Surrey and Borders Partnership NHS
NHS Foundation Trust

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Private & Confidential
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HM Coroner's Court
Station Approach
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Friday, 19 September 2014

Dear Mr Travers,

Inquest into the death of Francis Andrade – REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Further to the conclusion of the inquest into Mrs Andrade's death on 25th July 2014, you wrote to Surrey and Borders Partnership NHS Foundation Trust in accordance with Regulation 28 report to prevent future deaths, stating that during the course of the inquest the evidence revealed matters giving rise to concern. We would like to take this opportunity to continue to offer our sincere condolences to the Andrade family for their loss.

The area of concern you raised that relates to our Trust and our response are detailed below:

Where there is a history of overdoses being taken by family member A using medication that is prescribed to family member B, consideration should be given to what steps could reasonably be taken to secure that medication with a view to restricting access to it by family member A.

Due to the limited influence we have on how members of the public store or manage their medication it will, unfortunately, be unrealistic for us to say we can fully mitigate against this risk going forward. We have however taken steps to ensure that our staff interactions with family carers and people using services recognise this risk and highlight it as an area to be considered by all parties involved.

Further to our own internal investigation we have since recommended that staff should ensure that when specific risks are identified in a person [e.g. a person is assessed to be hoarding medication and using other person's prescribed medication to overdose], this must be followed by comprehensive risk management care plan/s in collaboration with the person/s and shared with the Team directly involved in the person's care. We believe that a process managed through effective care planning arrangements with clear engagement with the person using our service and the carer, would be the most effective process that may go some way to mitigate this risk.

We monitor compliance with care planning through our Board Key Performance Indicators to ensure that the process of care planning remains embedded. Our Home Treatment Team has developed a local protocol to ensure safety of medication management and further to the investigation they are expected to establish a safety plan with the person and family for the safe storage of medication if a history of overdosing on family's medication has been revealed.

Further to the outcome of the inquest, we will be holding a workshop as part of our Suicide Prevention Action Group process to share the learning to a wider group of clinical staff to ensure embedding of the learning.

Our Board has been made aware of your letter and we would like to once again offer our sincere condolences to the Andrade family for their loss and hope that the steps we have taken as outlined above assures you and them, that we have learnt and continue to learn from Mrs Andrade's death. Please do not hesitate to contact me or [redacted] Director of Quality (DoN) if you require any further information.

Yours sincerely

[redacted]

Fiona Edwards
Chief Executive

Cc

[redacted] – Director of Quality (DoN)
[redacted] - Medical Director
[redacted] - Director of Risk & Safety (DDoN)
[redacted] – Director of Mental Health