Ms Leila Benyounes
Assistant Coroner for Gateshead and South Tyneside
Coroner Office
Town Hall and Civic Offices
Westoe Road
South Shields
Tyne and Wear
NE33 2RL

[redacted]

Dear Maam

Inquest touching the death of Christopher Vickers

We write to formally respond to your Prevention of Future Deaths (PFD) Report, dated 29 February 2024, following the sad death of Mr Vickers. We note that the Regulation 28 Report is directed to both Cumbria, Northumberland Tyne and Wear NHS Foundation Trust (Trust) and South Tyneside Council. This response is provided on behalf of the Trust.

We note that your concerns in this matter relate to multiple missed opportunities to not follow clear processes and policies in relation to safeguarding referrals and the convention of a multi-disciplinary/multi agency meeting.

As a Trust we have given Mr Vickers' death and the learning associated with it significant consideration, and have implemented a number of changes to ensure that, where appropriate, relevant safeguarding referrals and multi-agency meetings are convened. We have made changes to our practices, multi agency working and monitoring, details of which are described below.

As explained at the inquest, since Mr Vickers' death, there has been a lot of work within the Trust to improve awareness and skills, through bespoke training, email communication and team meetings. This has emphasised the importance of when referrals to safeguarding should be made, and what process should be followed.

Process and Systems Change

Within the Crisis and ADHD team, MDT (Multi-Disciplinary Team) processes have changed, and safeguarding and consideration of a multi-agency meeting is now a standing agenda item. It serves to act as a reminder to clinicians to review and ensure all areas of identified risk have been addressed, and responded to where appropriate.

Similarly in the Community Treatment Team (CTT), Safeguarding and multi-agency meetings are also now a standard item on the agenda for the meetings. MDT meetings take place after each assessment, replacing previous practice which could be a conversation between the people carrying out the assessment (as was the case with Mr Vickers).

In addition, staff also have the opportunity to refer to a complex case panel with a practice guidance note to assist with that process.

Within Crisis services a new process of a weekly telephone triage review has been implemented. This looks at calls to the Crisis Team, which have not required a face-to-face assessment, as was sometimes the case in the past and in relation to Mr Vickers.

This new process looks at 5 records where there have been multiple triage contacts within the last 5 months, in addition to 5 random telephone triages. As part of this review, the quality and safety of the contact is considered and this includes checking to see if any safeguarding issues have been actioned and if appropriate, and whether a multi-agency meeting should have been convened.

Safeguarding issues are reported through an incident reporting system, which is reviewed by a dedicated Safeguarding Practitioner who will offer any relevant safeguarding advice to the reporting service and its manager. This advice will, where appropriate, advise on local authority referral and multiagency communication, with any recommended actions monitored by managers. A template has now been implemented for the Safeguarding Practitioner to assist with ensuring that the advice is provided in a consistent way.

In Mr Vickers' case, the concerns highlighted around referrals to safeguarding related to issues of domestic abuse to others. Since Mr Vickers' death the Trust's Multi-Agency Risk Assessment Conference (MARAC) policy (now the domestic abuse policy) has been updated and circulated to staff via the Trustwide policy bulletin. As part of this policy, there is guidance for staff around identifying if someone is at risk of abuse and when a referral for a MARAC should be requested (which is a police coordinated multi agency meeting including health representatives, police and children and adult social care). However, following the inquest, a decision was made to review the domestic violence policy, and this is due to be completed by July 2024, to ensure that the Trust incorporates all the learning from this inquest, and other incidents, and provides clarity on staff roles and responsibilities in relation to safeguarding referrals.

Monitoring Arrangements

Within all teams, clinician supervision takes place every 4 weeks, which includes a random sample of cases being checked, and safeguarding and the need for convening a multi-agency meeting is now embedded as part of this review process.

With regard to the Crisis Teams, along with the telephone triage review, a monthly audit of 20 random triage calls also takes place, to ensure all actions have been identified and implemented.

A compliance audit against the domestic abuse policy will look to ensure that MARAC referrals are being actioned in line with Safeguarding advice.

Family and Carers

In addition to the above, a significant amount of work has been carried out to improve engagement with families and carers, which in turn will improve the identification of any concerns of domestic abuse so that relevant actions can be taken in response. This is incorporated into our new risk assessment framework which went live on 7th April 2024 and in the Triangle of Care Improvement area which is a quality priority for the Trust.

We hope that the actions elaborated above addresses your concerns, but please contact us if you have any questions or comments to ensure that we as a Trust learn from this sad event and make our care safer for those who require it.

Your sincerely

Medical Director / Deputy Chief Executive