Inspected and rated Outstanding
CareQuality Commission

NHS
Dorset HealthCare University
NHS Foundation Trust

Corporate Office
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2 April 2025

Dear Sir,

Re: Regulation 28 Report to Prevent Future Deaths following the inquest touching on the death of Alexander Kieran Ari Channing

I am writing following your letter dated 31st January 2025, following the inquest touching on the sad death of Alec.

Firstly, I wanted to acknowledge the incredibly sad circumstances of this case. I was so sorry to hear about Alec's death, which I can only imagine must be a tragedy which his family and friends continue to live with. My thoughts are with everyone who knew Alec and with the staff who worked alongside him.

I acknowledge receipt of the Regulation 28 Report and the concerns you express as the Assistant Coroner overseeing the inquest, I note specifically the concern in relation to Dorset HealthCare NHS Foundation Trust ("Dorset Healthcare"):

> *There was a lack of involvement of a responsible clinician in the process of discharge planning from the district hospital in Exeter to the care of Bournemouth CMHT at Dorset Healthcare NHS Foundation Trust.*

We would like to provide an assurance that Dorset HealthCare is fully committed to learning and taking any steps necessary to prevent future deaths and we understand the significance and importance of Regulation 28 Reports.

Having carefully considered the concern described, we have again reviewed the circumstances of Alec's discharge from Royal Devon and Exeter Hospital (whilst under the care of Devon Partnership Trust). In terms of what took place, Dorset HealthCare was unfortunately not involved with discharge planning on this occasion, apart from being contacted by Devon Partnership Trust to arrange a psychiatric outpatient appointment for Alec. The normal arrangement between NHS providers is for discharge arrangements to be led by the team seeking to transfer care. Learning from the circumstances of Alec's death, we are seeking to strengthen our relationship with Devon Partnership Trust to ensure that there are effective and comprehensive discharge pathways between the two organisations.

Whilst we are confident that Dorset HealthCare does have relevant policies and procedures in place and our usual practice is to engage with discharge plans when patients are being transferred from areas outside of Dorset, this has been a tragic reminder of the need to

ensure this responsibility is understood by all of our clinicians and managers. We fully appreciate that we must take all steps possible across the NHS to facilitate the effective and well managed discharge of patients when they are transferring between services in different areas.

Following the conclusion of the inquest, feedback was provided at a local level at multi-disciplinary team meetings in the relevant area, this feedback included the concerns expressed by the Coroner and the experience of Alec's family.

Learning and Review Groups have been introduced in the Trust, in line with the Patient Safety Incident Response Framework, introduced in the NHS in 2023. They form part of Dorset Healthcare's organisational patient safety framework and are intended to share and disseminate learning across the directorates. Learning will be shared within the Learning and Review Groups at the next meeting which is scheduled for April 2025. The specific learning will be around the discharge of patients to and from services outside the Dorset Area.

I hope I have been able to provide reassurance that we have given proper consideration to your concerns and acted on the learning from this tragic case.

Yours sincerely

[redacted]
[redacted]
Chief Executive