NHS
Devon Partnership
NHS Trust

Trust Headquarters
Wonford House Hospital
Dryden Road
Exeter
EX2 5AF

Telephone: [redacted]

Web: www.devonpartnership.nhs.uk

Mr Ian Arrow
Senior Coroner for Plymouth, Torbay and South Devon
Plymouth Register Office
1 Derriford Business Park
Plymouth
PL6 5QZ

Your Ref: [redacted]

Our Ref: [redacted]

14 December 2020

Dear Mr Arrow

Re: Benjamin Popavach (deceased) - Inquest 9 October 2020
Regulation 28 Report to Prevent Future Deaths

Thank you for your letter of 23 October 2020 following the inquest into the death of Benjamin Popavach. 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 Serious Incident Investigation following the death of Benjamin; the report was shared at the inquest and I can confirm that the action plan developed in response to the RCA investigation has been progressed.

Your report requested the Trust confirm that the actions identified in the Serious Incident Investigation have been progressed.

Following review of your report and consideration of your recommendations we have reviewed our action plan. The areas of learning identified in the report are detailed below with the actions that were proposed to address these.

Outcome of Review	
Issue	**Description**
Areas for Learning	Ben's history suggested he could be very high risk when in the community, given his family history, repeated pattern of stopping or reducing his medication, being hard to engage, relapse, and self-harm attempts in May 2019 and January 2020. He was repeatedly assessed as low risk on the ward. No additional risk assessment was done to identify the possible and likely risks when back at home, and to plan for these.

Immediate changes	Ensure risk assessments are completed for patients going on leave, which identify risks in the community and agreed actions to be taken by staff in case of a breakdown in a plan.
Sharing the learning	To be shared with ward staff and community teams

We had proposed to take this report and learning to the Medical Advisory Committee Meeting (MAC), however, due to the recent COVID activity this has not yet been possible. I can confirm that the learning from the review has been shared with all of our Medical Staff and the members of the MAC, it will also be added for further discussing at the next available meeting.

The learning from the review has been shared with our Senior Nurse Managers for sharing within their teams and will be taken to our Senior Nurse Forum for discussion.

The report and learning was shared at the Eastern Locality Learning from Experience meeting and the Adult Directorate Governance Board meeting in September.

Additionally, [redacted], Deputy Medical Director is taking the learning to our Clinical Advisory Group which is a senior clinical forum for further discussion including our Safe from Suicide team with a particular focus on leave contingency plans and any other learning from the review.

I would like to note that following further contact from Benjamin's family we are currently reviewing their detailed feedback which we anticipate will identify further areas of potential learning and action for the trust. Any actions resulting from this work will be included in the original action plan.

I understand from our team that we were not informed of the inquest taking place so we were not able to attend and provide this assurance as we would normally have expected. I would like to assure you that we would always be very happy to attend whether a 'face to face' attendance or virtual given the current Covid arrangements.

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

[redacted]

[redacted]
Chief Executive