NHS
Coventry and
Warwickshire Partnership
NHS Trust

Ms Linda Lee
Assistant Area Coroner for Coventry and Warwickshire
Manor House Drive,
Coventry
CV1 2ND

23 December 2024

Ref: Regulation 28 report - Death of Mr Darren Hope

Dear Ms Lee

I am writing to you in response to the Regulation 28 Prevention of Future Death (PFD) report, which followed the inquest for Mr Darren Hope.

Thank you for the report. I do understand the need to reflect on learning from events in healthcare, and the PFD system is one way of supporting the sharing of learning activity.

The three concerns that you have raised with the Trust are repeated below for ease of reference:

- **Concern 1**: Section 17 leave conditions may not always be thoroughly reviewed or clarified before a service user is signed out for leave. This lack of verification can lead to unaddressed discrepancies, which may impact the safety and appropriateness of unescorted leave.
- **Concern 2**: There may be a lack of accessible or reliable means for service users on unescorted leave to contact the facility if they encounter difficulties. This could impact their ability to seek support or assistance when needed.
- **Concern 3**: There may be limitations in the reporting system's ability to identify and address substantive issues that directly impact patient safety. If critical concerns are overlooked, there is a risk that valuable insights for preventing future incidents may be missed, reducing the system's effectiveness in promoting long-term safety improvements.

From talking with my colleagues involved in the case and the inquest, some of the response I am setting out below has already been shared as part of the inquest, but I have also reflected on additional work that we have completed or are planning to complete in order that a comprehensive response is provided to you.

Response to Concern 1:
The Trust acknowledges that in respect of Mr Hope being signed out of the ward, on leave on 3 July 2023, the correct process was not carried out in line with the Trust's Section 17 Leave Policy in that ward staff had not verified the Section 17 leave form was correct.

[redacted] – Acting Chair
[redacted] - Chief Executive

Supporting safe and effective Section 17 leave is a core issue within our Mental Health Directorate and it is worth appraising you of the focussed work that we have been undertaking.

In January 2021, a cross directorate approach was undertaken to review and update the Section 17 Leave Policy taking into account staff views. The task and finish group were made up of a mix of professionals from both acute and community services including Nursing Staff, Ward Managers, Matrons, Psychiatrists, Psychologists, AHPs and Mental Health Act leads. I have set out the updates to the Section 17 Policy at appendix one. Since the update of the Section 17 Leave Policy, clear guidance is provided on the Trust intranet in the form of a section 17 toolkit which has a Step-by-step guidance to facilitating Section 17 agreed leave of absence.

The guidance is aimed at promoting good practice and to ensure Section 17 and agreed absence from the ward for detained patients, is in line with the Trust's Section 17 Leave Policy and the MHA Code of Practice. Other elements of the toolkit include:

- Accompanied Leave Checklist, which is a handover document which is completed with the person accompanying the patient.
- A blank copy of the updated Leave of Absence (Section 17) form.
- A staff briefing poster of the new Section 17 leave Policy.
- Powerpoint teaching presentation of Step-by-step guidance to facilitating Section 17 agreed leave of absence for staff.

The work which has been done around improving contingency planning, as set out in oral evidence by [redacted], Associate Director of Nursing and Quality (MH Directorate) has also improved clarity for staff and the patient in relation to the requirements of the granting of leave. There has been an appreciable improvement in adherence to policies and record keeping as demonstrated in recent audits.

In May 2022, an audit of the section 17 leave forms was completed, and reasonable assurance was provided. The review was undertaken to ensure that the completion of section 17 leave forms aligns with the Trust Policy, in particular:

- To ensure non-Approved Clinicians discuss the Section 17 paperwork with the covering Approved Clinician and document this discussion.
- To check the ward staff are aware of the process of covering Approved Clinicians.
- Target standard is 100% to be documented for patients on Section 2 or 3 requiring Section 17 leave.

Follow up reviews have been undertaken, in both February 2024 and August 2024 as part of the Quality Improvement clinical audit cycle. Areas of good practice observed included:

- All patients who had discussed Section 17 leave had a completed corresponding Section 17 Leave Form in their Mental Health Act Folders on the ward.
- 100% of staff asked explained that they were aware of the process of how to support a patient being granted Section 17 leave, and also who the corresponding covering Approved Clinician was for their ward.

I am also pleased to confirm that as of November 2024, all 16 inpatient wards in the Mental Health Directorate now have a named consultant who is an Approved Clinician (AC) as their Responsible Clinician (RC).

Response to Concern 2:
It is understood and accepted that when Mr. Hope was detained at the end of May 2023, the police kept his mobile phone. As a result, Mr. Hope was unable to use his personal mobile phone when on leave.

The Trust has undertaken a substantial amount of work in relation to the process for granting and implementing Section 17 leave over the past few years. The statement on the final day of the inquest prepared by [redacted], Associate Director of Nursing and Quality (MH Directorate) set out the details of the improvement work already in place.

The current Section 17 leave policy states that the Multi-disciplinary Team (MDT) must check and confirm that the patient is aware of how to contact the ward and have the resources to do so in the event that they need to during contingency planning for unescorted leave. This is outlined in the policy as follows:

5.4.3 Unescorted Leave
Staff must ensure that the necessary arrangements are in place. These would have been identified when the decision to (Page 15 of 36) grant unescorted leave was made (prior to that leave commencing). This may also include:

- *Transportation,*
- *Access to accommodation,*
- *Agreed support arrangements whilst on section 17 leave are in place,*
- *Patient has the necessary resources to support them during their unescorted leave,*
- *Patient understands how to and can contact the ward for additional support whilst on leave,*
- *Patient understands any conditions that are part of the section 17 leave authorisation.*

Those with a significant interest in the patient e.g., family, carers etc are made aware of the patient's return to the community unescorted and how they can contact the ward for support or to provide feedback on the leave, subject to the normal considerations of patient confidentiality.

