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Oxleas NHS
NHS Foundation Trust

[redacted]

18 November 2016

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Mr John Thompson
Clerk to Senior Coroner
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Dear Mr Thompson

Re: Regulation 28: Preventing Future Death Report

I am writing to you in response to the PFD (Preventing Future Deaths) report dated 11 October 2016 and received on 13 October 2016. This was issued in relation to the death of Debrata Sircar (case file no: 00519-16(JB).

The report highlighted the following matters of concern:

He was at risk from falls, associated with his alcohol abuse and had frequently presented in A&E department with symptoms and injuries associated with intoxication. He was unfit to be treated in the community. There appeared to be no sense of urgency in securing a bed. He was booked for a Mental Health Act (MHA)Assessment 11 days after it was advices he needed hospitalisation, by which time he had died. The court was informed the delay related to the unavailability of a local authority MHA practitioner. In the intervening 11 day period there was an absence of an interim care plan, identified in the SUI investigation. Although there were plans for increased contacts in future for interim care for those pending MHA assessment, it was unclear who would take the lad and how a patient would be psychiatrically monitored in that period. The Trust acknowledges the long period of time it took to arrange a Mental Health Act assessment however this was not, despite what the court heard, due to the unavailability of an Approved Mental Health Act Practitioner (AMHP).

On 12 February 2016 a referral was received by the Central AMHP team for a Mental Health Act assessment. This referral followed concerns from Mr Sircar's ex-wife and children regarding his mental and physical health and the fact that he was not caring for himself.

At this point no referral had been made to the Home Treatment Team (HTT). The duty AMHP provided the referrer with consultation, suggesting the following actions: the referring Community Psychiatric Nurse (CPN) to contact the HTT to present DS's case, as per protocol (HTT had recently been involved in his care and treatment, post discharge from inpatient services in January 2016). Contact was established that day with Mr Sircar and he was agreeable to contact from the HTT. The Responsible Clinician (RC) and the CPN who visited him that day identified that the assessed risks could be managed through HTT. HTT however did not feel that was the case. This disagreement meant that the case was referred back to the AMHP service.

On 15 February 2016, as per protocol, the police risk assessment was sent to the allocated care co-ordinator (CCO) for completion and an update on Mr Sircar's situation was requested. The completed police risk assessment was received from CCO the following day on 16 February 2016. This was then forwarded to the police on 17 February 2016. Communication took place with both the community team and family the following day. On 19 February 2016 the police returned the police risk assessment with the message that they would not be attending the assessment. The AMHP team then began coordinating the assessment without police involvement. On 22 February 2016 the AMHP team made further attempts to secure the necessary Section 12 medical input into the assessment and were informed that Mr Sircar had passed away.

As acknowledged already and outlined above, there were certainly delays in the organisation of the MHA assessment. These were multifactorial but were not due to the unavailability of an AMHP. Any issues relating to cross-agency working with the police are escalated to the regular Metropolitan Police Service/ London Ambulance Service/ Oxleas interface meetings. Given that delays can occur in the organisation of assessments, it is crucial that risks are managed in the meantime. The lack of an interim risk management plan was identified as part of our Serious Incident investigation and was the reason for our investigation identifying the following action:

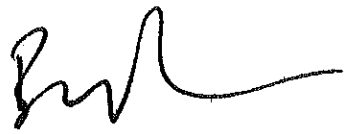
- The request for a MHA Assessment should trigger review of zoning and risk management plan, which would include increased contact with the allocated worker. HTT should have an agreed role in delivering the risk management plan while an individual is awaiting a MHAA.

Following our review, we have instigated the following change in practice:

- When a client is referred for an MHA assessment they should be rezoned into Red until the MHA has been completed. Any referral to HTT during this period should highlight what role is expected from HTT with regard to risk Management.
- Zoning meetings to review those individuals considered high risk (i.e. those in the red zone) take place three times per week and agreed actions to mitigate risks are minuted. In addition, regular weekly interface meetings between community and home treatment teams now take place to ensure that the clinical pathway between services is working properly.

I hope that my response has addressed your concerns.

Yours sincerely



Ben Travis
Chief Executive