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Dr Simon Fox
HM Assistant Coroner (Avon)
The Coroner's Court
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20 December 2022

Inquest into the death of Ami Louise Mitchell

Regulation 28 Report to Prevent Future Deaths

Dear Dr Fox

Thank you for the Regulation 28 letter you sent us dated 3 November 2022 regarding the tragic death of Ami Mitchell who died on the 31 May 2022. We are very sorry that Ms. Mitchell lost her life and we have accepted the findings of the internal report commissioned following her death.

In the conclusion of the Inquest held 3 November 2022 you shared your concerns in regards to lack of formal diagnosis and lack of escalation in management or in admission that took place in Ms. Mitchells care and treatment.

The Trust has completed a review of the diagnostic processes for service users in South Gloucestershire, which has in turn informed an action plan to address the improvements.

Lack of formal diagnosis

Our improvement in this area includes the assurance that that all service users receive a diagnosis and formulation from which care and treatment is informed by the NICE guidance appropriate for the diagnosis. In order to achieve this the trust must ensure the diagnosis or working diagnosis is clearly recorded in the clinical record, that the diagnosis or working diagnosis is discussed with the Service user and their family where appropriate and that there should be a protocol to adhere to where there is a difference of opinion.

We have ensured that there is now a Consultant medical lead for diagnosis in the area of South Gloucestershire and that this lead with senior support will work with the local team to put in place a diagnosis, which has been discussed informed by best practice guidelines and

discussed with service user and their carer. We expect this progress on these actions to be audited in 3 and 6 months of the implementation for internal assurance.

Lack of escalation in management or in admission

The trust will achieve improvement in this area in part by the previous improvement around diagnosis, which will clearly support the escalation of a pathway. The Clinical lead for South Gloucestershire will also ensure that all care and treatment plans (Crisis Plans) have a clear expectation of management escalation including possible admission if relevant. This might include clarity on escalation to admission if deemed appropriate.

I also believe that our ambitious Trustwide Strategy, currently out to consultation will direct a wider improvement in pathway clarity.

The Clinical Strategy element of the Trustwide Strategy is underpinned by five principles which have been created in consultation with patients and service users, staff and the wider community. We have developed five priority pathways, Complex Emotional needs, Dementia, dual diagnosis, neuro-development, and psychosis. The future of psychosis services is an integrated pathway that is co-produced with service users and their carers, delivering timely interventions with appropriate length treatments, to enable recovery. We want to provide the best care, at the right time, through consistent services that are accessible by all communities.

We aspire to be a prevention-focused, trauma informed service with renowned expertise in early intervention for psychosis.

We attach the updated action plan for your information and will be happy to send you an updated version six months from today, after completion and quality control.

Yours sincerely

[redacted]

[redacted]

Chief Executive