NHS
Coventry and
Warwickshire Partnership
NHS Trust

Our Ref: Wayne Pierce Walton [redacted]

9 March 2026

Ms Deborah R Lakin,
HM Assistant Coroner,
The Coroner's Office,
Coventry City Council,
Manor House Drive,
Coventry,
CV1 2ND

Dear Ms Lakin,

**Re: Inquest touching the death of Mr Wayne Pierce Walton**

I am writing to you in response to the Regulation 28: Prevention of Future Deaths Report, which was received from your office on 19 January 2026, following the inquest conducted in respect of the death Mr Wayne Pierce Walton. Staff from the Trust were grateful for the opportunity to give evidence at the inquest, including sharing our work to improve the care and safety of those who use our services.

Your summary of the inquest included reference to key points, which were raised by yourself and members of Mr Walton's family, and for which you requested the Trust consider and provide a response back to you. I have set out the two points and a response below.

1. *Staff involved in the decision-making process for a patient's discharge as an inpatient, into the care of the Home Treatment Team, were unaware of the policies applicable to the Home Treatment Team and were therefore unaware of the requisite information that should have been added into Risk Assessments and Safety Plans, for the benefit of their colleagues in the Home Treatment Team. As risk assessment and risk formulation documentation had not been adequately completed, the Home Treatment Team were not able to identify a full and up to date risk analysis. Had the inpatient staff been aware of the importance of these documents for their colleagues' benefit, in addition to the need for accurate completion for internal reasons, there was a risk that important information was not passed on.*

Our investigatory work from the Patient Safety Incident Investigation (PSII) report PSII2172, focused on learning and improvement, ensuring staff are supported to understand the processes to embed effective documentation of a person's risk, as well as Trust processes to support safe discharge and/or transition between services.
We are revising our Standard Operating Procedure (SOP) for *Internal Transfers within Adult and Older Adults Mental Health Services* (version 5), to reflect the function and structure of the new Electronic Patient Record (EPR) system (SystmOne), and provide clearer guidance on the agreed date of handover of care, the continuation and ownership of care packages during transfer, and the requirement for a joint handover meeting between teams, with an agreed date understood by all.

Once ratified, we shall audit our internal transfers between teams to assess compliance, as well as any further opportunities to gain experience, on an ongoing basis.

You will be aware that staff who attended the inquest, shared examples of the improvement work services are engaged in, which I have set out below, alongside other developments which I feel important to share, as part of a comprehensive response.

**Clinical Risk Assessment**

The Trust is one of ten organisations nationally participating in the National Collaboration Centre for Mental Health programme, supported by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) and led by NHS England (November 2024 to March 2026).

This programme focuses on the co-production of personalised inpatient safety planning, ensuring our local approach is shaped by national evidence, expert guidance, and the lived experience of patients and carers (*Appendix 1)*.

As part of this work, the Trust has launched the updated *Risk and Safety* section within the EPR, supported by a demonstration package and quick reference guide to assist staff in embedding the new approach into practice. This enhancement strengthens clinical safety, improves the quality of documentation, and aligns practice to national guidance.

To ensure the system is delivering the intended quality and safety benefits, our next steps, following the EPR launch, are to:

- Repeat the audit, which will assess alignment to *Staying Safe* guidance and measure the impact of the new system on documentation and practice
- Receive feedback from patients and staff, collecting, analysing and reporting feedback from patients regarding involvement in safety planning, alongside staff confidence and usability data
- Implement iterative improvement of documentation, learning from post-launch feedback to inform further refinements to the EPR templates and workflows, to maximise effectiveness and ease of use.

**Discharge Planning**

The Trust has a clear and well-governed framework in place, to support the safe and effective discharge of patients from its inpatient mental health services. Discharge planning commences on admission and is overseen through regular multi-disciplinary team (MDT) review, with crisis teams routinely involved to support early identification of needs and safe transition.

The process is guided by the Trust's *Discharge from Inpatient Mental Health Wards* SOP (V1.1, February 2025) and the Trust's *Bed Management* Policy, which set out defined responsibilities, standards, and safety requirements, to ensure consistency across all wards.

The Trust systematically reviews patient and carer feedback and incidents which staff report, to support monitoring the quality of discharge planning and application. A structured audit, aligned to the *Discharge from Inpatient Mental Health Wards* SOP, has been introduced to provide additional assurance regarding the quality of documentation, safety planning, and involvement of patients and their families or carers *(Appendix 2).* Collectively, these arrangements ensure safe, effective, and well-governed processes in place to support safe discharges.

Regarding the second point you raised with the Trust:

2. *There is in existence, a policy entitled "Personal Relationships at Work" which addresses personal relationships of a particular type, but which does not address the potential for a conflict of interest when a member of staff, or a person shadowing a member of staff, recognises that they may know a patient other than because of a personal relationship as envisaged in the aforementioned policy. The absence of guidance on how to manage this situation, may place both the member of staff and the patient at risk of harm.*

In developing our response, it is important to acknowledge the clinical context in which practitioners may operate, when caring for individuals with complex needs and often social circumstances which can be challenging. Clinicians are required to balance risk, need, and individual preference, whilst working within dynamic and, sometimes, unpredictable environments.

The Nursing and Midwifery Council (NMC) Code (2015) establishes firm professional standards acknowledging that nurses must apply their professional judgment and discretion when making decisions in circumstances which may be complex, time-pressured, or unprecedented. This includes adapting care approaches to meet specific needs of the individual, provided such decisions are evidence-based, clearly reasoned, and demonstrably in the person's best interests.

The Trust has introduced an addendum to strengthen existing governance arrangements and provide clearer guidance for staff (*Appendix 3*), included as an appendix to the existing *Personal Relationships at Work* policy. It introduces a clear process for managing situations in which staff recognise patients through non-personal prior acquaintance, such as community links, former workplaces, school settings, or casual social connections and aims to support in ensuring professional boundaries are maintained and care remains impartial, safe, and centred on the patient's best interests.

The guidance strengthens organisational expectations around professional boundaries, reminding staff to pause, assess risk, notify managers, and follow agreed escalation pathways whenever prior community or social links could impact safe and objective care. The guidance applies to all staff groups, including students and observers, and is underpinned by the NHS shared decision-making principles, and expectations for confidentiality and staff wellbeing.

I trust the above provides you with further assurance that the Trust has responded to the findings of the inquest. We will continue to take the opportunity to gain experience from safety events in healthcare and to support the coroner's office to conduct their inquest responsibilities.

Yours sincerely,

[redacted], Interim Chief Nursing Officer, CWPT

Copy: [redacted], Chief Nursing Officer, NHS Coventry and Warwickshire and NHS Herefordshire and Worcestershire