NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

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Tel: [redacted]

Mr James Bennett
Coroner for Birmingham and Solihull
Steelhouse Lane
Birmingham
B4 6BJ

Our Ref: [redacted]

Your Ref: [redacted]

Date: 26 September 2024

Sent via email only: [redacted]

Dear Mr Bennett,

RE: PREVENTION OF FUTURE DEATH KIERAN MICHAEL LAVIN

I write in response to the Prevention of Future Death report dated 1 August 2024. I would like to begin by offering my sincere condolences to the family of Mr Lavin. I would like to take this opportunity to assure both the Coroner and the family that we have taken the concerns that you have raised very seriously and have taken necessary steps to learn from these. I will aim to address each of the points that you raised within your report in turn.

Documentation concerns
You flagged two areas of concern within this aspect, one was around recording of important information and the timely recording. The second related to your concerns around the risk associated with staff not complying with the trust's policy on documentation.

With the above in mind, we will be setting up regular Risk Huddles which will include the psychologist, which will be on a monthly basis (the frequency can be increased if the need arises). Risk huddles proactively manage quality and safety, enabling teams to focus on developing / reviewing risk formulation using the 5P's (Presenting, Predisposing, Perpetuating, Participating, Protective) model and formulate plans for service users. The aim is to raise the understanding and quality of risk formulations. Comprehensive risk formulation consistently improves quality of care and risk management of patients.

We do however acknowledge that communication could be improved through improvements in relation to documentation and therefore we also have a reflective session for the staff in the Urgent Care Centre [which includes the Psychiatric Decisions Unit (PDU)] to further explore the staff members' thoughts and feelings around various issues including risks and any actual and perceived barriers that may be faced. This took place on 16 September 2024.

The quality and standards of the handover process in the PDU will be reviewed, with particular attention to ensuring that critical information is documented and communicated before key decisions, such as patient transport, are made. The handover process will also be revised to establish clear standards that require the documentation and communication of urgent information prior to any significant decisions, including patient discharge.

Review of risk for informal patients transported by family members
In response to the risk assessment for transfer of informal patients, as earlier noted; the learning in this respect was also in relation to communication.

I would like to begin by thanking the family for their suggested checklist for this risk assessment. We are grateful for this offer. The factors identified in the checklist submitted by the family barrister includes risk factors that would and should be considered in a risk assessment and management conversation. However, it would not be possible to score these as this would be an arbitrary process, with no grounding in research or evidence based clinical practice. Given the areas of risk that need to be considered, having such a prescriptive list could potentially result in staff members omitting to review key areas of risk that may not be indicated on the list, thereby inadvertently replacing comprehensive clinical risk assessment and management processes, which would have serious negative impact on the quality and safety of patient assessment and management.

The established research evidence, supported by NCISH data, NHS England, National Collaborating Centre for Mental Health and Royal College of Psychiatrists, is clear that Tools that seek to stratify or score patients have a very low positive predictive value (PPV). The PPV % quoted is in the range of 5% i.e. only 5% of the times, such tools will accurately predict or identify risk; 95% of the times, they do not. Furthermore, research evidence is clear that no one tool is better than another. Individual and personalised approaches to identification of risk factors for an individual, with clear identification of appropriate mitigations, open discussion with patient and relevant families and carers, with a collaborative and mutually agreed plan with a view to optimising safety and reducing risk, is the evidence-based approach (referenced by NICE Guidance). NICE have warned against the use of unvalidated suicide risk assessment tools.

Consequently in response to your concerns the Trust have carefully considered the additional ways in which we can assure that staff are carefully considering risk on a case-by-case basis. Meetings have been undertaken with the Executive Medical Director, Deputy Medical Director, Clinical Director for the area and, other key Senior leaders to discuss this area of improvement. We have agreed that the action points noted above will also address this area of concern. In addition, further Risk Assessment training is available for any staff that may need it (identified by the individual and/ or in supervision).

The findings of the investigation into the Mr Lavin's death and the inquest have been shared with staff in urgent care in our Clinical Governance Committee meeting. In addition, we will also arrange focussed meetings with staff in the PDU and Urgent Care Centre to discuss the findings further, in order to promote better understanding and working so as to improve the quality and safety of patient assessment and management in so far as is possible.

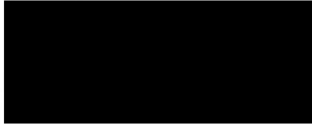
Since Mr Lavin's death, we have appointed to a newly-created post of Urgent Care Team Manager (Band 8A nurse) who will be able to provide closer and tailored supervision to our staff, both as a team and individually.

As already conveyed to you, we have updated our Transport Policy to emphasise that an open and thorough discussion needs to be had with any family member/friend/carer prior to agreeing the transport of the patient by them. The option for patients to be transferred in this manner will remain, as that upholds the dignity and autonomy of the patient, and is in the spirit

of least restrictive practice. This continues to enable patient choice and inclusion in decisions about them. Allowing for this, where appropriate, is also reassuring to the patient and family, and can significantly improve patient experience and outcomes, particularly in but not limited to the early period following admission. The changes made will strengthen the communication and handover processes through the increased knowledge and support from the Risk Huddles. This will improve the quality of the risk assessments and feed into the changes already made to the policy. This will improve the overall safety culture within the Trust.

If you have any further questions, please do contact me.

Yours sincerely



Chief Executive
BSMHFT