Whittington Health NHS

Dr Richard Jennings
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Email: [redacted]

Private and Confidential

24th June 2015

HM Coroner Mary Hassell
HM Coroner's Office
St Pancras
Camley Street
London N1C 4PP

Dear Ms Hassell

Re: Finnulla Catherine MARTIN inquest

Further to the Finnulla Martin inquest held on the 28th April 2015 and the PFD report dated 29th April 2015. Please find enclosed the trust's response by way of an action plan.

Should you require any further information, please do not hesitate to contact me.

Yours Sincerely

[redacted]
Executive Medical Director

Whittington Health NHS

Regulation 28: Prevention of Future Deaths

Action plan following the report of:

Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Into the death of:

Finnulla Catherine MARTIN (date of death 16.11.14)

Identified MATTERS OF CONCERN for Whittington Health:

1. There seemed to be some degree of confusion surrounding the voluntary attendance of a patient with mental health needs accompanied by the police, that suggests a multi-agency discussion and agreement would be beneficial.

No.	Recommendation	Key Action(s)	Completion Date	Responsible Lead(s)	Progress on actions and dates:	Evidence of implementation and date of implementation
1	Multi-agency discussion and agreement	a) Development of care guidelines relating to patients brought into the Emergency Department by the police. b) To implement use of a mental health Proforma to improve the quality of	Guidelines to be signed off at August 2015 ED Board and all other actions to be completed by 01/08/15	[redacted] Consultant in Emergency Medicine [redacted] Professional development	a) June 2015 – On track. The police guidelines have been drafted and shared with mental health Trust. Version 3 in progress (attached). To be	The set of guidelines (draft v3 attached) The completed Performa (see attached) Minutes and action notes from Operational

		assessments and ensure this is available to mental health colleagues c) The guidelines to be agreed by Whittington Health, Camden and Islington FT and Metropolitan Police Services in local boroughs of Haringey and Islington.		Nurse [redacted] AD Acute Services	reviewed at next operational meeting (09/07/15) b) Proforma has been developed and being piloted (attached) c) Senior police colleagues from Islington have attended ED Board May 18th. Planning to invite Haringey in July TBC	meetings and ED Board.
1b.		To develop a new operational group between Whittington Health and Camden & Islington Mental Health Trust to improve communication, operational processes and oversee governance. To invite police representation as require	June 2015	[redacted] AD Acute Services (WH) [redacted] Operational Manager (CIFT)	Meeting terms of reference agreed First meeting held 11/6/15	Terms of reference (attached) Minutes from meetings

2. Coroner Hassell was told at the inquest by Camden & Islington that the Whittington has been unable to locate the Whittington triage record of Ms Martin's attendance, and did not discover any record of the call made by Ms Martin's sister to the emergency department that night.

Whittington Health response – all triage assessments are recorded electronically. Patient FM was triaged. Arrived with police at 21:00 and was assessed and triaged at 21:15:
Pt brought in by police c/o suicidal ideations. Family concerned about patient. Patient voluntary. pmh: unknown.
National Triage category – mental illness – category 2 very urgent- discriminator – high risk of self-harm

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2	For all Camden and Islington Foundation Trust employees and associated locum staff to have good understanding of the Emergency Department computer system 'Medway' to improve information available to them	Provide written guide on use of Emergency Department computer system To repeat training on the Medway system To review progress at operational meetings	End of July 2015	[redacted] AD Acute Services	Agree which aspects of Medway system CIFT staff will use – **completed** User guide for CIFT staff under development – draft attached	The written guide (attached) Training log
2a.	Recording of calls made to the Emergency Department	To agree and develop a risk assessment tool to identify calls that requires action and those that do not. To agree a local standard operating procedure	August 2015	[redacted] Clinical Lead & Consultant in Emergency Care [redacted]	This action is to be discussed at ED Operational Board	The risk tool Formulation of standard operating procedure

		Undertake staff training on the tool and complete audit to review the impact		[redacted]		