NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

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[redacted]

Private & Confidential
Sarah Murphy (Area Coroner for Cheshire)
Cheshire Coroner's Service
Museum Street
Warrington
Cheshire
WA1 1JX

Date: 3 November 2025

Dear Madam,

We write in response to the Regulation 28 sent to the Chief Executive

CORONER'S CONCERNS
During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:
That Ms Tetley was removed from the inpatient bed list on the 25 June at 10:37 hours before an attempted review by a mental health practitioner at 11:30 hours the same day. Following daily documented reviews between the 18 June 2024 to the 24 June 2024, it was documented that Ms Tetley required inpatient admission and daily reviews. I am concerned that there is a risk that patients are removed from the inpatient bed list before an appropriate review that day, by a mental health professional.

Trust Findings

The Trust has conducted an internal review into the care of Ms Tetley, focusing on the period between 18 June – 25 June 2024 and subsequent follow-up.

It outlines what happened, where processes failed, and what organisational learning has been identified across four key domains:

1. Record keeping and communication.
2. Assessment and admission decisions
3. Clinical governance and escalation
4. Learning and system improvement

On the 18th of June 2024 Ms Tetley presented to the Accident and Emergency Department (AED) with active suicidal ideation (intention to jump in front of a train). She was awaiting an informal admission for safety and initiation of depot medication. Daily reviews by *First Response* continued until 24 June 2024. Ms Tetley also had a Consultant and Key Worker in the community.

On the 25 of June 2024 the Trust held a Clinical Prioritisation Meeting. At this meeting there was a Multidisciplinary Team (MDT) decision made to remove Ms Tetley from inpatient bed list, the rationale was she was viewed as requiring support for her homelessness status rather than having an acute mental illness that required inpatient admission. Ms Tetley's consultant (Dr Singh) and Community keyworker were *not* involved in the decision; however, they had the opportunity to attend the meeting. They raised concerns about the safety of Ms Tetley not being admitted on the 25 June 2024 after she had left AED, their concerns including her vulnerability as she was homeless, she did not have any medication and there was no safety plan in place. These concerns were raised with the Operational lead from First Response who stood by the MDT decision that admission to an acute inpatient bed was not required.

On review the MDT decision was not documented within Ms Tetley's clinical record (breach of CP3 Health Records Policy). The Clinical Prioritisation Meeting is held daily and all patients who are waiting for admissions to a mental health inpatient bed are discussed and prioritised based on their clinical needs. The meeting was chaired by a Senior Clinical Lead from the First Response service, with Home Treatment (HTT) and Liaison Psychiatry leads, medical support, Patient Flow Team in attendance. This meeting supports the allocation of inpatient beds based on the severity of clinical presentation, safety concerns, and the appropriateness of admission. The reviews that are completed within the meeting are patient-centred and risk-informed, ensuring that decisions are guided by the person's individual need.

During the Clinical Prioritisation Meeting on 25 June 2024, there was difference between Ms Tetley's clinical records and the meeting minutes. Ms Tetley's clinical record stated that she believed that an admission was her only viable path to recovery, whereas the minutes from the Clinical Prioritisation Meeting stated that the Home Treatment Team did not consider that an inpatient admission was indicated for Ms Tetley and recommended exploring the homeless pathway prior to removing her from the inpatient list. Ms Tetley's wishes to be admitted do not seem to have been considered or discussed at the meeting.

During the Clinical Prioritisation Meeting, a discussion took place between the First Response staff regarding Ms Tetley's current presentation and care needs. Following clinical review and consensus among all attendees, it was agreed that she would be removed from the inpatient bed list. The decision was based on the assessment that Ms Tetley's primary need at that time related to accommodation rather than acute mental health admission, and that her care would be better supported through appropriate housing interventions.

Ms Tetley was removed from the bed list before a further clinical review by the Mental Health Practitioner: this was planned for the 25 June 2024.

The Mental Health Practitioner attended A&E on the 25 June 2024 but did not assess Ms Tetley directly (she was asleep). The decision not to admit was based on previous daily reviews

and A&E staff feedback. On review there is individual learning for the member of staff, and this is being addressed via supervision

Ms Tetley later learned of the decision not to admit, became highly distressed, and expressed renewed suicidal intent to her Probation Officer. Ms Tetley's keyworker, Consultant and Probation Officer had raised urgent safety concerns. The concerns by the Key worker and Consultant were raised to the Operational Lead for First Response who stood by the decision made at the Clinical Prioritisation Meeting. On review the Trust has identified learning around the escalation of clinical differences which is detailed further below,

Following Ms Tetley leaving the AED on 25 June 2024, her community Keyworker, and the Home Treatment Team (HTT) tried to contact her via phone, initially voice messages were left as the calls went direct to her answer phone. Contact was made with Ms Tetley by her Community Keyworker on the 3rd of July 2024, following this there were a further six appointments with her Community Keyworker as well as three telephone contacts, on one occasion Ms Tetley attended AED. It was difficult to remain in contact with Ms Tetley as she moved accommodation three times during this period. On each visit a full Mental Health Assessment was completed, noting admission to a psychiatric inpatient unit was not indicated.

