South London and Maudsley **NHS**
NHS Foundation Trust

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Private and Confidential

Dr Andrew Harris
HM Senior Coroner
London Inner South
Southwark Coroner's Court
1 Tennis Street
Southwark SE1 1YD

4th July 2014

Dear Dr Harris,

Re: Mr Gary Richards, aged 39, died 16 October 2012, Case ref: 2515-12

I am writing in response to the Regulation 28 Report to Prevent Future Deaths dated 9 May 2014, which you sent following the Inquest into the tragic death of Mr Richards.

In the report you raised three main matters of concern. I have set these out again below, each followed by my response and details of actions taken by the Trust, where appropriate.

1) **Psychiatric staff did not properly assess his risk of self-harm, nor communicate his vulnerability to others. At discharge on 10 May 2012 his risk of self-harm was not fully measured. On being seen on 14 June 2012 his risk assessment was not recorded and the risk plan not sent to his GP. The consultant explained that the risk was not mitigatable as no mental illness was found. Evidence was heard that his forensic history indicated that he belonged to a group of patients with 80 times the risk of suicide compared with the general population, yet he was considered at low risk. The value of performing a proper risk assessment to demonstrate the risks and vulnerabilities of the patient to other agencies, such as housing and social services, does not seem to have been considered, although it was reluctantly conceded by the consultant to be of value especially as homelessness presented as the primary problem.**

It is correct that there is no formal documentation of risk in the correct location on the PJS (our electronic patient record system) either at the point of his presentation under Section 136 or whilst on the Triage Ward. This was noted by the Trust's investigators in their report. However, there is clear evidence in the clinical records that risk was assessed and is documented in the detailed entries made by the ward medical staff during his admission. It was acknowledged that there was a risk of suicide but this was not linked to mental illness but rather the difficult social circumstances he found himself in, in particular, his homelessness. I am not aware specifically of any research evidence that suggests that those with a forensic background have a suicide risk 80 times higher than the general population but I do acknowledge that the risk is greater in those who have a mental illness and a forensic background. I do not feel that this is relevant in Mr Richard's case as he did not have a mental illness.

I believe that the clinicians involved in Mr Richards' care were aware of the impact of his homelessness on his risk of suicide and that their focus on ensuring that he received the help that he required, by referring him to the Single Homeless Intervention and Prevention agency (SHIP) was the correct course of action to follow. This was, in reality, all that they could do to mitigate the suicide risk.

The Trust's policy on risk assessment is clear in its documentation and staff have been reminded to ensure that when risk is assessed, that this is documented in the correct fashion in the relevant section of the electronic patient record to ensure that this is easily accessible by all clinical staff.

2) **After discharge in May, he was not followed up, as there was no address and his mobile phone number was not recorded. After attendance in June, again there was not a mobile phone number recorded. After attendance in June, again there was a failure to contact him for follow-up, reported to be due to a phone failure. The failure to ensure reliable communication pathways for follow up is a potential risk for vulnerable patients.**

On the day of his discharge in May, Mr Richards was very angry and on being informed of his discharge, he left the ward without waiting to have any follow-up arrangements confirmed.

A further review of Mr Richards' records indicates that when he was seen in the outpatient clinic in June, the service was aware of his mobile phone number. In fact, he had been called the day before by a social worker at the community team and asked to attend the outpatient appointment on 14 June as his GP had been concerned that he had again reported suicidal ideation.

In September, following his presentation at A&E, the team leader at the community team attempted to ring him to offer a community appointment.

She tried, using the number on file, but it was unobtainable. There was no other way of making contact with Mr Richards, so she left a message at the A&E department asking him to make contact with her should he re-present as he had booked an appointment to see her on 2 October.

The contact details for all patients are confirmed at the point of discharge and are re-checked periodically. This appears to have happened in Mr Richards's case but as he remained homeless, the mobile which he had given was the only way he could be contacted. He had not taken up any of the accommodation offers made by SHIP.

I am very sorry that the investigation report which was forwarded to you had not made this clear.

3) **The Serious Untoward Incident Report (Acute Mental Health Comprehensive Level Two Report, 10th October 2012) found seven areas of concern and service delivery problems, including weaknesses in risk assessment and recognition of suicide plan, lack of clarity of responsibility for risk assessment, inadequate 7 day follow up and communications with GP and problems in support as no mental illness. A plan was adapted which required review of clinical pathway focusing on risk assessment, staff induction and a review of homeless services and interagency working. Despite the intervening eighteen months, progress on these was not evident and it was clear that these actions had not been completed.**

It is concerning that the investigation revealed that there was a lack of clarity with regard to who is responsible for completing risk assessments. The care pathway for the triage ward is very clear that a risk assessment is conducted on admission. As mentioned above, this did occur but was not recorded correctly. I am satisfied that these assessments were indeed carried out, but the issue is that they were not recorded in the correct location and therefore, not immediately obvious to others viewing the records. All staff have been reminded that the risk assessment should be recorded in the correct place.

Conducting 7 day follow up of homeless people can be difficult but I am satisfied that staff made attempts to contact Mr Richards using the telephone number he had provided and through leaving messages for him to contact his community team, should he re-present at the A&E Department.

All new staff to the Trust are inducted through a central induction programme. This is supplemented by individual induction programmes in each ward or team ensuring that staff are fully familiar with the specific ways of working at a local level. This includes how to assess and document risk for all patients.

Although Mr Richards did not have a mental illness, staff did acknowledge his suicidal intent and were aware that this was directly related to his homelessness. It is clear from his records that there was recurrent mention of committing suicide by jumping in front of a train. Although this may not have been noted specifically by the clinical team, his recurrent mention of suicide was. I do not feel that the method by which he said he would commit suicide is significant in this particular case. The way of addressing this was through assisting him in finding accommodation through SHIP. In order to obtain help through SHIP, he needed to be officially homeless and could not be considered as such, as long as his name was on the tenancy of the property he had shared with his wife. He was advised of how to go about obtaining legal advice to rectify this in order that he could obtain support from SHIP.

Homelessness features highly amongst the patients that the Trust cares for. However, I am pleased to inform you that we have been successful in obtaining funding in the sum of £500,000 from the Guys and St Thomas' Hospital Charity to pilot a mental health specific homeless project working with those who present to our services. This will be linked to an existing scheme which is in place across King's and St Thomas' Hospitals for those who enter our services who are homeless, and where our staff will have direct access to the expertise in an already established homeless scheme. I am sure that this will lead to an improvement in the service we can provide to patients who are in this unfortunate situation.

I note that although Mr Richards' GP was notified of his discharge from hospital in May, there is no record of a discharge summary having been sent. This is clearly unacceptable and this has been taken up with the ward consultant. There is a clear expectation that a discharge summary will be sent to GPs for all discharges.

I hope that this letter addresses the issues that you have raised and I would like to thank you for bringing your concerns to my attention.

Yours sincerely,

Dr Matthew Patrick
Chief Executive