Hampshire and
Isle of Wight Healthcare
NHS Foundation Trust

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[redacted]

17 September 2025

HM Assistant Coroner Henry Charles
Hampshire, Portsmouth and Southampton Coroners Service
Castle Hill
The Castle
Winchester
SO23 8UL

[redacted]

Dear Mr Charles

Please find enclosed the Trust's response to the Regulation 28 report issued following the inquest into the death of Samantha Young. There has been considerable discussion of the issues you raised and the response has had input from a number of executive directors as well as senior clinical staff.

I trust our response helps you understand the steps we are taking to address these areas and that you will not hesitate to contact me should you have any further queries.

Yours sincerely

[redacted]

Chief Finance Officer, Deputy Chief Executive and SIRO

Enc.

A. Assessment of the risk that a patient poses to themselves or others is clearly a cornerstone of the work of an NHS Trust dealing with mental health. At the material time there was a lack of any training as to compilation of risk assessments. I was informed by a senior manager of Hampshire and Isle of Wight Healthcare NHS Trust that with the translation of Southern Health NHS Foundation Trust into the new Hampshire and Isle of Wight Healthcare NHS Foundation Trust that issue of training is being addressed. However it emerged at the inquest that there do not appear to be any firm plans to train agency staff. Agency staff form a significant percentage of frontline staff. Hampshire and Isle of Wight Healthcare NHS Trust should review its provision of training for agency staff, in particular in respect of risk assessments.

Ensuring we have a workforce that is both competent and confident in carrying out key activities to provide safe care to the patients we support is a high priority for us as an organisation. As such we have recently reviewed our training offer to ensure that staff are allocated role specific core training alongside their mandatory training requirements.

As was described in evidence at the inquest, a programme of risk management training is being developed for staff working in mental health services in order that this is standardised across our relatively new organisation. The finer details of the programme and practical elements such as mode and duration of delivery are being worked through, and the intention is to roll the programme out across the organisation in 2026.

By way of some context, it is important to note that risk management, for a mental health registrant, will have been an integral part of core training. Student nurses' skills in risk assessment will be assessed within every student placement undertaken and form a core competency that must be met and signed off prior to successful completion of nurse training. In that respect, the risk training we will be providing to our staff is intended to be a refresher which allows for the most recent best practice to be reflected upon, thereby maintaining confidence in practice.

The position in respect of agency staff and training is a complex one. On the one hand, agency nurses are not our employees and often are a very transient part of the workforce. They are employed via their agencies and typically do not have access to the in-house training programmes of the various NHS Trusts they work at for a number of logistical and financial reasons.

By virtue of choosing to work via an agency, their access to training will typically not be through a single training department as would primarily be the case for staff employed by the NHS. Instead, whilst many agencies will provide access to statutory and mandatory training, it is the responsibility of the agency nurses to maintain their continuing professional development beyond this by accessing any additional training they may deem necessary. This can be from a multitude of different routes including accessing private training providers, freely available e-learning programmes or through professional journals, attending conferences/workshops etc. This onus on registrants to take responsibility for remaining competent in their area of practice is clearly set out in the Nursing and Midwifery Council's Code of Conduct.

It is unfortunately not feasible for an NHS Trust - already incurring significantly higher costs for agency staff - to also absorb the additional expense of providing them all with access to the full training programme offered to its own employees, particularly when there is no guarantee that the agency member will return to the Trust after their initial placement.

All that being the case, we of course recognise that we have a duty of care to ensure that our patients are being seen by staff who are qualified and competent to do so, whatever their contractual position in so far as employment goes. Whilst this duty of care is in part discharged through the frameworks

which govern the agencies in question (which require them to ensure their staff are appropriately trained) we are keen to explore what more we can do.

Given the specific focus on risk management arising from this case and more generally, we are considering ways in which we can support agency staff to develop in this area.

The particular group of agency staff we are keen to prioritise are those staff working in the community where they are likely to be on longer term placements. By the nature of their work in community teams, they will hold a more central role in the risk assessment, formulation and management of a patient.

Pending the roll out of our new risk management training programme for our staff, community mental health teams are now receiving bespoke risk management training sessions delivered on a team-by-team basis at their local base. These sessions are open to both agency and substantive staff.

