CORNWALL COUNCIL
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Mr Andrew Cox
Senior Coroner for Cornwall and the Isles of Scilly
Cornwall Coroners' Service
Pydar House
Pydar Street
Truro
TR1 1XU

Your ref:
My ref:
Date: 18 July 2025

Dear Mr Cox

RESPONSE TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS, Mr HUSSEIN RUJAK, HEAD OF SERVICE LEARNING DISABILITIES & MENTAL HEALTH, CORNWALL COUNCIL

We write in response to the Regulation 28 report (hereinafter referred to as the "Report" or "Reports") provided to the Council's Adult Social Care Operations (hereinafter referred to as "Us", "We", "Our") by the Senior Coroner on 28 May 2025 in relation to concerns raised following the inquest into the death of Callum Hargreaves.

We can confirm that we have also had sight of the "Response to Regulation 28 Report to Prevent Future Deaths provided to the Housing Options Service and would also wish to extend our deepest condolences to the family of Callum. We hope Our responses will go some way in assuring the family that, where improvements can be made, changes to existing practices and protocols will follow.

For clarity, and insofar as they relate to the local authority, we have extracted the points raised by the learned Coroner in the Reports, these are as follows:

The Report

"1. One issue that arose was whether Callum presented with an imminent and significant risk of harm to justify a short-term admission into hospital as is provided for in NICE guidance. [redacted] [redacted] said this was expressly discussed by the clinicians concerned. It was felt he was likely

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to be withdrawing and there were no resuscitation facilities available in Longreach. She also said the vulnerabilities of others on the ward needed to be considered all of which contributed to the decision not to detain Callum in hospital. She accepted that this rationale was not recorded in the notes.

2. *Callum was asked whether he wanted his mother (who he described as his rock) notified of his discharge. He said that he did not. This was not tested or challenged where GMC guidance is that it may be appropriate to do so. The Nearest Relative details on the MH 1 form were not completed.*

The expert who reviewed the case felt there were 'obvious gaps' in the record keeping and that as Callum's mother was one of the few levers available to the assessing team, Callum's decision not to involve her should have been explored further. You may feel these omissions should be learned from when assessments are conducted in the future and, in particular, when notes of an assessment are subsequently recorded."

The Concerns

From the points raised above, and consideration of the Reports in totality, We understand that the learned Coroner seeks Our response to the following discrete concerns:

1. The potential insufficiency of notes evidencing the rationale behind the decision not to detain Callum in hospital.

2. Whether Callum's instruction that he did not want his mother contacted about his admission should have been further tested, challenged or explored.

3. The adequacy of information recorded in notes.

Action Taken and Our Response

(For succinctness, Our response to 1 and 3 is set out at '1' below)

1. It is acknowledged that in every instance where an assessment as to an individual's suitability for a short-term admission into hospital is being made, the rationale for admission or non-admission should be clearly and accurately recorded. This is important to ensure consistency in approach, adherence to all extant policies and guidance and to ensure that any rationale underpinning any such decision can be fully understood.

   From the 14th of May 2025, the local authority has been proactively implementing a change in where Mental Health Act (MHA) assessments are recorded. This is a departure from the current practice of recording on the health database (RIO) to recording on the Adult Social Care database (Mosaic). This change will allow us to incorporate MHA assessments into our audit programme, thereby supporting improved quality and consistency in documentation and recording.

2. We accept that there was scope to explore and challenge Callum's capacitous instruction for us not to contact his mother more thoroughly and the views of the learned Coroner in relation to the information that was recorded.

   We have developed and disseminated guidance for Approved Mental Health Professionals (AMHPs) on safety planning following assessments. This guidance has been shared with all AMHPs within our service and is currently progressing through our governance processes before formal adoption. Upon formal adoption, it will be implemented immediately thereafter. Unfortunately, due to the systems of governance within the local authority, no more precise details about timetabling can be provided at this point.

   We believe that this guidance will provide greater clarity and assurance to practitioners on the appropriateness of departing from accepted protocols on client confidentiality in similar circumstances.

Closing Comments

We trust the above addresses the concerns of the learned Coroner and as contained in the Report. We hope that the action taken and the steps the local authority intends to take provide the assurance required.

We are grateful to the learned Coroner for his findings and for the opportunity to respond. We would echo the sentiments of the Council's Housing Options Service and would also like to assure Callum's family that the local authority will continue to work to improve practices to support the residents of Cornwall.

Yours sincerely
Dhywgh hwi yn hwir

[redacted] **- Head of Learning Disabilities and Mental Health**
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