Devon Partnership NHS
NHS Trust

COPY

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Dr E Earland
HM Senior Coroner
Exeter and Greater Devon Coroner's Office
Room 226
Devon County Hall
Exeter
EX2 4QD

Your Ref: EAE/VTVL File No: 2146/13

Our Ref: RMS 2734 / STEIS 2013/28295

5 February 2016

RECEIVED 09 FEB 2016

Dear Dr Earland

Re: William Jeffrey Maskell (deceased) – DOD 25/09/13 - Inquest 1 to 3 December 2015
Regulation 28 Report to Prevent Future Deaths

Thank you for your letter of 14 December 2015 which we received on the 17 December 2015 following the inquest into the death of William Maskell. As an organisation we are committed to learning from these tragic events and have since receiving your report and recommendations taken the opportunity to share your findings with the service involved as well as across the wider trust.

The Trust has undertaken a Root Cause Analysis Investigation following the death of William; the report was shared at the inquest and we were able to confirm that the action resulting from the report had been completed. It is clear following review of your report and consideration of your recommendations that there are continued improvements that can be made to prevent future deaths of this nature.

The Trust has had further discussions with the University with a view to identifying specific action that can be taken to improve the joint working between us; we have nominated our Adult Directorate Practice Lead for the Community to work with colleagues from the University to progress the following actions;

- Ensure that STEP and CRISIS staff are aware of the quickest means for university staff to gain access to a student's room, so that if advice is sought by the wellbeing team, Trust staff can give accurate information and signpost them to the appropriate agency.

- The Trust will get clear information from the university with regard to which university staff can gain access to the student's rooms

- Work with the university in their development of a procedure for consultation with statutory bodies when investigating a potential deterioration in mental health status or wellbeing which is not confirmed as high risk.

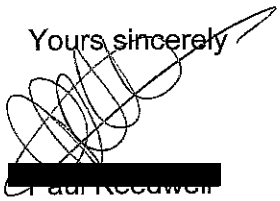
- Consider the development of a contingency plan for students with an identified care coordinator, this would be agreed by the student and all parties involved in the students wellbeing; it would contain the steps that would be taken if there was felt to be a deterioration in that students mental

health status / wellbeing and would be clear about everyone's role and what would be expected of them both in and out of hours. This would be tailored to the students individual needs and be clear about when it would be appropriate to gain access to the students accommodation, who would do this and how.

It is understood that this work is expected to be completed by the end of May 2016.

I hope that the actions described demonstrate our commitment to the learning we have undertaken and that the Trust is committed to this continued positive work with the University. If you require any further information please do not hesitate to contact me.

Yours sincerely



[redacted]
Director of Nursing and Practice

On behalf of Melanie Walker, Chief Executive