Whittington Health NHS

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust
A University Teaching Trust

Camden and Islington NHS
NHS Foundation Trust

Whittington Health
Magdala Avenue
London N19 5NF
[redacted]

Barnet, Enfield and Haringey Mental Health NHS Trust
Orchard House
St Ann's Hospital
St Ann's Road, London N15 3TH

Camden & Islington NHS FT
St Pancras Way
London NW1 OPE
Chief.executive@candi.nhs.uk

24 July 2017

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

Dear Coroner Hassell

Prevention of future deaths report – Dominic Michael White

We write further to your prevention of future death report dated 24 May 2017. Following the inquest, you recorded two matters which gave you cause for concern with regards the care provided to Dominic White.

The first matter (level of mental health observations) spans Whittington Health NHS Trust, Camden & Islington NHS Foundation Trust, and Barnet, Enfield and Haringey Mental Health NHS Trust. This response, therefore, is a joint response from all three organisations addressing the concerns you have raised.

The second matter concerns the decision making of the Approved Mental Health Professional. The AMHP is employed by the London Borough of Islington. When AMHPs are carrying out their duties, they act on behalf of the Local Authority. The London Borough of Islington will therefore provide you with a separate response to this issue.

Mental health observations

During the inquest you heard that following Mr White's death, the level of mental health observations of a patient at the Whittington Hospital Emergency Department is clearly documented. However, you are not sure whether there is yet a robust protocol in place to ensure that all relevant personnel (Whittington ED doctors, nurses and security officers; and visiting independent s12 doctors, Barnet, Enfield and Haringey staff and Camden & Islington staff) are aware of the agreed level of observation.

You have recorded your concern that sometimes, when anyone *can* look at a record, nobody actually does.

Protocol for implementing observation levels for mental health patients

We set out below our agreed approach for ensuring that all relevant personnel are aware of a mental health patient's level of observation. In order to address both concerns identified in the PFD, the Whittington and Camden & Islington have reviewed their mental health policies. These are being updated to ensure the roles and responsibilities are explicit and will also include case studies to assist in decision making. This will be included in Camden & Islington NHS Foundation Trust's Mental Health Liaison Operational Policy and the Whittington Health NHS policy for mental health patients in the Emergency Department which is currently being updated.

1. Camden and Islington Foundation Trust's mental health liaison team is responsible for recommending what the level of observations should be and for documenting this in the mental health care plan;

2. The mental health liaison team is responsible for informing the nurse in charge of Whittington Hospital's ED and the named nurse looking after the patient in the ED what the recommended level of observation is;

3. The nurse in charge of ED and the mental health liaison team are jointly responsible for ensuring that security staff and any other relevant Whittington ED staff are fully aware of the required observation level;

4. Whittington Hospital's ED staff are responsible for ensuring that the patient is observed in line with the observation level as documented in the mental health care plan;

5. Visiting AHMPs and section 12 doctors must introduce themselves to the nurse in charge of ED and the named nurse responsible for the patient and request a clinical handover (Including the current observation level) and to view the mental health care plan. Whittington Health ED Nurse in Charge and named nurse are responsible for facilitating this.

6. As part of improving communication between organisations signage has been introduced in Whittington ED, which is prominently placed around the nurses' station, to ensure that visiting doctors and AHMPs are aware of this process and that the name of the patient's allocated nurse and any 1:1 or 'special' staff member is visible outside the patient's cubicle (see images).

7. To support patients in ED staffing levels have been increased to allow for an additional ED Assistant on each shift to provide support and 1:1 for mental health patients if required. All ED Assistants have been provided with additional training in mental health including communication skills, how to manage a difficult situation and Level 3 Breakaway training.

8. To ensure that the level of observations is being complied with and that the clinical decision making regarding Mental Health patients is robust Senior Whittington ED staff members (nurse in charge, site team, ED registrar or consultant) conduct a situation report 5 times per day in which the status of the department including

length of stay of mental health patients and risk assessment is discussed, this is followed by a review in which plans for patients are confirmed and quality of care is checked.

In addition to the actions taken as part of the response to the prevention of future deaths report the following actions have also been undertaken:

9. A learning event based around this incident took place on the 15th June 2017 with 43 attendees from all three organisations. Discussions were held around joint working and staff members wrote personal pledges which were shared with the family. As a result of this, the Islington AHMP team has been invited to attend Whittington ED for a training session with ED staff so both teams can learn from each other.

10. The Emergency Care Improvement Programme has conducted a 'deep dive' into mental health care of patients presenting with mental health concerns at Whittington Health and in the local area. The results of this review will enable development of a plan for improvements in this area and how to support the trust(s) to achieve these improvements

11. In addition as part of the Emergency Care Improvement Programme a joint audit of a number of patients presenting to ED with mental health issues will be undertaken. Further improvements will be made in line with recommendations resulting from the deep dive.

12. Whittington Health has commissioned an independent review of the cluster of serious incidents relating to mental health, which will commence in July 2017.

We hope that our joint protocol as set out above provides assurance as to how seriously we are taking the concerns you raised, and our ongoing determination, and commitment to ensure that we keep all our patients safe.

Yours sincerely

Simon Pleydell
Chief Executive
Whittington Health

Maria Kane
Chief Executive
Barnet, Enfield & Haringey
Mental Health Trust

Angela McNab
Chief Executive
C&I NHS Foundation Trust