Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Maria Voisin
Senior Coroner
The Coroner's Court
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Chief Executive's Office
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18 September 2015

Dear Ms Voisin

Simon Peter Reynolds deceased

I am writing to respond to the concerns you raised in your Regulation 28: Report to Prevent Future Deaths relating to Mr Reynolds.

Documented Risk Assessment
It is our policy and standard to have a risk assessment completed at the time of admission. In Mr Reynolds's case, a risk assessment had taken place with risk indicators linked from the progress notes to the risk assessment, however, this was not in a clear form. The admission paperwork for the 136 suite has been revised to incorporate the risk headings recommended by the Royal College of Psychiatrists. The adoption of this new paperwork ensures risks are clearly identified for detainees and its success will be evaluated in 3 months.

Record on Rio
The nurse-in-charge should have made an entry on the RIO record. Staff are encouraged to make their written record in as close a proximity to any assessment or event taking place as possible. Since the inquest, we have examined the audit trail of entries on RIO and determined that the entry was made on RIO at 00.11 hours, which was not long after staff had finished dealing with the incident and participating in the debrief. The day-time nurse in charge did not go off duty until 23.00 hours (one and a half hours beyond the end of her shift) in order to handover all necessary information and support staff.

The nurse in charge at the time Mr Reynolds was accepted onto the unit did not make any entries on RIO, but gave handover to the nurse in charge at night who updated the RIO record accordingly. Priority had to be given the traumatic incident when it occurred and in those most difficult of circumstances, the timeliness of documenting on RIO was unfortunately compromised.

Observation Levels
Standards and guidance are in place to govern the settings of observation levels. The Trust provides a range of training programmes for staff to support them in risk assessment and observation. I am pleased to confirm that staff on Mason Unit were up to date with their training. Additionally registered staff are supported in their roles through the provision of a Clinical Toolkit. The Toolkit includes specific modules on undertaking mental state examinations and risk assessment. Additionally, I am taking the following actions to improve patient safety:

- Reviewing our Observation Policy to take account of revised guidance from the National Institute for Health and Care Excellence - "NICE NG10 Violence and aggression: short-term management in mental health, health and community settings". This Guidance includes definitions on the levels of observations which need to be reflected in our policy and practice.

- Reviewing staffing levels on the Place of Safety suite as part of the wider national Safer Staffing initiative, to ensure optimal staffing levels at all times, which will in turn support timely observations and recording of information.

- Continue the implementation of the 'Safewards' interventions already underway. Research has demonstrated that incidents of harm to self and others can be reduced through the implementation of the 'Safewards' Interventions as observation alone is insufficient and can increase risks.

If you require any further information regarding any of these initiatives, then please do not hesitate to let me know.

Yours sincerely

Thyley Richards

Iain Tulley
Chief Executive

Medical Director