NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

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Mrs Louise Hunt,
HM Senior Coroner,
Coroner's Court,
Steelhouse Lane
BIRMINGHAM B4 6BJ

Sent via e-mail only : [redacted]

Dear Mrs Hunt,

Our Ref: [redacted]

Your Ref: [redacted]

Date: 25 April 2025

Dear Mrs Hunt

Re: Prevention of Deaths report (Matthew Lynch Deceased)

Thank you for your Prevention of Future Deaths report dated 4 March 2025. May I take this opportunity to offer my sincere condolences to the Family of Mr Lynch for their terrible loss. As you will be aware the Trust carried out an investigation into the circumstances of Mr Lynch's death and a number of improvements in practice have been made in the Trust in order to ensure that we learn from the death and provide safer services. There were some areas you have identified requiring further action and assurance from the Trust and I will address each of these as you have set them out in your report.

1. **Internal Investigation**

As part of the transition to Patient Safety Investigation Review Framework, the review took a system-based approach to the investigation, focusing on the processes within which the team was operating. This approach allowed the Trust to identify weaknesses in key systems, including the identification and management of changes of address and medication compliance oversight.

The review acknowledged the risk of relapse identified in May 2023 on page 14, identifying that whilst plans were made within the Multi-disciplinary Team, there was no clear process to track these actions, leading to a lack of oversight. If there had been stronger oversight, the team would have been aware of the non-compliance with medication sooner, allowing for timely intervention. This would have included tracking the perpetrator's prescription. To address this, the team has now implemented an actions tracker to ensure better oversight of agreed plans and follow up.

In relation to the prescription, where the Community Mental Health Team is supplying a service user with their medication, this is recorded on the Electronic Prescribing and Medicines Administration System (EPMA). The Trust outlined at the inquest how this system now has better functionality and this

is monitored through the monthly medication audit, which is overseen by the Matron, followed up with individual service users by their Case Manager and reported through to the Integrated Community Teams Clinical Governance Committee and Trust Medicines Management Group for assurance.

The review also found the process for updating and tracking address changes was not robust enough. To strengthen this process as referenced in the report, the team has implemented a "meet and greet" role to improve the accuracy of address updates and ensure better coordination. I will go into more detail around this point under point three.

2. Mental Health assessments

At Inquest our witness gave evidence following the survey which had been carried out which identified that there were two areas where practice should be improved. These included:

Improved training for AMHPS and doctors. The Trust is working with colleagues at Birmingham City Council on this and there is training in place with Doctors and AMPHS.

Improve availability of identification of a named hospital which will admit / availability of beds. The Trust confirmed that actions on early identification of hospital with a bed which will admit the patient is challenging but work is ongoing though the Urgent and Emergency Care Pathway and Bed Strategy.

Following the inquest our Associate Medical Director for Mental Health Legislation has been working with Birmingham City Council on a short joint guidance for the doctors and AMHPS which will be included in the Trust's Mental Health Act Assessment policy. This is now a priority for the organisations and the aim is for this to be completed by the end of June. This guidance will progress through the relevant governance processes to ensure it is properly embedded in both organisations. The aim is that this will assist in ensuring that patients who are currently being admitted and need detention under the Mental Health Act are under a section that is most appropriate for them, in line with the code of practice. Assurance on appropriate use of the Mental Health Act is gained through the Trust Mental Health Act Committee and reported to Trust Board.

The Trust offers specific training to all trust section 12 approved doctors as part of their approved clinical reapproval training/ section 12 reapproval. This training is mandatory as part of the reapproval process and has been in place for the last 5 years. The Royal College of Psychiatrists offers this training to our Doctors. All doctors from the Trust on the section 12 rota and who participate in mental health act assessments for the Integrated Care Board are assured as section 12 approved. Once the joint guidance has been agreed, this will be used to train both doctors and AMHPs and be incorporated into our procedures.

3. Information sharing between agencies and support worker training

In terms of ensuring our service user demographic information is up to date we now have Meet & Greet workers based across our CMHT receptions to check with service users that the information we have on record for them is correct and up to date where necessary, this includes address, contacts and telephone number.

In addition to this, when checking the address is correct, the Meet & Greet workers now also ask what type of accommodation their address is, if it is identified that this is a supported accommodation or a hostel and this is recorded with the details. The service user will be informed that we will potentially share any information about their care or treatment if the need arises, or in case of an emergency. Any information being shared will be carefully considered as part of an MDT discussion/review and the decision to disclose information is proportionate to the circumstances. As a Trust we will always ensure that a patient's confidentiality and consent is adhered to.

We have also written to all clinical staff to remind them that if they are notified of a change of address (or contact number) that this is recorded on the service user demographic information in Rio, the electronic patient record, which updates the "front page" and not just in the "progress notes".

In relation to service users not being available when staff are visiting them at home. This is recorded in Rio following that visit, including; what attempts have been made to contact the service user and what the initial plan is in response to a lack of contact. Where there are repeated unsuccessful attempts, this is escalated to the MDT for discussion, review and a plan regarding the next steps. This is documented on the MDT action tracker, which is then monitored. The Trust will review the standard operating procedure for non-contact with appointments to ensure consistency in escalation to the MDT.

Following the review into the deaths in Nottingham, the Trust has reviewed the Did Not Attend policy and does not discharge patients following a lack of contact and is in the positive position of having an Assertive Outreach Team where specifically experienced case managers actively engage in the care provided to high risk individuals in the community.

We recognise the benefits of working in partnership with Birmingham City Council and Supported Housing Providers and will continue to commit to strengthening our joint procedures, relevant information sharing and enabling our professionals to work collectively at every opportunity.

I hope that the actions taken offer reassurance that the Trust has taken your concerns seriously. If you require any further information, please do let me know.

Yours sincerely

[redacted]

[redacted]
Chief Executive
BSMHFT