NHS
County Durham
and Darlington
NHS Foundation Trust

Executive Corridor
Darlington Memorial Hospital
Hollyhurst Road
Darlington,
DL3 6HX
E-mail: [redacted]

Our Ref: [redacted]

29th July 2024

Ms. Janine Richards,
Assistant HM Coroner,
County Durham

Dear Ms Richards,

Re: Andrew Naylor

We are writing in response to your request for the Trust to take action in relation to concerns as detailed below:

(1) There is no specific protocol or policy in place to ensure that patients are warned of the acute risk of respiratory depression and death following administration of the drug [redacted], should they drink alcohol or misuse drugs.

(2) There appears to be a lack of a joined up process between acute clinicians, alcohol and drug treatment teams, and mental health teams, to consider the safety of a discharge, and to ensure that crucial information relevant to risk is shared appropriately (which may also be, to an extent, hampered by a continuing inability to see each other's records), and whether discharge should be delayed or care stepped down, until a place of safety is identified, and to ensure that a robust safety plan is in place upon discharge.

(3) There was no consideration given by either the acute or mental health teams to contacting the deceased's family or friends, which may have provided an essential safety net in the absence of accessible professional support. The TEWV Trust are candid that work in relation to this issue is a work in progress and remains incomplete.

You felt that although both Trusts indicated that they are in the process of addressing the concerns raised in this Inquest, but considered that at the time of the conclusion of this Inquest that there remained a risk that future deaths could arise.

The Trust would like to offer its sincere condolences to Andrews's family for their loss. We take very seriously the concerns which you have raised and have provided a response below.

There is no specific protocol or policy in place to ensure that patients are warned of the acute risk of respiratory depression and death following administration of the drug [redacted], should they drink alcohol or misuse drugs.

The Trust has a Management of Acute Alcohol Withdrawal Policy which has been extended until September 2024 to enable the Organisation to explore the most appropriate, and safest, way to include the suggestion raised by yourself. This will require careful stakeholder

engagement to establish the safest advice to give the patient. Initial advice from a community drug and alcohol service provider is that a blanket statement to the patient advising not to drink or take drugs for 24 hours in the event someone leaves early in a detoxification treatment could actually cause more harm. This could be viewed negatively by patients undergoing detoxification, reduce confidence in their care team and ultimately be counter-productive to a good outcome. The importance of establishing a constructive therapeutic, reciprocal relationship and conveying key messages in this context cannot be overstated.

This policy is being reviewed and the Trust intend to have the updated policy, incorporating patient advice after seeking further advice, approved by September 2024.

There appears to be a lack of a joined up process between acute clinicians, alcohol and drug treatment teams, and mental health teams, to consider the safety of a discharge, and to ensure that crucial information relevant to risk is shared appropriately (which may also be, to an extent, hampered by a continuing inability to see each other's records), and whether discharge should be delayed or care stepped down, until a place of safety is identified, and to ensure that a robust safety plan is in place upon discharge.

Mr Naylor was reviewed by liaison psychiatry on the ward prior to discharge and it was documented by the team as being under the care of the community mental health team, who liaison psychiatry would request follow up by, and that he was safe for discharge. In relation to post discharge care, the Management of Acute Alcohol Withdrawal Policy details the follow up that should occur for the patients such as Mr Naylor, including referral on to specialist drug and alcohol teams and services and there was a plan for him to be followed up by the alcohol liaison service post discharge. In relation to his residential status, this was consistently documented as being in a named hostel during his admission.

There was no consideration given by either the acute or mental health teams to contacting the deceased's family or friends, which may have provided an essential safety net in the absence of accessible professional support. The TEWV Trust are candid that work in relation to this issue is a work in progress and remains incomplete.

Whilst the Trust had next of kin contact details it is acknowledged that there is no evidence within Mr Naylors records that any attempt was made to contact them. As he had capacity our staff would not automatically have contacted them, however the importance of informing next of kin in scenarios such as Andrews has been reinforced to the clinical teams at huddles.

Conclusion
We trust that the responses detailed in this letter are sufficient to address the concerns you have highlighted. However, please feel free to contact us if you need any additional information or have further queries.

Yours sincerely

[redacted]
[redacted]
Executive Director of Nursing

[redacted]
[redacted]
Executive Medical Director

cc. [redacted], CEO
[redacted], Associate Director of Nursing, Patient Safety and CNIO