A member of:
Association of UK University Hospitals

NHS
Sussex Partnership
NHS Foundation Trust

12 August 2021

Office of the Chief Executive
Trust Headquarters
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West Sussex
BN13 3EP

Mr Healy-Pratt
Assistant Coroner for East Sussex
Coroner's Office (East Sussex)
Unit 56, Innovation Centre
Highfield Drive
St Leonards on Sea
East Sussex
TN38 9UH

Dear Mr Healy-Pratt

Mr Rodney Dixon

I write in response to your Regulation 28, Report to Prevent Future Deaths, dated 21 June 2021, following the Inquest into the death of Mr Rodney Dixon.

I was very sad to learn of Mr Dixon's death and I personally convey my sincere condolences to his family.

I understand that Mr Dixon took his own life, at home in Eastbourne, on 15 July 2019 during the course of a Mental Health Act (MHA) Assessment. I also understand that you were satisfied that those carrying out that Assessment (the 'Assessors') collectively had sufficient information to make the decision they did and that Mr Dixon's decision to take his own life was reasonably unforeseeable. However, I recognise and understand that you are concerned about potential future risks that may present themselves to other patients; specifically, by sub-optimal MHA Assessment training and the accessibility to the MHA Assessors of relevant patient information prior to completing MHA Assessments.

Your office has helpfully shared the Response provided to you by East Sussex County Council (ESCC) and I note that they have explained their responsibility for the recruitment, training, warranting and management of the Approved Mental Health Practitioners (AMHPS) and provided details of changes that they have initiated. It is regrettable that a direct discussion, between Sussex Partnership NHS Foundation

Trust (the 'Trust') and ESCC, about your concerns, has not occurred as yet. However, I am pleased to be able to assure you that the Trust's Deputy Chief Nurse has contacted [redacted] at ESCC to obtain details of the changes they have made to enable the Trust to gain a full understanding. The Trust will then facilitate the sharing of that information with the Trust's doctors to ensure that those who also work as independent s.12 doctors, at the behest of ESCC, do so in the knowledge of ESCC's changes in practice.

Regarding accessibility of relevant patient clinical information, I would like to assure you that it has long been the case that ESCC have had access to the Trust's electronic record system, Carenotes, to enable patient information to be accessible to them. The expectation is that the ESCC AMHP would access the necessary information and appropriately share it with any independent s.12 doctor who does not have access. In addition, it has been the working practice for many years that the Trust also shares information verbally and/or by providing hard copies of relevant patient records to AMHPs and to independent s.12 doctors, as needed. This further communication route facilitates the sharing of information if, for any reason, electronic access to Carenotes is not achievable. The Crisis Resolution Home Treatment Team are the Trust team that are available to support the MHA Assessors with access to relevant patient information and are available 24 hrs a day. However, I recognise your concerns and, therefore, have asked the Deputy Chief Nurse, when she discusses matters with ESSC, to identify if there are any difficulties with these established access processes that need to be addressed.

I hope that this Response is of reassurance, to both you and Mr Dixon's family, that the Trust has looked seriously at how it can support the MHA Assessment process, to learn from Mr Dixon's death and to keep patients safe.

Your sincerely

[redacted]

[redacted]
Chief Executive