Devon Partnership NHS
NHS Trust

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Ms L Brown
HM Assistant Coroner
Exeter and Greater Devon Coroner's Office
Room 226
Devon County Hall
Exeter
EX2 4QD

Your Ref: LCB/SJ File No: 432 2017

Our Ref: STEIS 2017/4729 RMS 26205

28 April 2018

Dear Ms Brown

Re: David John Ireland (deceased) – DOD 13/02/17 - Inquest 6 February 2018
Regulation 28 Report to Prevent Future Deaths

Thank you for your letter of 27 February 2018 which we received on the 5 March 2018 following the inquest into the death of David Ireland. As an organisation we are committed to learning from these tragic events and have since receiving your report and recommendations taken the opportunity to share your findings with the service involved as well as across the wider trust.

The Trust has undertaken a Root Cause Analysis Investigation following the death of David; the report was shared at the inquest.

Your report contained the following matter of concern -

(1) No advice was provided that Mr Ireland could attend the emergency department should concerns about his mental health continue

Following review of your report and consideration of your recommendations I am can confirm that as described at the inquest it would be our expectation that any contact made with the crisis team should include describing the options available to service users, families and carers should concerns continue. These options depending on the severity of the concerns would include further contact with the crisis team (out of hours this would be dealt with by the single point of access team), contacting their general practitioner (or out of hours service) or attendance at an emergency department where there would be access to one of our Liaison Psychiatry Teams.

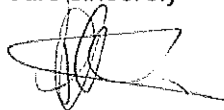
We will be including specific reference to this concern in our next Trust wide 'Safety Briefing' which is made available to all staff, we have also asked for this concern to be raised with the relevant teams through their local learning from experience groups and equivalent forums. We would be happy to provide a copy of the Safety Briefing when it is available.

We will be including the need to give this advice in our local induction for temporary workers (agency staff) within these teams.

We have asked the relevant teams to review any answer machine messages they use and include appropriate reference to all sources of further support.

I hope that the actions described demonstrate our commitment to the learning we have undertaken and that the Trust is committed to this continued positive work within our services. If you require any further information please do not hesitate to contact me.

Yours sincerely



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