NHS
Coventry and
Warwickshire Partnership
NHS Trust

Deborah R Lakin
Assistant Coroner
The Justice Centre,
Newbold Terrace,
Leamington Spa
CV32 4EL

2 April 2024

Dear Ms Lakin,

Re: The late Mr Narjit Gill

I am writing to you in response to the Regulation 28: Prevention of Future Deaths Report which was received from your office on 9 February 2024, which followed the inquest conducted in respect of the death of Mr Narjit Gill.

In concluding the inquest, you raised a concern that there was a "Failure to remove the ladder [redacted] from the tree in Mr Gill's garden when it was seen on 3 May 2023 by mental health practitioners who visited Mr Gill at his home, in light of his continued expression of suicidal ideation."

Working with my executive colleagues and with clinicians and service leads, we have given full and serious thought to our response to the concern that you have raised.

I understand your inquest received and heard evidence in respect of the care and treatment that was provided to Mr Gill, including in the immediate days prior to his death. Clinicians had been in contact and had visited Mr Gill at his home address and had also spoken with Mr Gill on the telephone. Clinicians were supporting Mr Gill to manage his mental health and wellbeing, taking a person-centred approach to his needs at the time and a least restrictive option. Although Mr Gill had reported attempts to harm himself, however he had also identified protective factors in place that were focussed on the impact of his death on those close to him. He had been in recent contact with his friend and was future orientated in wanting to find purpose through employment and resolving a housing issue.

Our internal learning review following his death did not identify systemic failures in care, but had identified some learning points, which focussed on ensuring staff understanding of internal referral processes to support safe transition between services; documenting important events and ensuring that pertinent detail is captured in health records, including recording of a rationale when assessment for capacity is recorded.

[redacted]

In thinking through our response, I wanted to ensure that I contextualised the circumstances that community-based clinicians work in, when supporting people with often complex needs and social circumstances.

A person who receives care in the community is deemed to be able to make decisions about their own safety. The review of Mr Gill's care and treatment had identified that he was not detainable under the Mental Health Act, and he did not require a mental health act assessment at that time. We are required to treat all patients in the least restrictive manner, and this would include where we would be "required to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken", and "to end or reduce significantly the danger to the patient or others"[1]. At the time of Mr Gill's assessment (3 May 2023) he was deemed able to manage himself safely with continued input from community mental health services. He was not deemed to be in imminent danger, and this was borne out in the discussion with the clinician later the same evening.

A person admitted to an inpatient mental health ward, would have presented with clinical risks that the service and the individual cannot manage safely in the community. Within our inpatient areas, it is our responsibility to ensure that objects either belonging to the Trust or part of the fabric of the building and environment are not able to cause patient harm or indeed be used by a patient to self-harm. Depending on individual clinical risks, it is also our responsibility to restrict or remove items and property belonging to a patient if they or others could use it to cause harm. Examples of these would be mobile phone charging leads, and cigarette lighters. With the exception of offensive weapons, all property would be returned to the patient during periods of leave, or at discharge.

The decision making required of staff, and their ability to act, is different in the community setting, whereby a person receiving mental health care and treatment is also surrounded by objects commonly found in home settings that can be used to harm themselves (e.g power leads, ignition sources, knives, scarves and belts, or items that can be used to gain height such as a ladder, chair or footstool). Whilst we would expect clinicians to talk with an individual about self harming behaviour, the property belongs to the patient and staff would not have an automatic right to take that property from them.

There are other avenues of support and actions available to staff, should they be concerned about a patient's capacity to make decisions. For example, if a patient had an offensive weapon, it would be pertinent to call the police to support that item being removed. Or, if a patient was seen to be hoarding prescribed medication, that the prescription be reduced/minimised and perhaps the person required to attend a named venue to receive and consume medication on site.

All approaches to safe risk assessment involve engaging with the patient to understand their current capacity, their risk behaviours and their ability to keep themselves safe in a

[1] https://www.rcpsych.ac.uk/improving-care/nccmh/quality-improvement-programmes/MHSIP-reducing-restrictive-practice/reducing-restrictive-practice/about-this-collaborative

[redacted]

person-centred way. We will continue to support clinicians to undertake dynamic risk assessments approach while supporting people to receive care and treatment in the least restrictive way, making sure that inpatient admission is appropriate to a person's needs, exploration and consideration of other initiatives and alternatives to admission and supporting people to remain within their local communities.

Whilst we cannot advocate for the removal of patient property from their possession in a practical manner, including where removal of objects from height may present a safety risk to staff, we do agree that there is an opportunity to continue our improvement journey and learn from Mr Gill's death.

As part of our ongoing improvement work, we have recently updated our information packs focussed on 'Suicide Prevention: Red Flags". This work is presented as a poster and a screen saver and highlights significant events which can contribute to a change in a person's needs. The React, Engage, Discuss (RED) flags cover emotional, physical, relationship, financial and social factors as well as drawing attention to risk assessment and helpful phone numbers.

After successfully recruiting to the key post of "Lead For Clinical Risk and Suicide Prevention" we have been able to recommence our internal Risk Assessment Training. the training which comprises of a 4 hour session targeted at clinicians and provides staff the tools and knowledge to conduct a comprehensive risk assessment. The training focuses on current and historical risk, positive risk taking and personal safety plans.

We are also:

- Continuing our work to implement the NICE Guideline "Self Harm: Assessment management and preventing recurrence", which was published in September 2022. The guideline sets out an important and systemic change in the way that we currently approach risk assessment, in that it deliberately moves away from using risk assessment tools and scales (e.g. low, medium or high) to determine who should or who should not be offered treatment. Implementing the guideline will support clinicians to 'Risk Formulate' and focus the co-produced assessment on the person's needs and how to support their immediate and long-term psychological and physical safety.
- Continue to engage with external national bodies to access training to support embedding of the co-produce standardised approaches to risk based training in respect of the implementation of the NICE Guidance.

I have set out what I believe is a focussed response to the issue you have raised with me, but please contact me if you have any additional questions, that I can assist you with.

I would be grateful if you would share a copy of my response with Mr Gill's sister, [redacted], and with the Chief Constable of Warwickshire Police.

[redacted]

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer

Copy to:
[redacted], Chief Nursing Officer / Deputy Chief Executive
[redacted], Chief Medical Officer

[redacted]