Avon and Wiltshire
Mental Health Partnership NHS Trust
Bath NHS House
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Bath
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1 September, 2021

M E Voisin
HM Senior Coroner (Avon)
The Coroner's Court
Old Weston Road
Flax Bourton
BS48 1UL

Inquest into the death of Maria Stancliffe-Cook

Regulation 28 Report to Prevent Future Deaths

Dear Ms Voisin,

Thank you for your Regulation 28 report dated 8 July 2021, issued following the Inquest into the tragic death of Maria Stancliffe-Cook who died on 1 August 2019. We are very sorry that Maria lost her life and we have accepted the findings of the independent report that we commissioned from Niche. We know that you will share a copy of this response with Maria's family and would like to express again our sincere condolences for their loss.

At the conclusion of the inquest held on 5 July 2021 you shared your concerns with regard to the downgrading of risk status by practitioners who had 'no previous dealings with Maria'. We acknowledge your concerns alongside the recommendations made within the Niche report. Please be assured, we have completed a full multi-professional review to consider how we can ensure that our staff can continue to work in an autonomous manner whilst maintaining the safe care of patients as indicated within your Regulation 28 report. The implementation of learning from this is our absolute priority.

We have approximately 3000 service users within our Bristol services across three local geographic areas and a number of speciality work-streams. We have carefully considered the proportionality of risk in changing policy, balanced with the quality improvement process directly related to risk assessment and management. Whilst our staff work within teams, individual practitioners undertake the majority of patient engagement, assessment, formulation and review. All registered practitioners are held to account by their professional body as well as the Trust policy, procedures, values and expectations. We have supervision, appraisal and audit systems in place to ensure the competence and capability of our staff. However, we are continuously using experiences and feedback as a means to learn and improve our standards of care and practice.

We have updated and continue to work with the action plan shared during the inquest. We will continue to support staff, patients and carers to ensure that all systems, policy, procedures and guidelines are consistently and robustly implemented in practice.

We will achieve this through; audit, governance and assurance across all levels of the Trust. We do not believe that a change of policy would support the quality improvement work that has commenced and is already being introduced into practice. Instead, the Trust is continuing to support the delivery of these commitments with the actions detailed below, to improve the understanding and application of risk assessment and ensure that practitioners are able to demonstrate a clear and informed decision making process whenever risk is assessed.

Risk Assessments

The Trust has in place a regular monthly audit of sample records for risk and care management of patients in the community and in-patient services. The most recent audit data has shown 90% compliance with Trust standards and performance indicators.

A 'care planning steering group' is in place, which is working with (and is co-produced alongside) those with lived experience to ensure quality improvements and compliance indicators are developed to support staff in practice.

A new care plan and risk supervision tool has been introduced as a means to support staff to audit their patient records through management supervision each month. The tool is more comprehensive than the Trust sample audit and is specific to risk assessment, management, crisis and contingency, formulation of care and how individual practitioners are meeting the standards as indicated within the tool.

The tool was developed as a quality improvement measure. It is completed through the supervision structure, which allows any areas of concern with record management or care delivery to be addressed with immediacy and plans introduced for performance support if this is indicated.

The tool also identifies; patient, carer and family involvement to ensure that collaborative care is being provided or clearly identified if it is not indicated.

The new tool has received positive feedback from staff using it, as it provides a framework of protected time to consider the safe aspects of patient care.

A 'task and finish group' has also been formed to specifically develop a new face-to-face training package to address risk assessment and management including suicidality, self-injurious and complex behaviours. Again, this is a co-produced delivery group and to the training is expected to commence in the next couple of months.

A report published by the Royal College of Psychiatrists in July 2020 on *Self-Harm and Suicide in Adults*, provides a comprehensive overview of the evidence base for suicide prevention measures and the role of mental health services within the wider system. This report highlights the increasing awareness of the limitations of risk assessment with regard to suicide risk and notes that 'use of terms such as 'low risk or 'high risk' are unreliable, open to misinterpretation and potentially unsafe (Cole-King and Platt, 2016)'. The report also highlights some best practice, including the importance of Safety Plans that are co-produced with the patient. One of the report authors is Dr [redacted], who is a Consultant Psychiatrist, Suicide Prevention expert and Director of '4Mental Health', a reputable training provider.

Dr [redacted] is a strong advocate of using Safety Plans for all service users and not just those seen as 'High Risk'.

Earlier this year, the Trust procured the services of '4Mental Health' to provide AWP staff with a training package to be delivered in September and October 2021. The training package is 3.5 days and will initially be delivered to 60 members of staff. This is anticipated to promote consistency and benchmark standards of competency, linking the research of Dr [redacted]. It specifically includes the co-production of Safety Plans. This training was identified to provide support to address the quality of risk assessments and care plans. These are areas of practice which have been recognised as thematic learning from investigations.

Update on Niche Recommendations

You have kindly acknowledged that we have taken some positive steps to make changes. The independent investigation conducted by Niche made five recommendations and also noted areas of good practice where trust staff made efforts to obtain information from partner agencies and to share information to develop a greater understanding of risk. We have provided further updates on the five recommendations from the independent report below, but also attach a copy of the current action plan:

Recommendation 1 (staff access and consistency of care plans, risk assessments)

We have detailed the changes being implemented in respect of care plans and risk assessments above and therefore will not repeat this information here.

Recommendation 2 (capacity assessments)

We have started detailed work to review and audit the quality of capacity assessments. There has been wide communication (including, but not limited to the Trust's intranet) giving staff advice on how to complete capacity assessments. We intend to review how effective this is and continue to make further improvements.

Recommendation 3 (research into suicide prevention)

Suicide prevention remains a key area of development and concern. We are particularly focussing on developing guidance for staff regarding autism, risk assessment and suicide prevention. These will form part of a Clinical Toolkit and RiO Clinical Support. Our Library Services have started sending out literature on suicide prevention so that staff are up to date with the latest research and thinking on suicide prevention.

There is a quarterly Suicide Prevention Workshop held for Bristol services that hosts guest speakers, reviews identified literature and explores challenges in practice through break-out groups. The next workshop is in November 2021 and is hosting the Specialist Autism Team who are providing a presentation for staff on how to support individuals experiencing complex and/or suicide risk.

Recommendation 4 (applying Triangle of Care principles)

Since Maria's death, we have ensured that there is a named carer lead in each team. We are currently undertaking an audit of the Triangle of Care to ensure that identification of carers has been correctly

recorded. This will help us to ensure that carers' views and knowledge are sought throughout the assessment and treatment process and that the carer is regularly updated and involved in care plans, medication management and strategies. The information from these audits will inform improvement plans which will be managed through local quality improvement. We are assessed externally for the Triangle of Care accreditation and will make our submission in autumn 2021.

In addition to this, an e-learning package emphasising good practice when dealing with families and carers, is due to be released at the end of October 2021, with the aim to reach all staff. A team level, carer lead, training package is being developed with our expert by experience carer group which we hope to pilot in the autumn. Specific training sessions are delivered by the Carer Involvement Co-ordinator and Lead Psychologist for In-patients for Bristol services and has been received well by teams and carer involvees.

Recommendation 5 (communication with families)

The Trust will be recruiting 1.5 WTE Family Liaison Officers, in line with best practice, to ensure that family engagement is ongoing and delivered with the right resource. We attach the updated action plan for your information and would be happy to send you an updated version six months from today, after completion and quality control if you would like.

Please be assured that learning from the circumstances of this tragic death will also be shared more widely with colleagues.

Yours sincerely

[redacted]

Chief Executive