Midlands Partnership University
NHS Foundation Trust

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Mr Andrew R. Barkley
H M Coroner for Staffordshire and Stoke on Trent
Stoke Town Hall
Kingsway
Stoke-on-Trent
ST4 1HH

9th April 2024

Dear Mr Barkley,

Regulation 28 Report to Prevent Future Deaths regarding the death of Mr Jamie Peter Norman Pilkington

I am writing in response to your Regulation 28 Report dated 22nd February 2024 following the inquest into the death of Jamie Peter Norman Pilkington which concluded on the 13th February 2024.

At the time of Mr Pilkington's death he was referred to MPFT's Mental Health and Social Inclusion Hub by his GP. The team completed their assessment with Mr Pilkington on the 8th February 2023 and a referral to the Integrated Mental Health Team was completed. The Integrated Mental Health Team completed their first and only contact, with Mr Pilkington on the 3rd March 2023.

The agreed actions from our review in response to the MATTERS OF CONCERN outlined in your correspondence are as follows:

1. During a Mental Health triage with the Mental Health and Social Inclusion Hub on 8th February 2023 there was a failure to complete the Risk Assessment in relation to his risk of suicide

There is evidence within the progress notes that risk had been discussed and Mr Pilkington did recognise he was having intrusive thoughts that had been exacerbated by recent events. He appeared to be future focused and stated he wished to engage with services, he was confident he would contact services should his needs or risk change.

While the FACE risk assessment was not completed on this occasion, the purpose of the tool is to guide clinical discussions with service users in order to identify and explore areas of risk. Completion of the FACE risk assessment, and indeed any risk indicator tool is no longer seen as an effective predictor of suicide. This is highlighted in the revised NICE guidance NG225 Self-Harm: assessment, management and preventing recurrence (Sept. 2022), which guides services not to use assessment tools and scales to predict future suicide or repetition of self-harm. Instead, clinicians are to focus the assessment on the person's needs and how to support their immediate and long-term psychological and physical safety.

MPFT has explored the guidance and what this means for clinicians working with those who may be at risk of suicide. It is recognised that the existing FACE risk assessment is no longer indicated for use in suicide as it is not possible to predict suicide due to the dynamic nature of this. There is building evidence of the effectiveness of safety planning in suicide mitigation, which requires the training and roll out of safety planning skills and tools across the whole organisation. By December 2023 we had trained 1281 staff across the trust in suicide awareness training (e-learning), the safety planning training is face to face and is resource intensive to deliver due to ensuring fidelity against the model therefore numbers for this are lower.

We are exploring the addition of the Safetool (safety planning) onto our electronic patient record system to support the electronic completion of this.

2. When referred to and assessed by the Integrated Mental health Team on 3rd March 2023 again there was a failure to complete a Risk Assessment as to his risk of suicide.

The notes show that updated Mental Health Assessment, Review and Care (ARC) Section was completed regarding risk, with some discussion on intent (but no exploration around his research methods), at this point Mr Pilkington stated he had no intent to act on these thoughts and wanted to live. The transfer to IMHT was routine and thus seen within the 4 weeks, as per Trust policy.

3. In an appointment on 3rd March 2023:

- **Suicidal/self-harm thoughts not explored in detail.**
- **There was no exploration of his statement to the effect he was actively researching methods of taking his own life.**
- **There was no exploration regarding efficacy/concordance with medication.**
- **There was no discussion around distraction techniques, coping mechanisms or information**
- **about contact details for other services.**
- **There was no discussion regarding his support network, next of kin etc.**
- **There was no indication of next steps, timescales or when he could expect to be informed of the onward plan and no definite date when his case would be discussed with the Multi Disciplinary Team.**

An exploration of risk would entail a conversation around factors such as risk to self, risk to others or self-neglect. If during that conversation any risks are identified these would be explored in further detail to include intent, severity, access to resources and following this a robust safety plan formulated collaboratively between professional, the service user and carer (if applicable). This would include protective factors; these can be seen as things that help an individual to maintain their safety, such as family members, pets, and future planning. At this juncture, information around how to access services should be reiterated in the event that circumstances change. There is evidence within the progress notes of exploration of risk and protective factors, although this is minimal.

The Overcoming Challenging Times plan is collaborative in nature, designed to enable the service user to identify changes in behaviours, risk and thought processes and empowers them to engage in activities that have previously proven effective in supporting them to manage their emotions and related risks. This is designed to support the service user or their carer to reach out for support should the issues identified in the plan escalate. Unfortunately, on this occasion this had not been commenced during the initial contact, although as a service it is the expectation that this be completed over the service user's spell of care. This may include techniques that may prove helpful. Examples of this may range from going for a walk, practicing breathing techniques, sharing concerns with friends or family, through to contacting mental health services.

4. On hearing evidence of the investigation into the Mental Health care which he received, beyond offering further training and support to nursing staff and mental health professionals, no assurance could be given of a system change to ensure that such Risk Assessments were completed or that appropriate and adequate exploration is made of matters which may affect how the risk of suicide is managed.

Upon completion of the initial report and agreeing the learning points, these were discussed within the team on 25th October 2023. A follow up email was sent to capture these points, allowing staff the opportunity to discuss further if required.

The informal training session was scheduled for 27th February 2024, however due to unseen circumstances this has been delayed until the 9th April 2024.

Whilst we recognise the FACE risk assessment was not completed on either occasion NICE guidance NG225 (Sept. 2022) Self-Harm: assessment, management and preventing recurrence, agreed that risk assessment tools and scales cannot accurately predict risk of self-harm or suicide, and that determining access to treatment or hospital admission based on inaccurate risk assessment tools could lead to repeat self-harm, distress and lower patient satisfaction.

MPFT has developed a three-year suicide prevention plan to address the changes in guidance and practice required to move from the traditional risk assessment and management approaches used in suicide to those of collaborative safety planning led by service users. This plan has five key components:

- Creating a skilled workforce; rolling out suicide awareness training to all staff, and focused risk formulation and safety planning training to key professionals,
- Moving to safety; moving away from risk assessment towards the use of safety planning,
- Family and carer engagement; ensuring that families and carers are included in safety planning,
- Supporting challenging times; recognising key risk periods for service users (i.e. transitions in care, at times of crisis),
- Monitoring; engagement in real time suicide surveillance, patient safety incident review and learning from deaths process.

We are committed to delivering against this plan, which has Board commitment and the resources to ensure the roll out of training and the system changes required to support clinical practice.

I hope the above information meets with your approval and satisfaction and that the actions outline suitably address your outlined matters of concern.

Please do not hesitate to contact me if you require any further information.

Yours sincerely,

[redacted]

[redacted]
Associate Director, Safety Risk and Compliance