A member of:
Association of UK University Hospitals

NHS
Sussex Partnership
NHS Foundation Trust

Sussex Partnership NHS Foundation Trust
Trust HQ
Swandean
Arundel Road
Sussex

4th June 2021

[redacted]
Your Ref:

Re: The Late Mr James Herbertson

Dear Ms Schofield

Thank you for your letter of 15th March 2021 under cover of which you raised several matters of concern under Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulation 28 and 29 of the Coroner's (Investigations) Regulations 2013, arising from the inquest of Mr James Herbertson concluded on 25 November 2020.

I was very sorry to learn about Mr Herbertson's tragic death and I wish to convey my deep and sincere condolences to his Family.

In response to your Regulation 28 Report, I have carefully considered the concerns you raised, and considered whether Mr Herbertson's death could have been avoided at the time it occurred. I have also considered potential of future deaths in similar circumstances and now provide our responses to your key concerns in tabular format overleaf.

Concern Raised	Action Taken or Required	Date completed or to be completed by	Lead and Level of Responsibility	Current status as at (date)	Evidence to demonstrate completion of the action
Involvement of Lead Practitioner in discharge process. **a)** *Lead Practitioner had not had the opportunity to establish a therapeutic relationship before JH was discharged from hospital and was not aware he had been discharged.*	The Trust agrees that it is best practice for the Lead Practitioner to be actively involved in the acute care discharge process and to ensure that contact is made within 3 days of discharge for follow up; as per the Care Programme Approach policy version 7 March 2020 (current policy appendix. 1). At the time of James' discharge, the policy in place (version 6 appendix 2 2017) was for a 7 day follow up, but due to the requirement to improve outcomes, this was reduced in 2020 to a 3 day follow up. In addition, discharge from an inpatient Ward occurs as part of a planned process and includes all relevant professionals. Discharge remains the responsibility of clinical decision making by the Multi-Disciplinary	NO ACTION INDICATED	[redacted] CLINICAL OPERATIONAL MANAGER	COMPLETED	Appendix 1: TPCL006 - Care Programme Approach Appendix 2: TPCL006 - Care Programme Approach Appendix 3: TPCLOP262 - Acute Inpatient Mental Healt

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	Team [MDT) which includes both the patient opinion and where possible, with family input. This is described in the Acute Adult Inpatient Mental Health Service Operational policy - Langley Green Hospital (2018) attached as per appendix 3. To confirm, James' Lead Practitioner was aware that he was to be discharged (as per Lead Practitioner statement, Clinical records and Serious Incident report) as the Lead Practitioner had attended the Section 117 discharge aftercare meeting on the 02.08.2018 and on the Ward which James attended, alongside his Lead Practitioner. On 17.08.2018, a discharge meeting where aftercare arrangements were agreed, took				

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	place. James' Carenotes indicate that he was given contact details for his Lead Practitioner. His Lead Practitioner was also notified of his discharge. On the occasions that the Lead Practitioner was not able to join the discharge meetings due to other work commitments, evidence was given to the Court that there was communication between her and the Ward in the weeks prior to James' discharge. The Lead Practitioner did, in the event, complete the 7 day follow up on the 22.08.2018.				
Involvement of family in discharge process. ***b)*** *Family unaware of discharge at the point of discharge*	**Action Taken or Required** Where the hospital/ Trust agrees communication with families/ carers is central to treatment and clinical decisions, it also has to maintain patient confidentiality where an	NO ACTION INDICATED - NO ACTION REQUIRED	[redacted] CLINICAL OPERATIONAL MANAGER	NO ACTION REQUIRED	Appendix 4: TPCLOP262 - Acute Inpatient Mental Healt

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	individual expresses the requirement not to have their clinical information shared. James gave sporadic consent to share details with his family, and there is evidence that where consent was available, the family were included where their views were shared in Ward reviews and details of acute inpatient care was given. However, there is little evidence that James' family were actively engaged in discharge arrangements or whether consent at the time was sought. Good practice as outlined in the Acute Adult Inpatient Mental Health Service Operational policy/ Langley Green Hospital attached (appendix 4), stipulates that clear communication is necessary to develop comprehensive Care				

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	Programme Approach compliant discharge care plans. There is evidence that prior to discharge, and with James' consent, attempts to contact the family occurred.				
Accommodation on discharge. ***c)*** *Accommodation on discharge was not safe or therapeutic for a person who had a recognised mental health difficulty. Whilst accommodation is a matter for the Local Authority the trust staff work with partner agencies in planning for 117 discharge.*	The Langley Green Housing officer was actively engaged in assisting James with post discharge accommodation options. However, despite efforts, James did not have recourse to public funds as he had recently returned from France after living there for 10 years. Both benefits and accommodation referrals were completed with James by the team who also assisted him with the attendance of appointments. As there was no recourse to public funds and James no	NO ACTION INDICATED - NO ACTION REQUIRED	[redacted] CLINICAL OPERATIONAL MANAGER	NO ACTION REQUIRED	NO ACTION REQUIRED J H Discharge notification 2018.pdf

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	longer had acute care needs, his accommodation needs fell to the local authority for access to and the organisation of housing requirements. Our Acute Adult Inpatient Mental Health Service Operational policy/ Langley Green Hospital states – *'In the event of a service user being of No Fixed Abode, the mental health and risk assessment will inform how best to arrange accommodation on discharge. This may include referral to the Council's Homelessness Persons Unit or local third sector provider'.* James' issues of homelessness were fully assessed through the risk assessment process (as per clinical notes 17.08.2018) which note that the MDT '*were not*				

