South West London and St George's NHS
Mental Health NHS Trust

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16/6/2014 acknowledge please receipt a copy to LC. + all the pp's

11th June 2014

Private and Confidential

Dr Fiona Wilcox
HM Senior Coroner
Inner West London
Westminster Coroner's Court
65 Horseferry Road
London
SW1P 2ED

Dear Dr Wilcox,

I am writing in response to the Regulation 28 Report to Prevent Future Deaths and the concerns you raised following the inquest into the death of Mr Philip Anthony Dean. [redacted], Head of Nursing for Community Services, [redacted] Consultant Psychiatrist and Wandsworth Clinical Director, [redacted] Associate Director for Psychology and Psychotherapies and Clinical Lead for Wandsworth Psychological Therapies and Wellbeing Service (IAPT) and [redacted], Serious Incident Lead Investigator have contributed to the response to the six matters of concern in the order raised for ease of reference as follows:

1. **That the Home Treatment Team (HTT) is not sufficiently funded to allow continuity of care and named designated workers.**

   The Trust is committed to ensuring continuity of care for service users and although it is not within the Trust's current Operational Policy for HTT's to work with designated workers the policy does state that service users accepted for home treatment, who have been newly referred or re-referred to Mental Health Services and so do not have an existing Care Coordinator, will be temporarily care coordinated within the team, in the context of a whole team approach.

The Mental Health Implementation Guide suggests that HTT's should provide a designated named worker, responsible for coordinating service users care, providing continuity of care, ensuring effective communication within the team and acting as a contact point for both service users and Carers. Although there are a number of practical issues that currently impact on the HTT's ability to operate a system of designated workers a pilot will be commenced, taking the learning from other HTT's nationally, and reviewed in six months.

The average length of stay for a service user in HTT is 2 to 3 weeks and a maximum stay of 6 weeks. Staff working in HTT's work shift patterns. The designated worker and service users ability to have contact would be dependent on the worker being allocated to a shift and day on which the service user is due to be visited. This would mean constantly making changes to the roster to facilitate contact, changing the service users visit time and or days (which are often down to preference), setting minimum number of designated worker visits a week or a mixture of all three options.

However, the Wandsworth HTT has implemented robust processes to aid continuity of care for service users. There are twice daily handovers for staff coming on duty. During the morning handover all service users who are due a visit in the morning, any patients that are on alternate morning visits who are not due to be seen that day and any issues which have arisen since handover from the previous days afternoon shift or night are discussed in detail. During afternoon handover those service users due a visit in the afternoon and service users on alternate day afternoon visits that are not due to be visited that afternoon shift are discussed. The morning shift then handover their visits and make any changes to that afternoon's visit list. This allows each shift access to pertinent information about the service user and reduces the likelihood of information being missed. A zoning system also operates which gives an overall indication of the service users risk and need.

In terms of funding the HTT has been identified as being under resourced based on the expected number of contacts for the teams caseload and the number of crisis episodes which are expected to be completed per month. A Trust wide Acute Care Pathway Project, undertaken in March 2014 identified that Wandsworth HTT was under established by 3 Whole Time Equivalent (WTE) of nursing staff. Furthermore, the project identified that Wandsworth HTT took over the management of the Trust's Crisis line in approximately 2009 without additional resource being provided equating to 2 additional WTE of nursing staff required. Medical staffing in HTT was not identified as a concern. Nurse understaffing has led to a slight dependence on agency staff in order to cover increases in workload which may have caused some problems with continuity of care and the ability to provide designated workers however HTT has now been allocated £214,000 investment as a result of the Acute Care Pathway Project which will be used to fund the posts required and will increase the nursing establishment to the appropriate level. This will assist considerably in the pilot to introduce designated workers. Recruitment has already begun to the new

3. **That liaison psychiatry does not record pertinent information such as GP recommends section, this denying those coming after the benefit of the GP's professional opinion**

   It is expected that the Liaison Psychiatry team do record pertinent information in the electronic patient record and that all documentation from referrers is uploaded and available on this system. It is expected that staff read all relevant documentation when making an assessment. It is with regret that the information from the GP was not passed on appropriately, however risk is a factor that shifts and changes and each assessment will include a new and up to date risk evaluation, based upon the person's current situation. As a result of the assessment made, an appropriate decision was taken to admit Mr Dean. As risk can change very rapidly, it is possible that the mental health assessor may come to a different conclusion to that recommended by the GP.

