Oxford Health
NHS Foundation Trust

Private & Confidential

Chief Executive's Office
Trust Headquarters
Littlemore Mental Health Centre
Sandford Road
Littlemore
Oxford
OX4 4XN

Mr R Simpson
Assistant Coroner for Berkshire

Sent via email to - [redacted]

3 March 2025

Dear Mr Simpson,

Regulation 28 report – Jan Raciborski
Inquest concluded on 10 January 2025
Response of Oxford Health NHS Foundation Trust

Thank you for your report dated 13 January 2025 following the conclusion of the inquest into the very sad death of Jan Raciborski on 5 February 2024. You have stated these concerns to me –

> None of the records of contact with Mr Raciborski completed by the AMHT in the period from August 2023 to the date of Mr Raciborski's death contained any written record of a risk assessment. I found that in Mr Raciborski's case this absence did not impact his treatment and was not a causative factor.
>
> However my concern is that the failure to properly record the details of a risk assessment can lead to inadequate information sharing and the possiblity of someone who relies upon the records gaining the wrong impression. In addition it does not allow the adequacy of the risk assessments to be properly investigated and could hinder investigations into deaths; which mean that a matter giving rise to a risk to life may not be identified in future investigations.

Your report has been shared with senior colleagues at the Trust including the Chief Medical Officer, the Chief Nurse and the Clinical Director, the Service Director and the Associate Director of Nursing for Oxfordshire Mental Health. It has also been shared with our Patient Safety team, one of whose members attended the first day of the inquest in order to hear the evidence and your examination of evidence first-hand.

The team manager of the South Oxon Adult Mental Health Team also attended court on the first day of Mr Raciborski's inquest and has subsequently listened to the audio recording of your summing up and findings of fact on the second day. The team manager's attendance at the inquest in order to listen to the evidence provided further valuable insight into the contacts that the AMHT had with Mr Raciborski. Following the conclusion of the inquest, the team manager has taken local actions in relation to your concerns including (a) all supervisors in

the Wallingford, Henley and Thame service are attending supervision training to refresh skills and she has asked that this is extended to all of the teams in South Oxfordshire and (b) a meeting in relation to CPA discharge discussions, within which the team discussed risk and how to document assessments of risk. The team manager will also complete spot checks of clinical notes with a focus on the concerns that you identified.

More broadly across the Trust, we know that maintaining good quality and effective written records is a core requirement of clinical practice. Staff receive training to help them to do so and their clinical record keeping is reviewed and discussed in supervision sessions. The focus is to reduce the reliance on one word risk assessment summaries, and move towards increased therapeutic engagement with safety planning, which has greater evidence to reduce poor outcomes.

The Trust Core Clinical Standards in Mental Health and Learning Disability Care Policy gives colleagues guidance and direction as to the requirements and recording of risk assessment and information for both inpatient and community settings. We developed a clinical audit tool in the autumn of 2024 in order to check patient records against the policy and the standards to which we aspire. The tool reviews the following areas relating to the recording of risk information:

- A qualitative review of the quality and completeness of the risk assessment
- The timeliness of the review dates of the risk assessment
- A qualitative review of the quality and completeness of the risk management plan
- A review of the involvement of patients, relatives and staff in the development of the risk management plan
- The timeliness of the review dates of the risk management plan
- Assessment of the risk of suicide or self-harm and where indicated completion of a safety plan to respond to the identified risks

The Trust's Clinical Risk Assessment and Management (CRAM) Policy sets out the standards for assessment, formulation and recording of risk assessment. The policy was most recently updated in February 2023 and is due for next review in February 2026. I have asked the CRAM policy owner to consider if an earlier review is required, given your concerns.

I hope that this provides you with assurance as to the steps that the Trust is taking following the conclusion of the inquest and your concerns. Please do not hesitate to contact me if I can assist any further.

Yours sincerely,

[redacted]

[redacted]
Chief Executive