Berkshire Healthcare
NHS Foundation Trust

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PRIVATE AND CONFIDENTIAL

Robert Simpson
Assistant Coroner for Berkshire
Coroner's Office
Reading Town Hall
Blagrave Street
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22nd May 2024

Re: Inquest touching the death of Daniela Vitalia Pani

Dear Sir

I write in relation to the above inquest which concluded on 28 March 2024.

On 28 March 2024 you made a report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. Your report was sent to:

[redacted] – CEO Berkshire Healthcare NHS Foundation Trust
British Transport Police
[redacted] – Interim Managing Director South-Western Railway

I am writing to provide you with the Berkshire Healthcare response which relates to your concerns about training and guidance for staff on how to deal with service users declining a 72-hour review meeting. Specifically, staff not being able to carry our face-to-face assessments in all possible cases.

The Trust recognise how challenging it is for clinicians when a patient prefers not to have a face-to-face review within the expected 72-hour period. Our existing training and guidance focused on staff making a clinical decision based on their knowledge of the patient, input from family/carer where possible and the current risk assessment. There is national guidance available, and this informed our approach. This NICE[1] guidance states:

1. Ensure the aim of care and support of people in transition is person-centred and focused on recovery.
2. Work with people as active partners in their own care and transition planning.
3. Support people in transition in the least restrictive setting available (in line with the Mental Health Act Code of Practice).
4. Record the needs and wishes of the person at each stage of transition planning and review.

[1] Overview | Transition between inpatient mental health settings and community or care home settings | Guidance | NICE

5. Identify the person's support networks. Work with the person to explore ways in which the people who support them can be involved throughout their admission and discharge.

This guidance goes on to say:

> "Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. They should ensure that it is collaborative, person-centred and suitably paced, so the person does not feel their discharge is sudden or premature".

In light of the guidance and also our clinical experience the Trust do not feel having a blanket rule about enforcing a face-to-face meeting in all possible cases would be helpful for the patient/practitioner relationship, nor would this approach prevent a future death, it may even increase the risk of suicide by adversely impacting the therapeutic relationship and increasing feelings of hopelessness.

Therefore, the approach the Trust has taken focuses on enhancing the existing clinical risk training and guidance for staff to include an increased focus on a collaborative risk formulation and safety planning. This includes a specific skills component on:

1. Engaging with the patient to understand why they do not want the face-to-face review.
2. Escalating to supervisor to consider decision making collaboratively.
3. Involving the family/carer if possible.

In addition to this we have provided additional guidance for 72-hour follow up and a short film clip for staff on how to deal with a person refusing or postponing the face-to-face appointment (this approach would still require a clinical judgement).

Trust Guidance for 72-hour follow up:

1. Establish the reason why the person cannot/prefers not to attend. Do this by engaging with the person, asking specifically about the following:
    - What is the reason they cannot attend?
    - What can we do to support them to attend?
    - Explain why this follow up is important (it can be a time of increased risk/need for some people, we want to help and it is an opportunity to see how they are getting on having been recently discharged)

2. Explain the importance of the appointment and attempt to be as flexible as possible with the 72-hour window. Offer a choice of location to overcome practical barriers.

3. Refer to the safety plan and the recent discharge plan.

4. Rule out imminent risks associated with withheld suicidal intent or ambivalence.

5. Involve family/carers if possible (see film clip).

6. Involve your manager or supervisor.

7. Options if you are concerned the person may be concealing their intent or they are at risk of harming themselves or others:
    - Cold calling anyway (see guidance on how to approach this),

- Arranging a Mental Health Act assessment, the family/carer if possible and MDT should be involved in the decision making to request this.

8. If you feel there is a legitimate practical reason to postpone the face to face and you have determined it is safe to do so, you must discuss this and seek support from service manager or their deputy and the patient's family/carer if possible. If all agree you can then arrange a telephone or video call with the face to face to follow asap (see guidance on what to cover in the follow up if you are unsure).

9. Always clearly record all steps taken in RiO.

In addition to the above, we have also provided additional pre discharge guidance for staff in the inpatient setting on including the detail, expectations and importance of 72-hour reviews within the discharge safety plan. During this conversation any barrier to attending the 72-hour review will also be explored.

To ensure the new training and guidance is impactful the Trust has developed a targeted risk audit that focuses on more complex cases where refusal may be more likely. A peer review process was already in place, and it now includes a focus on post discharge follow up and the safety planning process. We are also using the NCISH[2] safer wards audit tool which focuses on 72-hour follow up. The Trust Quality and Safety meetings at service and executive level already monitor 72-hour follow up as it is a tracker metric, the compliance is high (100% in March 24).

As a Trust, the safety and wellbeing of those we provide services to is paramount and despite the unfortunate circumstances in which this query has arisen, we welcome the opportunity HM Assistant Coroner has provided for us to review and enhance the training and guidance for staff on how to deal with service users declining a 72-hour review meeting.

Yours sincerely

[redacted]

[redacted]
Chief Executive

[2] NCISH | Resources (manchester.ac.uk)