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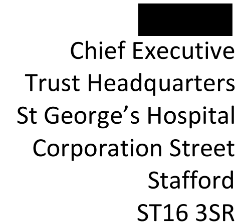
Midlands Partnership University
NHS Foundation Trust



Chief Executive
Trust Headquarters
St George's Hospital
Corporation Street
Stafford
ST16 3SR

Ms C McKenna
His Majesty's Area Coroner for Manchester North

3rd August 2023

Dear Ms McKenna

RE: Vaughan Lee Whalley (deceased)

Report to Prevent Future Deaths

Thank you for your letter dated 16th June 2023, reporting a matter to us, in accordance with Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

May I take this opportunity to reassure you that following the inquest in to Mr Whalley's death, we undertook a thorough investigation into the care delivered by the Midlands Partnership University NHS Foundation Trust.

***MATTERS OF CONCERN**:*
The five areas of concern were:

1. No assessment of the risk of suicide or self-harm upon release took place during Mr Whalley's time in detention.

2. There was a lack of clear communication to the police as to what, if any, assessment had taken place.

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3. The conversation between the Practitioner and Mr Whalley took place through an observation hatch in circumstances where no risk was posed to the Practitioner from being in the same room as Mr Whalley. This was not best practice.

4. The terminology used by the Practitioner was misleading in that it suggested there was no role for the Liaison and Diversion Service because no unmet needs or vulnerabilities had been identified. The evidence was that the deceased had declined consent for an assessment of unmet needs and vulnerabilities and therefore the notes should have made clear that an assessment of unmet needs and vulnerabilities had not taken place.

5. The "review" undertaken by a Health and Justice Operational Manager of the West Mercia Health and Justice Service consisted of a duplication of the Practitioner's statement with no comment, observations or identification of areas of learning.

Following discussions within the Health and Justice Services in the Specialist Services Care Group and with corporate services, I am now in a position to respond to the specific concerns raised during the course of the inquest.

1. **No assessment of the risk of suicide or self-harm upon release took place during Mr Whalley's time in detention.**

   As a result of the concerns raised we have undertaken a review of the risk assessment processes across our Health and Justice Services. Some inconsistencies in the standards were identified which we have addressed by the development of a Standard Operating Procedure for risk assessment to be applied across Health and Justice Services. The SOP incorporates standards for conducting and sharing risk assessments for people in Police custody. Included in the SOP is a requirement for risk related information to be recorded in the appropriate place in Police IT systems.

   The SOP remains in draft until it has been ratified by MPFT Policies and Procedures Committee on the 09/08/23. Staff have been advised of the revised standards and the standards have been incorporated into clinical practice.

   The revised standards will be supported and embedded by delivery of Suicide Mitigation Training to all clinical staff working in Health and Justice Services.

   Level 1 training is an e-learning programme for all clinical staff. Level 2 training is a taught session, also for all clinical staff. Level 3 training is a taught session for all registered practitioners.

   All clinical staff are required to complete the e-learning programme before attending Level 2 and/or Level 3 training as appropriate.

   Seven Level 2 and Level 3 training sessions are planned for delivery during September, October, November and December, with the final training session planned for the 15th December, with the aim that all staff working in Health and Justice Services are trained by the end of 2023.

We have written to the Chief Constable of West Mercia with an offer to explore the possibility of extending suicide mitigation training to Police staff working in custody if it is felt this would be appropriate.

2. **There was a lack of clear communication to the police as to what, if any, assessment had taken place.**

The review of Mr Whalley's care indicated that no entry was made on the Police IT system regarding the assessment carried out by the L&D Practitioner. The entry in Mr Whalley's Electronic Patient Record (EPR) indicates that verbal feedback was given to 'relevant parties in Police custody'. The content of the verbal feedback and the name of the person or persons to whom the feedback was reportedly given are not noted.

As noted above a Standard Operating Procedure for conducting and sharing risk assessments for people in contact with Health and Justice Services, including whilst in Police custody, has been developed and circulated to all staff working in Health and Justice Services. In addition to the requirement for staff to record a summary of risk related information in Police IT systems is the requirement for staff to record the content of any additional, verbal feedback relating to risk and the names of the people to whom the feedback was given in the EPR.