Work is also underway to agree what training material can be shared with the agencies we contract with in order for them to signpost this to staff who are due to be starting on our longer-term placements. By way of an example, at the end of August 2025, NHS England released an e-learning programme called *Staying Safe from Suicide.* It is accessible for all staff including those working in the private or voluntary sectors. We intend to make this one of the training modules that the agencies we work with will need to signpost staff to prior to them accepting a community placement with us.

In planning the delivery of our new risk management training programme we will also consider what other 'pre-course' material it would be useful for staff to have reviewed. Any additional material identified will be passed to agencies in the same way as above.

When we roll out the new risk management training programme we will also ensure it is available for long-term community agency staff to attend in the same way that it is for our substantive staff.

A new induction checklist has also been introduced that substantive staff go through with agency staff when they commence a placement. Following receipt of your report, this is being revised to include a specific prompt and self-declaration around risk management competency.

We believe the above steps will help encourage agency nurses to focus on risk management as one of the key areas for their ongoing professional development where they are working in roles that see them at the centre of risk assessment, formulation and management. As with our substantive staff, access to supervision and the wider multidisciplinary processes in place are additional key components in supporting these agency staff with the management of risk.

Whilst the above steps will ensure our long-term community agency staff are on a similar footing to Trust employees in respect of risk management training, the situation is admittedly more complex with our more transient agency workforce. These are staff who might have as little contact as attending a ward for a single shift with very short notice and who do not then work for the Trust again for several months. This staff group do not undertake the type of risk formulation and management that our longer-term community agency nurses do. We will be asking the agencies we work with to specifically ensure that these staff have maintained their competence in risk management but need to be upfront about the fact that logistically the other measures described above are not possible to take with this group.

Ultimately, we are seeking to reduce our reliance on agency staff to ensure a more consistent workforce. There has been a huge amount of work undertaken already and we have seen significant reductions as a result, with our agency use reducing by 65% between September 2023 and August 2025.

B. Wider family and friends of the deceased perspective were not contacted. A patient's family and friends are clearly an invaluable resource for learning more about a patient's mental health and specifically risk to life, the support available to the patient and the potential for synergistic support with the NHS Trust. This PFD is not the first time that the issue has been raised with Southern Health NHS Foundation Trust: in 2023 the Senior Coroner for Hampshire, Portsmouth and Southampton issued a PFD on similar grounds arising out of the inquest into the death of Kirsty Taylor. The Senior Coroner observed in the PFD that "I remain concerned (as it is a matter I have raised on many occasions at inquest and again as a result of the experiences of the family in this case), that communication with the families of patients with mental health difficulties is still not being effectively achieved. Nor are such families being sufficiently, effectively and meaningfully listened to or understood when they voice concerns, based on their experience of the patient outside of a treatment or assessment environment. Consequently, I am concerned that such matters are not being reflected sufficiently or frequently enough in the onward treatment of those patients or in the clinical curiosity afforded to their conditions." Moreover, in 2021 a report commissioned by NHS England into Southern Health Foundation Trust similarly reported on shortfall in communication with families.
Hampshire and Isle of Wight Healthcare NHS Trust should review guidelines and procedures concerning communication with family and friends of patients with mental health difficulties by its permanent and agency staff, and monitoring of whether such communication has taken place.

We are saddened by the concerns raised by Samantha's family regarding their experience of care, and we extend our sincere condolences for their loss. We recognise the importance of listening to families and learning from their lived experiences, especially when they feel let down by the care provided.

The Trust takes the findings of this Regulation 28 report seriously. We also acknowledge the reference to previous reports, including an earlier Regulation 28 and the wider NHS England report from 2021. This latter report was instrumental in shaping a significant programme of improvement across the organisation, particularly in how we engage with families and carers.

While we accept that Samantha's family's experience highlights areas where further progress is needed, it is not reflective of the Trust's overall approach or the substantial work undertaken to improve carer engagement. The Trust serves a large and diverse population - we have a team of over 13,000 staff, who provide services across 500 different sites, in people's homes, GP surgeries, care homes, community hospitals and general hospitals. Despite our best efforts, and the ability to evidence significant programmes of work seeking to improve carer engagement, there will be occasions where individual experiences fall short of our expected standards. These instances are deeply regrettable and are treated as opportunities for reflection and learning.

We are committed to ensuring that every family feels heard, respected, and involved in the care of their loved ones. In the sections that follow, we outline the programmes of work that are in place as we seek to embed a culture of compassionate, inclusive care across all services. We also share the key findings from our internal auditors which confirmed that we have robust guidelines and procedures in place in this regard.