A full 5 P Risk formulation was completed on the 19 September 2024 by Ms Tetley's Community keyworker. A 5 P Risk Formulation is a structured framework used in mental health to understand and manage an individual's psychological difficulties and potential risks; it helps clinicians build a comprehensive formulation by exploring five key areas. This was the last contact with Ms Tetley before her tragic death.

Key Findings and Learning Points

1. **Record Keeping and Communication**

- Differences between clinical records and the Clinical Prioritisation Meeting minutes. Ms Tetley's wishes to be admitted do not seem to have been considered or discussed at the meeting
- The Clinical Prioritisation Meeting Multidisciplinary Team (MDT) decision was not recorded within Ms Tetley's Clinical Records (SystmOne), this is a breach of the Record Keeping policy.
- Fragmented communication across teams First Response, Home Treatment Team, Liaison Psychiatry, Community Mental Health Team
- **Learning and actions**
    - All clinical decisions must be contemporaneously recorded in the patient's record.
    - Clinical notes must align with multidisciplinary discussions made in meetings.
    - Administrative support has now been added to ensure meeting outcomes are entered into SystmOne.
    - Safety messages ("Safety Soundbites") have been shared with staff highlighting the fragmented communication between the teams and importance of aligning clinical notes with multidisciplinary decisions. A safety soundbite is a brief, focused statement used to highlight a key safety concern and associated actions and

ensures that important safety information is communicated clearly and efficiently across the Trust.

2. Assessment and Admission Decisions

- The decision to remove Ms Tetley from the bed list was made on 25th June, 2024 however prior to her leaving AED there was no assessment completed on 25th June as she was sleeping and did not receive a daily review: this is not in line with clinical safety standards. The Mental Health Practitioner relied on indirect information (A&E staff handover) and previous daily assessment completed by First Response staff instead of completing an assessment.
- Missed opportunity to review Ms Tetley, communicate compassionately with her and review her.
- **Learning:**
  - Patients awaiting admission *must* receive a daily face-to-face clinical review before any removal from the bed list.
  - Practitioners must complete assessments even if the patient is asleep (return later if necessary).
  - Decision-making should always be informed by updated clinical evaluation and patient engagement.
  - All teams who are directly involved with the patient must be involved in decisions and their care, so care is delivered safely, and patients have what they need e.g. a safety plan and medications.

3. Escalation and Governance

Ms Tetley's Consultant [redacted] and her keyworker disagreed with the decision not to admit but were unaware of the decision until after she left A&E

- No clear process existed for discussing care or escalating clinical differences of opinion.
- **Learning:**
  - A new **Standard Operating Procedure (SOP)** – *Escalation Process for Clinical Differences of Opinion – Mental Health Bed List* – has been developed and is under peer review. This ensures clinical disagreements are escalated to Clinical Directors promptly.
  - A **Patient Flow Meeting** now follows the Clinical Prioritisation Meeting to ensure decisions are discussed and communicated across all teams. This meeting focuses on the admissions and discharge planning for all inpatients across CWP.

4. Compassionate Communication and Patient Engagement

- Ms Tetley was not informed of the decision regarding her care in a compassionate or supportive way. This omission caused significant distress and upset to Ms Tetley
- **Learning:**
  - Clinical reviews must include direct, compassionate communication with patients.

- Decisions affecting safety and wellbeing must be explained clearly to the patient and care team.

System Changes Implemented

- Outcomes of Clinical Prioritisation Meetings are now directly documented in SystmOne. Administrative support embedded within First Response to ensure record accuracy.
- Establishment of the Patient Flow Meeting to ensure consistent communication across services and all teams.
- Introduction of an open invitation for all clinicians to attend the Clinical Prioritisation Meeting to provide key clinical history and information to inform decision making for patients.
- Development of the SOP for Escalation of Clinical Differences.
- Reflective supervision undertaken with the Mental Health Practitioner involved.
- Reinforcement of training around record keeping, communication, and risk-informed decision-making.

The care provided to Ms Tetley did not meet expected standards. There were lapses in assessment, communication, documentation, and compassionate care. The Trust acknowledges the distress this caused Ms Tetley, and we are deeply sorry for this. There is significant learning for the Trust, and we have taken steps to ensure we deliver high quality care to others and reduce the risk of this happening to other patients. The Trust will be issuing a formal apology to Ms Tetley's family and acknowledge the harm caused.

Yours faithfully

[redacted]

[redacted]
Chief Executive
Cheshire and Wirral Partnership NHS Foundation Trust