14 February 2020

Rachel Galloway
HM Assistant Coroner
Manchester West
HM Coroner's Court
Bolton
BL1 1QY

Dear Ms. Galloway

Re: Response to Regulation 28: Report to Prevent Future Deaths, in relation to the inquest of Mr. David Richard Fowler Deceased.

I am writing to provide a formal response to the Regulation 28 for the prevention of future deaths issued to the TRU (Transitional Rehabilitation Unit) LTD following the inquest of Mr. David Fowler. I confirm the following action has been taken in response to the regulation issued:

There has been a comprehensive review of the policies and procedures underpinning critical decision making in care planning including individuals requiring treatment under the Mental Health Act and those being discharged from the Act. This has included a revision of procedures regarding multidisciplinary team communications, mental capacity assessments, care coordination and care planning, communication with family and statutory services and aftercare and discharge planning processes. A revised policy responding to all of the points raised in the Regulation 28 has been completed and introduced with further training to management teams in relation to this. This policy introduced various checklists and tools to be used in practice in accordance with this policy and ensures all relevant processes are followed at each stage of the care planning process.

I have attached this revised policy for the organisation involving all TRU services, MH28 Care Planning and Care Coordination policy, as this outlines and clarifies several procedures that are operational in relation to:

1. Communication with family members and statutory professionals.
2. Decision making protocol including a new decision making checklist as seen in appendix 6.0 of the policy, which outlines clear protocol relating to assessment of mental capacity.
3. A revised care planning review form that is utilised for every meeting reviewing a client's care as outlined in appendix 5.0 and formalises feedback on an ongoing basis from family during weekly, six weekly and formal

conference meetings.

4. Clarification of roles and responsibilities across team members in relation to care coordination and communication to family members including the Nearest Relative for individuals detained under the Mental Health Act and the next of kin for all individuals.
5. A clear transition planning process to ensure continuity of communication with families and continuity of care planning if an individual transitions from one service to another within TRU.
6. A clear discharge planning process as outlined in the care planning framework summary of appendix 1.0 and within the body of the policy. This includes the aftercare planning procedures undertaken in advance of any individual discharging from a legal framework, including the Mental Health Act, and/or any broader discharge from the service.

I have also attached two revised policies specific to care planning policies for adults detained under the Mental Health Act most relevant to this regulation. These are the MH12 Section 117 planning policy and the MH10 Communicating to family and external parties' policy for people under the Mental Health Act. These two policies outline specifically:

1. The clear and non-negotiable procedure and structure of a 117 planning meeting clearly involving family and statutory professionals.
2. Clarification over specific contact between the treating team and the Nearest Relative in relation to ensuring family members know when care planning reviews are taking place, ensuring their wishes and views are well represented if the family member does not wish or is unable to attend and to ensure clear and timely feedback from any meeting and certainly in respect to any planned discharges from the Mental Health Act.

These two policies specific to individuals detained under the Mental Health Act are supplemented by the broader MH28 policy as outlined above in supporting robust care planning and coordination.

I confirm there have been regular reviews of these procedures since the inquest and an audit framework has been devised to monitor continued compliance and service delivery in these areas including direct audit of the stages outlined in appendix 1.0 (care planning framework).

I also confirm the Responsible Clinician involved in this case has made a referral to the General Medical Council and the individual has undertaken further action related to professional development, supervision and training.

I believe the revisions above directly address, and resolve, the concerns raised through the Regulation 28.

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I hope the attached information is informative and outlines these improvements although please let me know if you require further information.

Yours sincerely

Head of Clinical Services

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