Collaboration with Partners and other Organisations

We work collaboratively and in partnership with a number of carer organisations and partners. A number of these carers organisations and carers and families have been engaged in the process to develop a new strategy for our newly formed organisation which was launched in June 2025.

The Trust works in collaboration with Hampshire Carers Together who are responsible for delivering the Joint Carers strategy for Hampshire. We are a member of the action group, and this enables us to ensure that our work is aligned. The Portsmouth Carers centre also published their carers strategy and they are now members of our Carers, Families and Friends group.

Triangle of Care

The Triangle of Care is an initiative promoted by the NHS, developed by the Carers Trust, to foster a therapeutic alliance between the service user, their family or carers, and the professional staff involved in their care. It emphasizes partnership, communication, and shared responsibility to promote safety,

support recovery, and sustain the wellbeing of both the service user and their carer. Having rolled out the programme to legacy Southern Health staff over a number of years, we are now introducing the Triangle of Care framework to our staff in Isle of Wight and legacy Solent teams (who merged with Southern Health last year to become Hampshire and Isle of Wight Healthcare). Much of this training is co-delivered with carers, carers leads and a former service user with their carer. The training has recently been updated in coproduction with carers.

The aims of 'triangle of care' are clear:

- Carers and the essential role they play should be identified at first contact or as soon as possible thereafter
- Staff are "carer aware" and trained in carer engagement strategies
- Policy and practice protocols re confidentiality and sharing information are in place
- Defined post(s) responsible for carers are in place
- A carer introduction to the service and staff is available, with a relevant range of information across the care pathway. E.g. Trust Carers Booklet.
- A range of carer support services is available.

The introduction of Esther coaching has further enhanced and reinforced the Triangle of Care principles. Esther Improvement Coaches are specially trained dedicated members of staff who support the development of other staff to create a culture of continuous improvement to ensure person-centred care. User involvement is integral to the model, building a network around the patient including family, friends, and key staff.

Currently we have in excess of 90 staff members as ambassadors. This training is unique to us as we decided that we needed a way of sharing and promoting ESTHER by involving more staff in the project. Having ESTHER ambassadors helps us to share the ESTHER message far and wide and gives us a strong network across the organisation. The ambassadors form a key part of our Trust-wide ESTHER network, which meets on a quarterly basis to share best practice, learning, and updates about ESTHER. They also get updates via email which they can share with their teams/ divisions and networks. In addition, we offer Esther coaching courses.

The aim of the coaching course is to upskill staff in soft skills such as coaching skills/ managing conflict/ storytelling and how to facilitate this, as a few examples. We look at topics such as consent to share, person-led care planning, and collaborative working. We also spend time exploring how we can make stories more central to our work and run sessions or ESTHER cafés where people can share their story with the team.

As an example, one of our coaches is from our Early Intervention in Psychosis (EIP) team and they have since used ESTHER and its principles to launch a project focused on how they work with carers and families. This started as an ESTHER café, and the feedback and stories shared at this have then helped develop their quality improvement project and carers continue to be involved. They meet monthly and have had positive feedback from those involved:

- "It feels a real listening, sharing & collaborative space. I can also see this sharing actually translating into real & tangible outcomes." – a carer.
- "The meetings are very inclusive and my views are listened to and openly received. It is very positive that EIP is actively seeking change in Mental Health services." – a carer.

<u>Carers Champions (Carers Leads)</u>

To support our focused work with carers and families there are Carers Champions in each team, and additional Carers Champions considered as "honorary" Carers Champions across the Trust. There

were 165 Carers Champions at the end of the 24/25 financial year and 56 Honorary Carers Champions. (Honorary Carers Champions are the ambassadors and influencers for all things carer-related).

Carers communication/information plans

Our new Carer Information Plan officially launched in May 2025, and is available for all services, replacing the previous Carer Communication Plan. Carers were involved in the development of our new plans and the response has been overwhelmingly positive.

This isn't just a system update but instead is a meaningful shift in how we recognise, value, and support carers across our Trust. Now live in our electronic patient record, RiO, the Carer Information Plan helps staff easily record key details about the carers involved in a service user's life, making sure their voices are heard and their contributions are acknowledged.

What makes this plan special is its focus on what really matters. It goes beyond basic information to include communication preferences, the kind of support carers provide, and personal insights like routines, hobbies, and known triggers of the service user. These details help us deliver care that is truly person and family-centred, strengthening the partnership between carers and care teams.

