Herefordshire and Worcestershire
Health and Care
NHS Trust

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11 April 2024

Mr D D W Reid
HM Senior Coroner
Worcestershire Coroner's Court

Sent via email to: [redacted]

Dear Mr Reid,

Re: The Late Rosie Young
Regulation 28 report to prevent future deaths - response

Thank you for sending your Regulation 28 report. I appreciate that issues arose in this Inquest, which led to your concerns that appropriate learning had not taken place. In your report, you highlighted the following points of concern, and I will respond to these individually:-

1. **Over the course of the inquest, it was quite apparent that few, if any, of the witnesses who gave evidence, including several employees of your Trust, were familiar with the version of the Mental Health Act Transportation Policy which was in force at the time of these events. This policy governed the assessment of risk involved in transporting a patient detained under the Mental Health Act 1983 to a psychiatric unit and stipulated the measures to be deployed to mitigate that risk.**

2. **The witness who presented your Trust's internal investigation report into events surrounding Rosie's death told the inquest that your Trust had not actually obtained, or even requested the applicable version of the policy (v.5) until April 2022 – 14 months after the previous version had expired – and that Trust staff at the s.136 suite in Worcester were still not aware of it by October 2023 – 30 months after the previous version had expired. That same witness told the inquest "I cannot tell you that a system is now in place to ensure that the Trust's staff have read, understood and signed a document to confirm that they are aware of every policy that applies to their role – despite the fact that the Trust's own internal review which highlighted this deficiency was months ago"**

The Trust fully recognises that the process for clinical policy management requires improvement. This observation has also been made during our recent CQC inspection and forms part of our improvement plan to address these concerns. As an immediate action we are undertaking current state analysis over the next three months to establish a tracker for clinical policies that outlines:

- Policies that are in date and have expired, or are approaching expiry,
- Policy owners and authors and the appropriateness of the allocation,
- Analysis of the completion of equality impact assessment,
- Which services and teams each policy is applicable to so that services and teams are fully sighted on which policies are applicable to their service.

Once current state analysis is established, we will formulate more detailed remedial actions for any gaps identified. We are already aware of a need to review the governance process for policy management, including provision of education and support for those involved in writing and reviewing policies. We are also aware of a need to clarify process and expectations in relation to equality impact analysis for each policy.

Part of the enhanced process will include management of policies written by system partners that are applicable to services within our organisation.

I can confirm that following the adoption of the West Midlands Ambulance (WMAS) Transportation policy on 1 February 2024 that this has been disseminated through clinical teams who may need to use the policy. The policy has also been updated on our intranet. However, due to issues unrelated to this matter, the Trust now contract with an independent provider (E-Med) to convey patients who are liable to be detained under the MHA and so whilst we have the WMAS transportation policy in place, it may be used less frequently on a practical basis.

For further assurance in relation to this specific case, following discussion at the monthly Urgent Care Interface Meeting (attended by all Clinical Leads and Service Managers), it has been agreed to broadly standardise the local induction process while accepting that there are a number of policies/procedures that will be specific to certain teams. As a consequence of these discussions, all services in Urgent Care will now employ the following guiding principles in addition to the standard corporate induction process;

- Local Induction (new starter): paperwork must include a list of policies and procedures that are service specific and/or necessary for staff to perform their role effectively. On completion of the induction, new staff should sign/date a form confirming that they have read and understood these documents (a copy of this form should be retained in their personal file). Given the remit of services, it is inevitable that any list may not be exhaustive – it will therefore remain the responsibility of individual staff to find relevant information (where necessary) or seek further advice/support from their immediate line manager.

- New and updated policies/ procedures: each service will create an electronic spreadsheet (on Excel) containing the names of all clinical staff – the team Administrator will then be responsible for local upkeep of the spreadsheet, listing the name/date of any new or updated policies or procedures and how this information has been communicated to individual staff members i.e. read-receipt email, business meeting, supervision.

I hope that you will feel assured that this will ensure staff are sighted on policies relevant to their roles.

