

Trust Headquarters

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28 September 2026

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

Report to Prevent Future Deaths - Mr Richard Laversuch

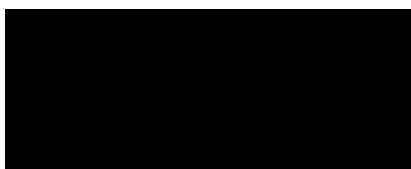
Dear Mr Walker,

I write further to your report of 5 August 2026.

The Trust fully accepts the seriousness of the concerns raised and remains committed to learning from the tragic circumstances of Mr Laversuch's death.

We are grateful for the careful consideration given by the Court and by Mr Laversuch's family and welcome the opportunity to provide assurance regarding the actions taken and planned in response to the matters identified.

Yours sincerely



**Executive Chief Medical Officer
HIOW Healthcare NHS Foundation Trust**

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I am concerned that five years after the death of Mr Laversuch there is not in place a clear and readily understandable policy framework and guidance for the admission of patients into wards after their detention has been authorised under the Mental Health Act and that there remains, on the evidence heard at inquest, a failure by some staff to understand what is required of a safe risk assessment.

I recognise and accept that there have been efforts to learn from Richard's death and formulate the appropriate guidance, but I am concerned that they are still not clear so long after his death. I am concerned that a patient who poses a significant risk to themselves and others may be admitted to ward unsuited to their risk and that there is a risk of future deaths.

Response to the Coroner's concerns

The Trust accepts the two concerns identified in the Report to Prevent Future Deaths: the need for a clear operational framework for admission following authorisation of detention under the Mental Health Act, and the need to ensure that staff understand and apply safe risk assessment. The actions below are intended to reduce the risk of a patient being admitted to a ward that cannot safely meet their needs.

1. Clear and readily understandable framework for admission

The Trust acknowledges that its existing Admission, Discharge and Transfer Policy did not provide sufficiently clear operational guidance for acute mental health inpatient services, including Psychiatric Intensive Care Units (PICUs).

A dedicated Standard Operating Procedure has therefore been developed for acute mental health inpatient admissions, including Parklands Hospital. The family's submissions to the inquest on this documentation was central to our review. The SOP provides a single pathway for staff and clarifies responsibilities, decision-making and escalation. It requires receiving teams to review the available Mental Health Act and clinical information, assess immediate risk, and determine whether the proposed ward can safely meet the patient's needs. Where suitability is uncertain, senior clinical review and escalation are required before the placement decision is confirmed.

The procedure includes a simplified flowchart and is being tested with frontline staff before approval to confirm that it is clear and practical.

2. Staff understanding of safe risk assessment

The Trust accepts that policy revision alone is insufficient. The revised procedure is aligned with national best practice and makes clear that risk assessment is a dynamic clinical process requiring professional judgement, formulation and an appropriate risk-management plan.

It distinguishes between the immediate assessment and management of risk on arrival and the subsequent formal assessment and formulation. Where a full assessment cannot immediately be completed, proportionate interim safeguards, including enhanced observation where required, must be put in place and documented. This requirement reflects specific learning from this tragic death examined at the inquest.

Training is underway, supported by targeted learning for staff who receive, assess and admit patients. It focuses on risk formulation and translating identified risks into an effective safety plan.

3. Monitoring and assurance

The Trust has already commenced audits that examine whether risk is being assessed, formulation completed and a safety plan developed. Audit results are reported through divisional and Trust-wide governance meetings. Any identified deficiencies are subject to corrective action and follow-up review by local leaders.

In order to strengthen organisation-wide monitoring of standards, compliance and improvement, the Trust has procured a digital quality assurance platform that will support a robust approach to the efficient ongoing monitoring of standards, compliance and improvement. Regular audits of a sample of admissions will assess whether the revised procedure is being followed, risks are promptly assessed and managed, ward suitability is being explicitly considered, escalation occurs when required, and risk-management plans are clear and proportionate.

Audit findings at subdivision, division and Trust-wide levels are considered alongside relevant incidents, complaints and staff feedback to provide assurance that the changes are embedded and remain effective.

4. Assurance to the Coroner

The Trust considers that these measures directly address the concerns raised by providing a clear admission pathway, explicit consideration of ward suitability, strengthened staff understanding of safe risk assessment, and ongoing monitoring of practice.

Together, these arrangements provide a clearer and more consistent basis for admission decisions and significantly reduce the risk of a patient being admitted to an environment that cannot safely meet their assessed needs.