Norfolk and Suffolk
NHS Foundation Trust

NSFT Trust Management
Norfolk & Suffolk Foundation Trust
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[redacted]

Assistant coroner Peter Taheri
Suffolk Coroner's Court
Beacon House
Whitehouse Road
Ipswich
IP1 5PB
[redacted]

Date: 31 May 2024

Dear Mr Taheri

Regulations 28 and 29 (coroners investigations regulations 2013) notification made in response to the death of Mr Paul Templeton

I write to you in respect of Mr Templeton who died on 20th April 2023. His inquest concluded on 21st February 2024. At the end of the inquest, you raised concerns outlined in this response within a prevention of future deaths notification.

I would like to reiterate to you and to Mr Templeton's family our sincere regret and apologies for the death of Mr Templeton whilst under our care.

You identified that action is needed to prevent future failure to recognise:

(a) when the prolonged choice of a patient detained under the Mental Health Act not to eat or drink should be regarded as an action to end their own life;
(b) when such a patient's prolonged choice not to eat or drink should be recognised as elevating that patient's suicide risk (including of suicide by means other than malnourishment).

In response to your concerns (a) & (b) we have acted to secure assurance that assessors working within Willows ward have the skills and awareness required to undertake comprehensive holistic risk assessments, including an understanding and awareness of the significance of food and drink in mental health risk assessment. A reflective Multi-Disciplinary Team (MDT) Away Day was held on 15th and 17th May 2024. During this, the team explored the application of clinical risk assessment skills to a range of different cases. This was undertaken to support the transition of knowledge into clinical practice and provide assurance of consistency between staff members. The case studies included scenarios related to food and drink to raise staff awareness. To maintain a good standard of clinical practice this will be discussed in clinical supervision and reviewed within future team meetings.

To ensure focus on appropriate clinical risk assessment, the Team are using Daily Team huddles to prompt assessors to consider holistic care / including eating and drinking within their clinical risk assessments. To support this, we have also made changes to the SBAR (Situation Background Assessment recommendation) record that the team use to communicate and share patient information at handover. The revised SBAR provides more information about eating and drinking (identifying quantity not just appetite) to inform clinical risk assessment.

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The Trust focus on clinical risk assessment is further supported through current updating of the Trust Clinical Risk Assessment and Management Policy. This Policy is progressing through Trust internal governance processes and is due to be published end of June 2024. This will provide additional support to staff clinical risk assessment practice.
We will secure assurance regarding clinical risk assessment through audit. The audit findings will report to the Care Group Quality Assurance Group for monitoring purposes and to support further improvement. For further assurance the report will be presented to the Trust Safety group and onward to the Trust Quality Committee.

We have also reviewed the training we offer to staff to support their assessment of clinical risk. The current clinical risk training offer is inclusive of mandatory suicide awareness training, Ligature training, Oliver McGowan Autism Training, Safeguarding level 3 trainings, and physical healthcare training. This includes the national NHS England approved suicide prevention (eLearning) package.

The challenge for the Trust is to secure a training package which sufficiently addresses both clinical risk assessment and food and nutrition. The national approved training, required as mandatory by the Trust, does not reference suicide through malnourishment. The Trust's 3P (Presenting, predisposing, precipitating, perpetuating & protective factor training) programme highlights the importance of good nourishment but does not link this to suicide. We recognise that to deliver content linking suicide prevention training with content referencing malnourishment we will need to develop and deliver a bespoke package of training supported by subject matter experts. We are in the process of discussing this with our Physical Health team and raising this with NHS England and the Royal College of Psychiatrists for their broader consideration.

From a Trust perspective, senior meetings have been held between the Trust's Education Department, Chief Nursing Officer and Directors, to review and refresh the NSFT Education Strategy, inclusive of reviewing / extending training offers which focus on clinical risk assessment. The outcome of this work is scheduled to report in June 2024.

The tragic death of Mr Templeton has identified a number of key learning points for the Trust. As described above, a number of actions have been undertaken that address your concerns.

Yours sincerely

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Chief Executive Officer