[redacted]
Chief Medical Officer
Carew House
Beacon Technology Park
Dunmere Road
Bodmin
Cornwall
PL31 2[redacted]
[redacted]r.cftinquests@nhs.net

10th September 2025

FAO Mr Andrew Cox, HM Senior Coroner for Cornwall and the Isles of Scilly
By Email: [redacted]

Dear Mr Cox

Regulation 28 Report for the Prevention of Future Deaths made following the inquest into the death of Mr Callum Hargreaves

I am writing in response to the Regulation 28 report, in my role as Chief Medical Officer for Cornwall Partnership NHS Foundation Trust.

I would like to firstly offer my sincere condolences to Mr Hargreaves' family. I am truly sorry for their loss.

I am grateful for the opportunity that your report has provided to clarify the Trust's position in relation to some of the queries raised within the expert evidence regarding discharge and safety planning.

You set out in your report that there did not appear to be evidence that Mr Hargreaves' decision not to inform his mother of his discharge was explored or tested by clinicians. Referring to GMC guidance, the expert felt that Mr Hargreaves'

reasons for declining consent could have been explored further with him. During the course of the inquest, the expert's indication was not tested out with the Trust's clinicians who had met with Mr Hargreaves, and this may have assisted with these concerns.

The Trust values family engagement in the context of the care and treatment of their loved ones. There are a number on ongoing initiatives which will ensure that contact and appropriate liaison with families is a priority. The details of these are

- Inpatient services have worked alongside carers to improve the information we provide at the point of admission, and we have processes in place to ensure that carers receive an information pack either in person, or through the post at the point that their loved one is admitted to the ward.
- Our inpatient environments now have assistive technology enabling remote attendance at clinical review meetings to improve family engagement with the admission and discharge process.
- Clinical review meetings are scheduled a week in advance giving family and carers the opportunity to link in with the ward team.
- Our daily priority meetings highlight those patients that require carer support or input, allowing the nurse in charge the opportunity to allocate a staff member the responsibility to make contact with carers and families.
- Family and carer involvement is embedded in the culture of the wards and is reported on and discussed at monthly performance meetings.
- We are trialling a carers audit to improve carer engagement, ensuring weekly contact is documented, and consent to share information is fully documented and continually updated on RiO. This audit also checks whether carers views are documented regarding care and treatment, discharge planning, and ensuring that any incidents of note are shared depending on consent.
- Each ward has an identified carers lead, and a working group has been established to consider how best to improve carer experience.
- The Trust has a 'Carers Corner' which is a forum specifically set up to support carers. This is a Trust wide initiative, although carers of patients on mental

health wards can attend the forum and we are publishing the dates when they meet.

- Carers are also invited to the 72-hour formulation meetings, allowing them the opportunity to talk about their concerns and worries and for the mental health team to get a good sense of risks and pre morbid presentation.

It is important that contact with family is balanced against the wishes of the patient in cases where their level of risk is not such that there are grounds to override confidentiality, or them expressly declining consent to share information. Where a patient is detained under the Mental Health Act, and therefore there is a compulsory admission to hospital, there is an obligation upon the Approved Mental Health Practitioner to contact their next of kin to inform them of this fact. In cases where a patient does not meet the criteria for detention, and they are not admitted to a ward, a clinical judgement needs to be applied to determine whether their level of risk justifies going against any wishes regarding information sharing. In most patients who would not be deemed detainable under the Mental Health Act, it is unlikely that there would be such grounds to breach confidentiality. Mental Health Act assessments generally require some aspect of intrusive and sensitive questioning of a patient, at times over a long period. There may be periods of reflection and time for the assessing team to consider the status of a patient's mental health away from the patient. Assessments may occur in a variety of complex and sometimes emotionally charged situations. The exploration of a patient's decision making is finely balanced by those hoping to build trust and acceptance from patients. At the same time, this is implicit in the process of rapport building and general approach to the assessment.

I am deeply sorry that Mr Hargreaves' mother was not aware or made aware that Mr Hargreaves was being released from hospital. Exploring the reasons for a patient declining to share information with family is appropriate in many situations. This would take place on a case-by-case basis, considering factors such as the patient's level of risk, their relationship with their family, the clinician's therapeutic relationship with the patient, the context of the assessment and the need to build longer term trust with a patient. Making contact with families on the basis of such assessment continues to be a significant focus of the Trust and is a priority for clinicians. However, the appropriateness of testing a patient declining consent, or overriding

their wishes, will also continue to be assessed through the lens of clinical risk on a case-by-case basis.

Yours sincerely,

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Chief Medical Officer

Cornwall Partnership NHS Foundation Trust