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NHS Foundation Trust

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23rd September 2016

Mr Andrew J Cox
Assistant Coroner for Cornwall and the Isles of Scilly

By Email only

cornwallcoroner@cornwall.gov.uk

Dear Mr Cox

Regulation 28 Report to Prevent Future Deaths

I refer to your Regulation 28 Report following the inquest of Danny Sweet. As an organisation our vision is "Delivering high quality care" and therefore we welcome the opportunity to reflect not only your concerns but also the evidence given by [redacted] during the course of the inquest. We have given careful consideration to your report and our response. We view this as a positive opportunity for the Trust to ensure there is learning.

We have tried to respond to each matter of concern as outlined in your report and detail the action to be taken.

- *Is it appropriate to reflect on how to deal with patients who present in an inconsistent manner? Is it appropriate to presume the best case scenario?*

We agree that it is appropriate to reflect on how to deal with patients who present in an inconsistent manner. It is not appropriate to presume the best case scenario and clinical staff are trained to use structured risk assessments. However we propose to launch a review into the clinical risk assessment of people who present with suicidal thoughts or acts across each of our services and in particular the Trust's use of the STORM

risk assessment as wider learning across the Trust. We hope to have completed the review by the end of February 2017.

- *Is it appropriate for a check to be built into the assessment process to ensure consistency in treatment decisions*

It is impossible to ensure consistency in treatment decisions because assessments are "of the moment" and there has to be flexibility for clinicians as situations can change. However, the Trust does recognise that there does need to be a clearly defined pathway decided at the initial presentation. The action that will be taken is that there will be a Learning from Experience meeting. We will ensure that clinical staff, across all services involved in the care of Mr Sweet, participate in the meeting. The meeting will be overseen by [redacted] Inpatient Clinical Director and Consultant in Rehabilitation Psychiatry. One of the purposes of the meeting will be to consider developing the pathway.

- *How the Trust deals with patients who appear to have capacity and yet decline treatment/care where family/friends state their condition is deteriorating.*

The Mental Health Act provides the legal framework to deal with patients who have capacity yet decline treatment. In light of your report and Mrs Sweet's witness statement the Trust acknowledges the need for staff to engage with family and friends in receiving information from them as well as building on the work undertaken by the Trust around the "triangle of care." The aim would be to ensure that not only are family and friends supported but also informed about services and mental health and involved in the care provided. We recognise the importance of staff engaging with friends and family in their assessments and on-going care. It will be a further purpose of the Learning from Experience Meeting to consider ways of doing this.

- *Should clinicians record in the records their concerns that patients have capacity and yet may go on to self-harm? It may be worth reviewing if clinicians should share those concerns with family/friends who try and bring to attention the patient's deteriorating condition.*
- *Should there be training to ensure that the entries in the notes and records are consistent.*

The Trust does provide training to staff in relation to record keeping and the importance of recording the rationale for decisions. We are already enhancing the record keeping of staff by implementing the "SBAR" (Situation, Background, Assessment, Recommendation) tool as standard in record keeping. This has been introduced to staff on our psychiatric inpatient wards and we will continue to filter this through across all services. We are therefore making efforts and taking action to introduce a more structured format to our records. This action is on-going.

- *The Trust's Serious Incident report is incomplete.*

The Trust acknowledges that the Serious Incident Report is incomplete. There are learning points for the Trust in relation to Serious Incident Investigations and the Trust's Director of Quality and Governance/Executive Nurse, [redacted] will take this forward. We will ensure that in the future all key clinicians, within the Terms of Reference, are involved in future investigations. We have also identified the importance of providing feedback to staff interviewed for the purposes of the investigation.

In summary there will be action taken by the Trust by way of a Learning from Experience Meeting to consider ways of developing a pathway; how to engage friends and family and to allow a further period of reflection. It is expected that an action plan will be developed at the Learning from Experience meeting. There will also be a review of the clinical risk assessments of people who present with suicidal thoughts or acts by the end of February 2017 and we will review the Trust's Serious Investigation process.

The Trust is truly saddened by the death of Mr Sweet and wish to extend our condolences to his family.

Yours sincerely

Phil Confue
Chief Executive