NHS
Cumbria, Northumberland,
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NHS Foundation Trust

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11th October 2024

Mr Andrew Hetherington
HM Senior Coroner for Northumberland
County Hall
Morpeth
Northumberland
NE61 2EF

Dear Sir

Inquest touching the death of Elise Walsh

We write to formally respond to your Prevention of Future Deaths (PFD) Report, dated 22 August 2024, following the sad death of Miss Elise Walsh.

At the outset we would like to again apologise to you and Elise's family that the existence of the note which Elise wrote prior to her death was not disclosed to your office sooner and did not form part of the Serious Incident Investigation. The note was discussed as part of the After Action Review, which should have then translated into the Serious Incident Report. Unfortunately the Investigating Officer involved in this matter has left the Trust and we have been unable to ascertain why this was not included in the Serious Incident Report.

The Trust now carry out internal investigations in accordance with PSIRF (Patient Safety Incident Response Framework). In line with PSIRF CNTW's review templates have been redesigned to ensure that identified issues / key lines of enquiry are carried forward and are not lost when a review progresses to a full Patient Safety Incident Investigation. Following on from the Inquest the Head of Clinical Risk and Investigations has spoken with the Trusts dedicated Investigating Officers to remind them that whenever an issue is raised as part of discussion during an incident review process it is then explored further and addressed in the completed report.

In relation to your concerns around the Trust's complaints process, I can confirm that the Trust have a robust system in place. The Trust has a central complaints team based at St Nicholas Hospital in Gosforth. All complaints are sent here to be logged on a database and triaged centrally. These are opened by trained staff and triaged by senior staff in the Safer Care Directorate. Whilst staff who open the complaints are not clinical, they are trained to review and immediately escalate any concerns to clinicians. Equally at the point of triage, staff are able to escalate any concerns to relevant teams, such as the Crisis Team or Community Treatment Team. Ordinarily complaints received by post are opened and scanned / logged on the system the same day and triaged within 48 hours. Following the Inquest the Trust have added a note to the complaints form that reads, ***Please be aware your complaint/concern will not be reviewed until it reaches the centralised complaints department. If you need to speak to someone more urgently then please inform a member of staff or call our crisis team on either 111 (selecting option 2) or 0191 814 8899.*** This change has been communicated to all Trust staff via a CAS (safety) alert.

As you heard at the Inquest, owing to confidentiality issues it is unfortunately not possible to implement a process across the Trust, whereby any complaint forms which are handed to receptionists are opened and immediately triaged. Following the inquest this matter has been discussed at the Trust Wide Patient Safety Learning and Improvement Panel (PSLIP) and unfortunately it has not been possible to identify a different system which would allow for such urgent reviews, however the PSLIP panel did request the above addition to the complaints form. As

explained at the Inquest, the Trust have however, implemented a system whereby if reception staff have concerns about a patient, they can call for support and a clinician will attend to support the reception staff until such concerns are resolved. If during this period of support the patient writes things down, then clinicians can make a decision as to whether or not it is appropriate to review what they have written, enabling them to act upon the contents if indicated.

We hope that the above addressed your concerns.

Yours faithfully

[redacted]
Medical Director / Deputy Chief Executive