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	able to associate him being homeless with any escalated risks, certainly not above and beyond to those risks to which he has been exposed through circumstances over the past 16 years of being of No Fixed Abode, James demonstrated full capacity to make decisions'. Since 2019 Sussex Partnership NHS Foundation Trust (SPFT) participates in monthly Rough Sleepers Multi Agency meetings in Horsham, Crawley and Mid Sussex to enable a joined-up approach for individuals who have housing, health and social care needs. In addition to SPFT, the police, probation, county council, and drug and alcohol services (Change Grow Live CGL) are all present. An information sharing agreement is in place to				

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	discuss individual cases to provide relevant support. Strategically, SPFT participate in a regular West Sussex Multi Disadvantaged meeting to develop improvements for homeless individuals in the county. In addition to the agencies already mentioned, SPFT is in regular contact with the CEOs of local homelessness organisations.				
Actions following Red Zone including (i) risk assessment (ii) recording in medical records/ Lead Practitioner's role on mental health deterioration including (i) managing risk (ii) referral to CRISIS team (iii) other escalation	**Action Taken or Required** The Serious Incident report highlights the Care and Service delivery problem that the service '*did not appear to have considered a referral to the crisis team despite clear signs of relapse and concerns raised by family'*. In addition, that '*there was no documented evidence of this discussion'.* As an action	ONGOING AUDITS – NO ACTION REQUIRED	[redacted] CLINICAL OPERATIONAL MANAGER	COMPLETED NOVEMBER 2020	PLEASE SEE ATTACHED AUDIT Sept 2020 - Snapshot Audit of Horsham ATS

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a) *The change in James' mental health condition was not recorded adequately in the community MDT on the 9th April 2019. Clear evidence that there was a lack of understanding by individual staff as to what actions they should be taking when a service user was placed in the 'red zone'.*	from the SI investigation the Trust reviewed the documentation of daily meetings, and completed an audit of the Carenotes noted by the service to ensure adherence. The documentation had to include the identified risk, plan of action and who was undertaking the action. The updated audit of November 2020 illustrated above 97% compliance to the specified requirements.				
b) *James' risk was not adequately assessed or recorded in his medical records following being placed in 'red zone'.*	The SI report appreciated the Clinical Risk assessment and Safety Planning Risk management policy and procedure was not adhered to. There is no record of risk assessment being reviewed when new information about potential risk is known. The action as a consequence was	COMPLETED	[redacted] CLINICAL OPERATIONAL MANAGER	CURRENT ONGOING	HORSHAM ATS 15 CLINICAL STAFF Evidence of clinical risk assessment and safety management on My Learning system 80% 13-02-2020 96% 06-11-2020

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	that all Horsham ATS staff received mandatory risk training. This action was completed in November 2020 where it is evidenced the team had recorded on the centralised data base 96% compliance.				Horsham ATS Staff Checklist MASTER.doc
c) *His lead practitioner was not available at the time and nobody appears to have taken responsibility to manage James' risk or make a referral to the crisis team.*	**Action Taken or Required** As an outcome of the SI investigation, the Trust understood the requirement for Lead Practitioners to have induction, training and supervision in order for them to be able to identify when risk assessments should be updated and reviewed. The Horsham ATS induction for new staff was reviewed to ensure inclusion of collaborative care planning, risk assessments	COMPLETED	[redacted] CLINICAL OPERATIONAL MANAGER	CURRENT ONGOING	SEE ATTACHED HORSHAM ATS STAFF INDUCTION CHECKLIST Includes Carenotes module training (incorporating risk assessments and care planning) and mandatory training modules including clinical risk assessment and safety management.

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	and suicide prevention. In November 2020, a new induction pack was in place for new starters with leadership support. Ongoing monitoring through monthly review of risk assessment and care plans continues to provide assurance of compliance. Within James' Careplan, there were also the Crisis and contingency contact details which included the ATS, Mental Healthline, MIND and the CRHTT. On 11.09.2018 James' Lead Practitioner met with him and gave him emergency contact numbers in the event he required immediate support.				 Horsham ATS Staff Checklist MASTER.doc  CRHTT Operational Policy 20201117 - fina
Response to text messaging when Lead Practitioner is not available/ does not see the	The Trusts Information Technology team have confirmed that the Trust does not have the ability to send	NO ACTION INDICATED	[redacted] CLINICAL OPERATIONAL MANAGER	COMPLETED	 TPCO060 - Contacting Service Us

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message. Mobile Phone and Test Messaging policy	automatic responses to individuals when they text a member of staffs' mobile phone. James had however requested that the services and the Lead Practitioner use text messages as the main method of communication in his discharge meeting. In the Trusts Policy 'Contacting Service Users By Mobile Phone and Text Messaging' (attached) the patient is to be made aware that their contact may not be answered, and that a crisis and contingency plan is agreed. On James' care plan, there were agreed crisis and contingency contact details which included the ATS, Mental Healthline, MIND and the Crisis Resolution and Home Treatment Team (CRHTT). On 11.09.2018 James' Lead Practitioner met with him				

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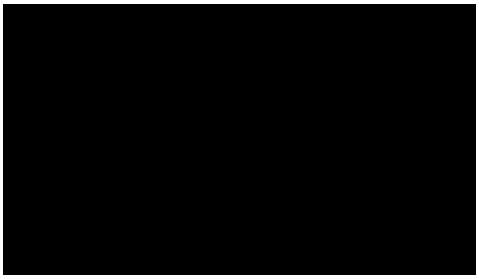
	and gave him emergency contact numbers in the event he required immediate support.				

Where indicated in the table above, the Trust has taken action to ensure that these very sad circumstances do not repeat again. I believe this letter reassures you that the steps we have taken to improve the support that we provide to our patients at the point they are discharged from inpatient admission and back into the Community and throughout their pathway, is safe and fit for purpose.

Yours sincerely



Chief Executive