If the service user declines to engage in a risk assessment staff will record this in the EPR, being clear that this does not mean that there are no risks of future self-harm or suicide.

3. **The conversation between the Practitioner and Mr Whalley took place through an observation hatch in circumstances where no risk was posed to the Practitioner from being in the same room as Mr Whalley. This was not best practice.**

The review of Mr Whalley's care confirmed that the conversation with the Practitioner took place through an observation hatch.

Following a review, the Health and Justice Services SOP 'Working in Police Custody' has been revised to include guidance for staff on the circumstances under which it is appropriate to review somebody through an observation hatch and the process for recording where and with whom an assessment took place and the rationale for conducting an assessment through an observation hatch if this was necessary. The SOP will be ratified at the MPFT Policy and Procedures Committee on the 09/08/23. I will forward a copy of the SOP as soon as it has been ratified.

4. **The terminology used by the Practitioner was misleading in that it suggested there was no role for the Liaison and Diversion Service because no unmet needs or vulnerabilities had been identified. The evidence was that the deceased had declined consent for an assessment of unmet needs and**

vulnerabilities and therefore the notes should have made clear that an assessment of unmet needs and vulnerabilities had not taken place.

As noted above, the Health and Justice Service SOP 'Working in Police Custody' has been reviewed. The SOP now contains guidance for staff, that in the event that a service user declines consent for an assessment of their needs and vulnerabilities, it is clearly recorded in the EPR and the relevant Police IT system that no assessment has taken place.

5. The "review" undertaken by a Health and Justice Operational Manager of the West Mercia Health and Justice Service consisted of a duplication of the Practitioner's statement with no comment, observations or identification of areas of learning.

As a result of the concerns raised regarding the quality of the review undertaken by the Operational Manager we have made a number of changes.

We have agreed a new process, outlined in the Health & Justice SOP Review of cases referred by the Coroner's Court, whereby Service and Team Leaders no longer review the care delivered within their own service or team. The new process outlines the responsibilities of staff involved in producing and reviewing statements and we have reviewed the template for reports to ensure that future reports do not contain a duplication of the statements of other staff members and do contain appropriate comments, observations and areas of learning.

Additional training in Court Report writing skills, focussing specifically on reports for the Coroner's Court, has been arranged for Team Leaders and Service Managers who may be called to provide evidence about the quality of care delivered to people who use our services.

The training will be delivered on the 19th of September 2023.

MPFT will be transitioning to the new Patient Safety Incident Response Framework (PSIRF) in September 2023. PSIRF will provide improved support for those involved in undertaking investigations improving the safety of the care we deliver to people; the quality of reports produced and supporting shared learning to maximise improvements in healthcare.

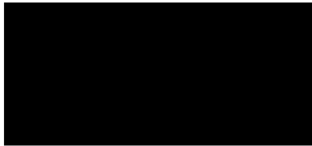
To support the embedding of this process within Health and Justice Services the Head of Health and Justice Services is currently undertaking PSIRF training during July 2023. In addition, the Clinical Director for Health and Justice Services is a member of the PSIRF Project Delivery Group responsible for ensuring that the processes are embedded across MPFT's clinical services.

We have also written to the Chief Constable of West Mercia to propose that future investigations of suspected self-harm deaths relating to individuals who have been in custody are carried out jointly between Midlands Partnership University NHS Foundation Trust (MPFT) and West Mercia Police to support shared learning and help prevent future deaths.

Progress against the actions outlined above will be monitored through our Health and Justice Services Integrated Governance Meeting and in Contract Review Meetings with NHS England Commissioners. In addition, compliance with the record keeping standards outlined in the SOP for risk assessment in Health and Justice Services will monitored through the regular audit of clinical notes.

I hope this response helps to address your concerns. However, if you require any further information please do not hesitate to contact me.

Yours sincerely



Chief Executive
Midlands Partnership University NHS Foundation Trust