NHS
Coventry and
Warwickshire Partnership
NHS Trust

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28 January 2022

Mr Sean McGovern,
Senior Coroner for Warwickshire,
Warwick Justice Centre,
Newbold Terrace,
Royal Leamington Spa,
CV32 4EL

Dear Mr McGovern

Re: The late Mr Robert Hammond

I am writing to you in response to the Regulation 28: Prevention of Future Deaths Report which was received from your office on 6 December 2021 in respect of the death of Mr Robert Hammond.

Your report focussed on our assessment and management of risk where there was a risk of a person self-harming or who had suicide ideation. Your inquest concluded that our Working with Risk documentation was not completed on approximately the first nine contacts with Mr Hammond and as a result the care plan for Mr Hammond was deemed unsatisfactory. I am aware that as part of your summing up of the inquest, you acknowledged the challenge of working with people with mental health problems and that your concerns in relation to this matter were in the context of the PFD issues that I will address in my response.

You heard evidence in relation to proposed actions arising from our internal investigation, but you were concerned that there was no determination for closure of some of those actions.

Clinical Risk Assessment and Management Policy

For context, I want to refer to our "Clinical Risk Assessment and Management Policy" which describes how clinicians providing care to patients should utilise the Working with Risk tools and framework.

Working with Risk 1 tools are used to assess a patient's "current risk". The Trust policy is that Working with Risk 1 assessments should be completed on initial assessment to

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form a baseline and thereafter when there is reason to believe that the risk has changed (increased). All clinicians should be alert to a person's "risk" during each contact and a full assessment documented when applicable. This does not usually mean on every contact but rather when indicated. Where risk is identified, the clinician and patient should work together to formulate a plan to reduce that risk. Families should be involved when appropriate with the patient's agreement.

Working with Risk 1 is complemented by other tools that clinicians can access and use to support active risk assessment, and these are:

- **Working with Risk 2**: which supports describing historical risk and risk management and should be completed if a patient is in receipt of care for three or more months.

- **Working with Risk 3:** which focusses on taking 'positive risks' and supports the clinicians clinical judgment if a positive risk can be taken.

- **Working with Risk 4:** which supports the development of 'My Personal Safety Plan' and is used when the patient is through the clinical crisis and can contribute to and implement a risk management plan.

- **STORM** (Skills Training on Risk Management) is risk documentation that is used to assess Suicide risk.

Unfortunately, whilst the Working With Risk 1 was completed for Mr Hammond on some contacts, including his first contact with Arden Mental Health Area Team (AMHAT) on 20 December 2020, there were other times when he voiced suicide ideation, and this was not formally assessed or recorded and should have been, including when he was seen by the North Warwickshire Home Treatment Team from 23 December 2020.

An action agreed as part of our internal review of the care and treatment received by Mr Hammond was to conduct an audit of risk assessment within our Urgent Care Services. The audit was completed and has supported our understanding of compliance within the team providing care to Mr Hammond and identifying further actions required to support staff which included bespoke training for staff, and the implementation of a standardised monthly audit of risk management care which will be completed by the end of current financial year.

The results and actions, from the routine audits will be shared within the Mental Health directorates safety and quality forum, with upward reporting to the Trust's Safety and Quality Committee. I anticipate that routine data monitoring and the review of the quality of documentation would commence in February 2022.

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The work that I describe above will deliver a system of assurance and reporting at all levels in the organisation on the completion and quality of risk assessments and associated safety plans where indicated.

Additional Work

I want to take the opportunity to apprise you of additional activity the Trust is undertaking to strengthen our patient risk management activity.

Our current "Clinical Risk Assessment and Management Policy" is based on a recognised framework that was first published over ten years ago. However, to further develop our policy arrangements for risk assessment, some of our senior clinicians and professional leads have been involved in reviewing clinical risk assessment and support plans as part of co-production work with NHSE/I, academics and the Mental Health and Learning Disability Nurse Directors' Forum (to be held 27 January 2022). The co-production work's task is to review and respond to the findings of the "Self-harm and Suicide in Adults" which is a report commissioned and published by the Royal College of Psychiatry.

The key learning from our engagement with the national network forum, as well as the findings of our local audit will support a wider trust wide review of our "Clinical Risk Assessment and Management Policy" arrangements.

I have directed that a dedicated project be undertaken to focus on drilling down and addressing the key areas for improvement identified through our internal investigation of the tragic set of circumstances surrounding this incident, as well as those factors highlighted throughout the coronial process. Some of this work I have described above and the working group has already started to conduct a deeper dive into diagnosing the root causes of the problem by the following means:-

- Review best practice for assessing risk, including methodologies and tools across other NHS Trusts.
- Continue to audit current practice so that specific areas for improvement can be identified.
- Commission a staff survey to identify human and cultural factors which will enhance practice.
- Conduct observational studies and process mapping to aide understanding and identify areas of common errors or pinch points.

This work will support and inform the next stage of designing improvements which can then be tested to include:

- A review of policies, standardised operating procedures, and tools for clinical risk management.

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- A review of induction programmes, mandatory training and professional development.

Both I and my Trust Board colleagues have taken this matter extremely seriously and will continue to do so. I trust that this letter provides you with an appropriate level of assurance regarding the actions taken, and those to be taken, to continue improving patient care.

I would be grateful if you could share a copy of my response to you, with the family of Mr Hammond.

Yours sincerely

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Chief Executive

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