The purpose of Section 17 leave is to facilitate recovery, well-being, and reintegration into society. It might undermine patients' rights under the Mental Health Act if it is blocked for non-clinical reasons.

It is not unusual for patients to be without their own mobile phone for a variety of reasons, including financial constraints, difficulties finding their phone, restricted access (as was the case with Mr Hope), or in certain circumstances, phobias or delusions related to devices like mobile devices. When a patient's leave is being planned and discussed, contingencies for such circumstances will be considered and agreed upon.

The patient's vulnerability, individual risk assessment, previous leave durations, and any contact-related contingencies would all be considered by the MDT. This would entail determining whether the patient has access to any other means of communication, such as through a friend, neighbour, or relative. The MDT will also talk to the patient about alternative ways the ward can get in touch with them while they're on leave in case of any difficulties.

An improvement we have made is the development and implementation of a 'contact card' which will be given to each patient who is accessing leave. The 'contact card' has key phone numbers that a person can ring if they need help including NHS 111, 999, the Crisis Team phone number and the Ward telephone number.

As part of the improvement work to support contingency planning, when discussing and planning Section 17 leave, the Mental Health Directorate is exploring the option of pre-arranged check-ins by the ward team. In this situation patients would be given set times and locations to check in physically or via other means (e.g. landline calls).

Response to Concern 3:
The inquest received evidence from our appointed investigator who, at the request of the court had set out her investigatory experience and the approach the organisation took with regards to the investigation into the death of Mr Hope.

The investigation report set out the sources of information that were used including:

- Carenotes (clinical notes)
- 48/72 Hour Report
- Section 17 leave forms
- Staff Interviews and statements provided to the investigating officer.
- Local policies (Absent without Out Leave and Section 17 Leave Policy)

The investigation considered how factors such as the environment, equipment, tasks, and policies influenced the decisions and actions of staff.

The investigation did not conclude with a separate action plan, but it did set out in detail that the issues identified, including AWOL response and Section 17 Leave arrangements, were already subject to improvement as part of a Quality Improvement Plan involving our adult male mental health wards.

The investigation report does not set out the attempts made to engage with the family of Mr Hope. There is evidence that the investigating officer made a number of attempts to engage with the next of kin of Mr Hope. My understanding is that the family dynamics were complex, and some of those dynamics were likely centred on Mr Hope's mental health and well-being at different points in his life.

We have to strike the balance between seeking engagement, accepting that some families will not want to be involved and also respecting the patient's right to keeping information confidential in death as well as in life. In the case of Mr Hope I can see evidence, and this was also heard in the inquest setting, that the investigating officer reached out by telephone

and text message. The investigating Officer advised that she could attend the family address to go through the report face to face, however she received a text message requesting the report and duty of Candour letter be sent via email and [redacted] (Mr Hope's mother) provided her personal address. Following receipt of the report and the letter there was further contact via a message sent to the Investigating officer in which [redacted] stated she would read them and get back to her if she needed to. Therefore, we can confirm that we made efforts to engage pre-investigation, during the investigation phase, and at the end of the investigation.

The statement on the final day of the inquest prepared by [redacted], Associate Director of Nursing and Quality (MH Directorate) set out the details of the improvement work already in place, as well our investigation approach. It also explained our transition from the Serious Incident Framework (NHSE, 2015), which focusses on 'root cause', towards adopting the Patient Safety Incident Response Framework (PSIRF) (NHSE, 2022), which moves away from a root cause (blame), and focusses on learning and understanding of the work system, acknowledging that staff and patients are part of the 'work system' and that it is the system that will support good or poor outcomes.

We have utilised NHS England's PSIRF toolkit to develop our arrangements and have worked with the Integrated Care Board and other local providers to sense check and develop our approach. Our transition to PSIRF is in itself a learning curve that we have to embed and will iterate over time. We have engaged with an external consultancy to support training for staff, support us to build our PSIRF Plan and PSIRF Policy arrangements, and to engage with the Trust Board and other senior leaders from an assurance and oversight perspective. We will continue to take the opportunity to learn from safety events in healthcare and to support the coroner's office to conduct their investigations.

I will write separately to the Area Coroner as I would welcome the chance for myself and colleagues to spend time to talk through some of the key programmes of work we are currently engaged within, particularly focused on our transition works associated with:

- Risk Assessment / Safety Planning Formulation.
- Management of Absent Without Leave.
- Transition from Serious Incident framework to Patient Safety Incident Response Framework.

I of course would be happy to assist you with any additional questions in respect of this matter.

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer

Appendix One - Section 17 Leave

Section 17 Leave Policy Changes

- A clearer definition of **unescorted**, **accompanied,** and **escorted** leave.
- Reinforcement of the importance of challenging leave being taken, if there are issues related to risk.
- Clarification on the ability of staff members to decline leave if there are safety concerns
  Clearer guidance around the responsibilities of all staff, including the Responsible Clinician, Nursing Staff, AHPs and Health Care Assistants.
- Guidance on the role of community teams in the planning and facilitation of Section 17 leave.
- Clearer guidance on the process of both agreeing, facilitating and reviewing Section 17 leave.
- Confirmation of the handover process for a patient going on accompanied leave.

Section 17 Leave Form Changes

- Inclusion of definitions for accompanied, escorted or unescorted leave options to reflect changes in policy.
- Adequate space for details regarding leave conditions.
- Introduction of separate Accompanied Leave Checklist.
- Acknowledgement that risk assessments should be reviewed, not necessarily updated unless there are changes in risks with rationale being captured in the electronic records.