3. **Your Trust's own internal investigation into the events surrounding Rosie's death was itself flawed, in that it had failed even to identify, let alone investigate, important issues with the care which Trust employees had provided to Rosie around the time of her death. Natalie Willetts, the Trust's Head of Quality and Nursing, said in her evidence to the inquest that although the report disclosed to the Coroner purported to be a root cause analysis (RCA) investigation report, it was nothing of the sort, not least because RCA techniques were not used in the investigation. Ms Willetts told the inquest:**

    a. **Neither of the two co-authors of the Trust's report (Della Jay – then Head of Safety, and Alison Schanz – another member of the Patient Safety Team) were actually named on the report, or identified to the Coroner's Office as co-authors of the report;**
    b. **One of the co-authors of the Trust's report (Della Jay) had signed the report off at the Serious Incident forum, something which was inappropriate and should not have happened;**
    c. **When the witnesses who ended up presenting the Trust's report at inquest escalated concerns in March 2023 about the report's inadequacies, and suggested that the Trust needed to conduct a more comprehensive investigation before the inquest, the decision was taken that this was unnecessary, and that learning could be identified from gaps in the report which the witness was now identifying. That decision was taken by Alison Scands, something that was inappropriate for her to do, given that she was one of the report's co-authors.**

    My concern is that, unless proper structures and procedures are put in place at the Trust, future investigations like this may continue to be flawed, and may fail (as this one did) to identify the sorts of issues which should be identifying. If the issues are not identified, the Trust is unlikely to identify learning from these issues, or to take action to prevent them in future. That, it seems to me, will mean that circumstances creating a risk of other deaths will occur of continue to exist in the future.

In relation to management of Serious Incident investigations the Organisation fully accepts that in this case our approach was flawed and insufficient. This appears to be due to internal miscommunication which led to confusion in approach. As an immediate action to rectify this, we have commissioned a Patient Safety Incident Investigation (PSII, the methodology under the new Patient Safety Incident Response Framework replacing Root Cause Analysis). The investigator has met with Rosie's parents as an integral part of the investigation, as have our Director of Nursing and Quality and Medical Director. Our investigation is almost complete and we are currently working on appropriate improvement actions prior to taking the report through our governance sign off process. The investigator will keep Rosie's parents updated as the investigation progresses. We would also be willing to share a copy of the report with your office should this be of assurance to you.

As you may already be aware we are transitioning across from the Serious Incident framework to the Patient Safety Incident Response Framework (PSIRF) and we will cease reporting of Serious Incidents on the old framework from 8th April 2024. We anticipate embedding the transition over the next twelve months which includes finalising a policy and an organisational

incident response plan. One key difference of PSIRF being that incidents that involve multiple system partners will be coordinated by the Patient Safety Team at the Integrated Care Board (ICB) in order to ensure a joined up and cohesive approach to system learning.

To ensure incidents are appropriately investigated we have instigated a new set of processes. A daily incident triage involving patient safety experts has commenced which ensures that all incidents are reviewed and allocated to the appropriate level of investigation. Where further clarity or a multi-disciplinary decision is required, this is escalated to the twice weekly safety huddle which is attended by the Medical and Nursing Directors. A tracker has been developed to enable the patient safety team to maintain oversight of all open investigations and ensure they are completed in the relevant timescales. Incidents of the highest severity or with learning are presented at the Serious Incident Forum, chaired by the Director of Nursing and all learning is then monitored through our quality governance processes.

We have some work to do to ensure that cases subject to inquest that are not being investigated under PSIRF, and therefore will not have an investigation report, have a sound methodology to outline service delivery to support the progress of the inquest. We hope to engage with you alongside our system partners, to find a solution that meets the needs of the Coronial process. We have also recognised that we can do more to join up working between our legal and patient safety teams and with this in mind have established a series of collaboration touch points to enhance the working relationship.

Further to this, we plan to hold a debrief session with all staff involved in this inquest to offer wellbeing support and identify further learning on our approach to the coronial process.

I hope that this reassures you that the Trust recognises short comings in relation to this tragic case and is taking steps to learn and improve as a result and hope that this adequality addresses your concerns.

I would be grateful if you would kindly send a copy of my response to those whom you copied your regulation 28 report. I have no submissions to make about publication of the response.

Yours sincerely

Chief Executive