We have also built this plan with privacy and protection in mind. It includes clear consent protocols and separates information appropriately, ensuring we meet GDPR requirements while staying true to the principles of the Triangle of Care.

Feedback has been really positive - staff have told us the plan makes it easier to connect with carers and tailor support. Carers have shared how valued and included they feel with many saying it is the first time their role has been properly recognised in this way.

Information Sharing

Policies and protocols with regards to information sharing (including the issue of capacity) are also in place. The Trust promotes the importance of both the 7th and 8th principles of the UK Caldicott Guardian Council in recognising the importance of the duty to share information being as important as the duty to protect patient confidentiality. They are included with our Triangle of Care work and information governance (IG) training. IG training is completed annually by every member of staff which will help to embed these principles further.

Information sharing remains a real focus of ours and we take every opportunity to champion this work. Our Carers booklet, which was co-produced with carers and is handed out to family/carers whenever they come in to contact with services also has specific references to information sharing.

Obtaining and providing feedback

The Trust has increased the number of ways that people can give feedback and opportunities to share their experience. This includes Carers groups, storytelling events, carers forums, surveys etc. We have a number of carers groups across the Trust, as well as supporting external groups. Most recently, the Trust has funded and supported the setting up of a BAME carers group in Southampton and continue to fund an adult mental health carers group from diverse communities. Feedback and issues highlighted from these different platforms is reported to the services involved, the Carers, Family and Friends group and the Patient Experience and Caring group as part of our business-as-usual reporting. As we develop our new Trust, an overarching Experience of Care group will be established and an unpaid carers group will report into the Experience of Care group.

Independent assessment of Trust performance in this area

In December 2023, representatives of the Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) and NHS England (Southeast) reviewed evidence provided by the Trust to demonstrate sustained improvement against a number of actions that had arisen from the 2021 NHS England

report referenced in this Prevention of Future Deaths report. They found that there had been considerable efforts made by the Trust and its staff to demonstrate improvement across the following key areas:

- Complaints handling
- Communication and liaison with patients' families
- Investigative structure and process to conduct transparent and fair investigation into serious accidents, deaths and complaints
- The extent to which recommendations from previous investigations have been developed, implemented and monitored.

In continuing recognition of the importance of carer engagement, the Trust last year commissioned an independent audit of this area. Specifically, the purpose of the audit was to review the adequacy of the Trust's arrangements for involving and listening to carers in order that the Trust learns from their feedback and experiences. This was undertaken by our Internal Auditors—an external professional organisation specialising in governance and assurance. Their involvement reflects the seriousness with which the Trust approaches this issue.

Received in January 2025, the independent audit report found *'there are comprehensive guidance and robust processes developed to ensure the national Carers Strategy and Triangle of Care guidance are followed across the Trust. A Carers Plan is in place to track ongoing actions and initiatives related to supporting carers. Triangle of Care standards are well communicated to all staff through training and engagement events. A robust governance structure has been established (prior to merger) to ensure effective oversight on the Carers Plan and carers' feedback, which is collected through various channels, including surveys, engagement events, and meetings.* On this basis it found the control design to be 'Substantial'.

The audit report goes on to find*: 'The control effectiveness is Moderate as the Trust has been monitoring the Carers Plan and improvement initiatives properly with sufficient evidence available to prove their delivery progress. However, while the Trust uses OpenRio to record patient and carer information, it does not currently capture all essential data, which could limit its ability to monitor carers identification and support provided. Moreover, new roles and responsibilities of the Carers team are still being defined post-merger.*

The data issue has been remedied with the information now captured on our data insights visualisation platform. Furthermore, the Trust is now nearly 1 year post merger, resulting in greater alignment in the Carers function across the new organisation with further work ongoing in this regard.

<u>Agency staff</u>

The Trust recognises that high-quality carer engagement must be embedded across all teams, including those supported by long-term agency staff. To this end, both the Triangle of Care training and the Esther coaching is delivered in a number of different formats to maximise access and this includes it being available to agency colleagues working in community placements.

In addition to formal training, agency staff are immersed in the culture and practices of the teams they work within. These teams will promote carer involvement through the work of carers champions and agency colleagues are expected to uphold the same standards. Furthermore, all staff, including agency workers, are required to complete the Carers Information Plan described above as part of their record keeping, which ensures that carers are identified, informed, and supported throughout the care journey. This approach helps ensure that carer engagement is not dependent on employment status but is a shared responsibility across the entire workforce.