her. She was aware of her need to engage with alcohol services. We are not entirely sure that any further vulnerability measures could/should have been taken at that point that would have generated any further input. Staff could have considered notifying Adult Social Care out of hours.

We do recognise, however, that EDs are often placed in a vulnerable position due to lack of background information provided on attendance, and not having full insight into a patient's social and safeguarding status in order to safely manage the situation. With this in mind, and accepting an element of human factors, complexity, and subjectivity, we should continually aim to improve our understanding in this area for this patient group.

Currently our mandatory Safeguarding Adults Level 3 Training for all clinicians is completed every 3 years and stands at 80% completion across our Emergency Care Collaborative (88% for the organisation overall and 80.5% for our individual EDs). This needs to improve in order that all our staff have an understanding of vulnerability and how to recognise it and act accordingly. We also recognise that while this training is important, there needs to be some additional supplementary means of ensuring that staff are continually learning and using safeguarding best practise.

Safeguarding supervision for staff working with children is mandated within the Intercollegiate Document. Staff working with children are offered Safeguarding Children's supervision which is attended quarterly. Safeguarding adults supervision is not mandated but recommended as best practice. Safeguarding supervision sessions can help staff explore their own experiences as well as support colleagues to understand, change, and improve their approach collectively. The ED Team recognise that engaging with this approach for all ages of patients would ensure our staff regularly discuss this and debate patient vulnerability, options for managing them safely, improve professional understanding, provide peer to peer support through professional conversations, and potentially offer suggestions around improvements to systems and processes.

RECOMMENDATION 4: Improve knowledge, understanding and evaluation of practise for vulnerable adults within the Emergency Departments.

- Develop an offer for an ED safeguarding supervision for adult patients (professional conversation) programme reflecting that which is mandated for staff working with children. Themes could be set for the professional conversations by the incidents that are being shared, as well as local network strategic objectives. This can be supported by the Trust's Safeguarding Team to ensure that national and local best practice is shared, and support is offered for complex or challenging situations.

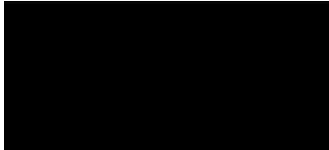
- Ensure that all relevant members of staff attend mandated Safeguarding Training at the appropriate level (reviewed in relevant governance meetings.)

- Trust Safeguarding Team to consider the development of future routine enquiry/domestic abuse training for the Trust (761 staff trained to date), and ensure attendance and learning for relevant staff. Consider how this can be best shared with ED clinicians.

Once again, thank you for bringing your concerns to my attention. I hope that the above provides assurance to you, Ms Thomason's family, and the public, that the Trust has taken them seriously and appropriate action is being taken.

I appreciate not all of the actions are yet implemented and I would be happy to provide updates on these in the future, should you require this. Please also let me know if you require clarity on any of the responses I have provided above.

Yours sincerely



Chief Executive
For and on behalf of North Cumbria Integrated Care NHS Foundation Trust