NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

[redacted]

[redacted] - Paula LENIHAN ([redacted])

Date: 21 November 2023

[redacted]

Ms Suzanna Rickard,
Assistant Coroner,
Birmingham and Solihull Areas,
BIRMINGHAM
B4 6BJ

Dear Ms Rickard,

RE: Prevention of Future Deaths Report Paula Lenihan (deceased)

Thank you for your Prevention of Future Death Report dated 2 October 2023. I am sorry that you felt that this was a necessary requirement under your obligation under Chief Coroner's Guidance No.5 to issue the same.

I understand that a Coroner's power to prepare a PFD report is set out in Paragraph 7(1) of Schedule 5 of the Coroners Act 2009, which states:
"(1) Where—"
(a) a senior coroner has been conducting an investigation under this Part into a person's death,
*(b) anything revealed by the investigation gives rise to a concern that circumstances creating a **risk of other deaths** will occur, or will continue to exist, in the future, and*
(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
the coroner must report the matter to a person who the coroner believes may have power to take such action."

I understand that during evidence presented at the inquest you concluded that the failure to update the risk assessment did not contribute to the death and accepted that the information was recorded within the records for staff to access. Your report sets out your belief that the risk assessment should be updated *'so that a professional looking quickly can absorb it; this is all the more important where professionals are under time pressure.'* This aspect of your report is not based on evidence heard at the inquest and the Trust does not accept that failing to update the Risk Assessment section of the medical notes, when the information is already within the records, would result in death. Even in times of pressure, clinicians would review all the necessary pertinent information prior to reviewing a patient. The Trust disputes that the threshold for a Prevention of Future Deaths report was met in this particular inquest.

I also understand that during the inquest you accepted that the Trust may not be able to do any more than is already planned and may have to repeat the evidence heard at the inquest to you in any response to a PFD Regulation 28 report. You added that your position on this was based on recent training that you had been provided with. This position is contrary to paragraph 4 the Chief Coroner's Guidance which states that '*Broadly speaking, PFDs should be intended to improve public health, welfare and safety*.' In December 2022, *Dillon v HM Assistant Coroner for Rutland and North Leicestershire [2022] EWHC 3186 (KB) (Admin)* the High Court endorsed the Chief Coroner's Guidance that PFDs should be meaningful and designed to have practical effect. Given that you accepted that it was unlikely the Trust would be able to provide any more information as it was already doing all it could, this does not suggest that any further improvements could be made to 'improve public health, welfare and safety' or have any 'practical effect'.

Further, you set out in your report that the evidence you heard explained that *'this group (the Task and Finish group) will be addressing matters as they are found rather than waiting until the final stage of its existence early next year.'* Again this offers assurances that the Trust would be alive to any issues which would arise from the findings of the Task and Finish group and would take action immediately. The Trust would be grateful to understand the details of the training you referred to as it seems to contradict the Guidance set out by the Chief Coroner in issuing PFD's, where you accept that the Trust cannot add any more to the evidence heard.

In response to your request for further action to be taken; I can provide you with the following update on the actions the Trust have taken:

The Trust has worked closely with teams, supporting with protected dedicated time for staff to update risk assessment documentation. A project Group has been set up to look at our risk assessment process. This has already met 4 times in recent months and includes a review of our medical out patient clinics and whether the current risk documentation process is fit for purpose, for our care support patients who are reviewed in these clinics. The review of our risk management policy is also complete and the revised policy will be ratified shortly. This work is being led by our Deputy Medical Director for Quality and Safety .

Completion rates for risk assessment for CPA patients within our community services have moved from 61.14% on 10th August 2023 to 98% on the 25th October 2023 and for care support patients we have seen an increase from 46% to 76.68 %

To ensure we continue to support staff in maintaining these levels of completion we will be monitoring via our monthly local CMHT clinical governance committee and trust wide performance delivery group.

I hope that this offers you further reassurance that the Trust were acting on the actions set out within the action plan, as explained in more detail during the course of the inquest. We look forward to receiving information around the training you referred to.

Yours sincerely,

Chief Executive

BSMHFT