4. **That such an extremely psychiatrically unwell patient does not have the benefit of assessment from a health care professional qualified to make recommendations for section at first instance, despite explicit referral for the same from the doctor who knows him best**

   It has not been possible to identify any Accident and Emergency Department which runs a psychiatry service that has 24 hour 7 day a week presence of Section 12 approved doctors, and none where the Section 12 doctor would always do the assessment at first instance, unless the patient were being assessed in a police cell. Therefore it appears that Mr Dean received the most appropriate assessment available and this is comparable to other psychiatric services available elsewhere. The staff in Liaison Psychiatry are very experienced in carrying out mental health assessments and receive extensive training and ongoing supervision.

5. **That secondary care services, both the HTT and Liaison Psychiatry, appear to be under-resourced especially in terms of medically qualified personnel and that this apparent under resource impacts on the ability of these services to make accurate assessments of patients**

   The Liaison Psychiatry service is under-resourced compared to national guidance on staffing levels. In this regard, so are the majority of Liaison Psychiatry departments, and the under-resourcing is a matter primarily for the Trust's commissioners, rather than a problem of resource allocation within the Trust. The Trust do have fewer Consultants than most London teaching hospital Liaison Psychiatry departments however the implication that only medically qualified staff can make accurate assessments is not accepted. An experienced and competent Band 7 nurse will do a much more robust assessment than a doctor who has been training in psychiatry for a few years and their assessments will be on a par with a senior doctor's. An example of this was demonstrated last year when a Trust Consultant Psychiatrist provided a Coroner with data which showed a low

rate of suicide in patients who were assessed and discharged home by St George's Liaison Psychiatry team, based on Trust data collection.

6. **That the SI report missed all matters in issue in this case**

As part of the Serious Incident Reporting process, the Trust identifies the level of investigation that is required for each individual serious incident. A concise investigation is led by one of the Patient Experience Leads from the Quality Governance Department, supported by the Serious Incident Lead Investigator or another experienced clinician. The concise investigation reviews the medical records, makes contact with the family/relatives, liaises with the service or teams involved, reviews policy and identifies learning.

An internal comprehensive investigation comprises a small panel of clinicians led by the Serious Incident Lead Investigator. This is a more detailed and comprehensive investigation covering all of the aspects of the concise approach plus specific terms of reference for the incident, meetings with family/relatives, interviews with teams and individual practitioners (including GPs), benchmarking and access to expert opinion in a particular field as required. A comprehensive investigation with an External Chair is initiated following an inpatient death; abscond of a patient from a secure ward; a homicide involving a patient in receipt of services; any Never Event.

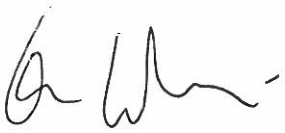
Having reviewed this investigation and the points raised at Inquest, the Trust has identified that this incident would have benefited from a comprehensive rather than a concise investigation. The GP would have been invited to contribute to the Trust investigation and provide an external context and further key lines of inquiry. This would have provided information about the GP concerns and these would have been explored in detail.

As a Trust we have learnt from this and as a result of a review of our serious incident procedures, initial findings from concise investigations are reviewed after ten working days so that the level of complexity can be considered and the case escalated to the level of a comprehensive investigation if necessary. All comprehensive investigations are led by an experienced clinician, quality assured by the Serious Incident Lead Investigator, signed off by a Board member and agreed with the Clinical Commissioning Groups. The Trust has commissioned externally led training workshops to develop knowledge, skills and quality assurance processes for investigations and report writing.

Root Cause Analysis investigations may identify issues that are concerning but are deemed not to have a direct bearing on the outcome and are not identified as a contributory factor to the incident itself. The concerns identified and highlighted from this Inquest will contribute directly to Trust learning and development with regards to contributions from family and relatives, external agencies and the quality of investigations, report writing and action plans.

In closing, I hope this letter has addressed the concerns you raised. If you would like to discuss any aspect of this letter by telephone, then please do not hesitate to contact me, on [redacted].

Yours sincerely,



[redacted]
Medical Director