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

Chief Executive's Office
South West London and St Georges
Mental Health NHS Trust
Trust Headquarters, Building 15
Springfield University Hospital
61 Glenburnie Road
London SW17 7DJ

21st November 2017

Ms Angela Hodes
HM Assistant Coroner Inner West London
65 Horseferry Road
London
SW1P 2ED

Dear Ms Hodes

Regulation 28: Report to Prevent Future Deaths

I am writing to you following receipt of the Regulation 28: Report to Prevent Future Deaths dated 28th September 2017 regarding the sad death of Mrs Gillian O'Keefe as a result of an overdose of medication. You have requested South West London and St Georges Mental Health NHS Trust respond to five matters of concern that you have detailed in your correspondence.

In order to examine all of the concerns a meeting was convened on 31st October 2017 by [redacted] Associate Director of Governance and Risk, with [redacted] Clinical Director of the Community, and [redacted] Head of Nursing and Quality for the Community Adult Services. The meeting reviewed the details of the case and whether there were missed opportunities, as well as the possibility of gaps in our services with regard to care and treatment that may have prevented Mrs O'Keefe's death.

I have responded to each of your concerns as they were raised in your correspondence:

1) That the decision to discharge Mrs O'Keeffe *'for non-engagement'* from the local Mental Health NHS Foundation Trust care in January 2017 appeared illogical when it was likely, having regard to the facts, that she was in greatest need of their help: she was a service user of long standing, she had an acute deterioration in her mental state in March 2016, that there had been concerns raised by her family in October 2016 and that no professionals had been able to make visual contact with her since October 2016.

The decision to discharge was based on the following:

- Mrs O'Keefe had never expressed suicidal thoughts nor abused alcohol or taken illicit drugs
- the GP confirmed that Mrs O'Keefe had picked up a prescription on 6th of January (4 days before the decision to discharge)
- the Care Co-ordinator noted that Mrs O'Keefe appeared stable in her mental state when last seen on 22nd November and that she had reasonable self-care
- the Care Co-ordinator had not noticed any hypomanic symptoms outside of some emails Mrs O'Keefe sent to Members of Parliament
- the risk to Mrs O'Keefe and to others was assessed as low.

It is stated in your correspondence that no professionals had been able to make visual contact with Mrs O'Keefe since October 2016. This is incorrect as visual contact was made with Mrs O'Keefe on 22nd November 2016 by the Care Co-ordinator who recorded that she appeared stable in mental state.

We have provided rationale for the decision to discharge but also acknowledge that more engagement should have taken place with key stakeholders prior to Mrs O'Keefe's discharge. Since this incident, our Clinical Disengagement/Did Not Attend Policy has been updated. The updated version is more prescriptive with regards to what actions need to be taken before a patient can be discharged and this includes engagement with the GP and inclusion of the GP in the decision to discharge. Adherence to this policy is audited through our clinical audit programme.

2) In view of her history and the inability of the Trust or GP surgery to make contact with Mrs O'Keeffe it was highly unlikely that she would self-refer.

The Trust agrees with this statement. Attempts had been made to engage Mrs O'Keeffe by telephone and through home visits. The team were of the opinion that her risk to self and others was low (although they acknowledged she was vulnerable). The discharge summary was sent to Mrs O'Keefe's GP, with the request

that they re-refer the patient if it was required. However, a crisis plan including relapse indicators was not sent to the GP or Mrs O'Keefe on discharge, nor was there liaison with the family at the point of discharge.

The importance of sending the Trust approved template for a crisis plan to GPs will be re-enforced to staff through team and local governance meetings and via the Trust's dissemination of learning mechanisms such as the monthly bulletin, etc. This will again form part of the clinical audit cycle. The importance of family liaison and engagement forms part of our triangle of care programme. This programme is just about to start its round of 'self-assessments' and with the community services this learning will be cascaded through this process.

3) There was no pre-discharge multidisciplinary meeting to include and inform the GP before discharge nor attempt to ensure that there was a seamless transition to the GP surgery.

Mrs O'Keefe did not attend the CPA (Care Programme Approach) meeting on 10th of January 2017. The Consultant Psychiatrist and Care Co-ordinator reviewed the care and treatment in her absence. The Care Co-ordinator had made several attempts by telephone and home visits to contact Mrs O'Keefe. The care plan documented that the GP should continue the prescription of Quetiapine and should follow up with Mrs O'Keefe and re-refer her if required. A letter outlining the care plan was sent to the GP.

There is no evidence that the GP was invited to this meeting. The Trust recognises that the decision to discharge would have benefitted from an early discussion and review between the RST and the GP prior to a formal discharge letter being sent out.

The Trust's revised Clinical Disengagement/Did Not Attend Policy states that the team should liaise with the GP and invite them to be involved in the decision to discharge the patient.

The importance of involving the GP in the decision to discharge will be re-enforced to staff through team and local governance meetings and via the Trust's dissemination of learning mechanisms such as the monthly bulletin, etc. The clinical audit cycle will reinforce the importance of this being in place.

4) Evidence was given at the inquest that there was no procedure or policy in place at the Trust to follow up on GP concerns or referrals particularly where there was likely to be a degree of urgency

The GP raised a concern with the Trust Consultant after a GP Liaison meeting at the Practice in February 2017. The GP was advised to re-refer the patient in writing. The Trust understands that the GP drafted a referral letter but that this was not sent to the Trust at the time.

The referral was never sent by the GP but this concern highlights the need for some clear guidance for GPs regarding concerns they may have. The Trust is in the process of formalising this with the lead CCG GP involvement. It will be shared with GP colleagues once it has been signed off.

It is also worth noting that the Trust is in the process of developing a primary care liaison team with the objective of improving communication between GPs and the Trust.

5) There appeared no easy or appropriate way that the family were able to share information and their concerns about Mrs O'Keeffe's mental health with the professional team, consequently, notwithstanding the family's continual and concerted attempts to notify Mrs O'Keeffe's care coordinator, they felt that the professionals were unaware of the parlous state of Mrs O'Keeffe's mental health and the family's serious concerns.

The occasions when the team were contacted by the family and their responses are detailed below:

24th October 2016: Concerns were raised by Mrs O'Keefe's sister. In response to these concerns, the Care Co-ordinator made an unannounced visit to Mrs O'Keefe on the same day but she was not at home. The Care Co-ordinator attempted to contact Mrs O'Keefe's sister but was unable to speak with her so left a message. The Care Co-ordinator also contacted the GP surgery who confirmed that Mrs O'Keefe had collected her monthly prescription on 17th October 2016.
25th October 2016: The Care Co-ordinator made another unannounced visit but Mrs O'Keefe was not at home. The Care Co-ordinator made telephone contact with Mrs O'Keefe who explained she was in a café and planning to visit her mum in Lincolnshire and that she would meet the care Co-ordinator at the team base on 28th October 2016.
28th October 2016: Mrs O'Keefe did not attend the appointment. The Care Co-ordinator made contact with her by telephone and Mrs O'Keefe explained she was still in Lincolnshire. The Care Co-ordinator left a message on Mrs O'Keefe's sister's telephone to update her and confirm whether she saw her sister at their mum's home.

The Trust was disappointed to learn that the family felt that there wasn't an easy way to share information and their concerns about Mrs O'Keefe with the team. The Clinical Director is currently scoping a quality improvement project in relation to Care Programme Approach (CPA) focussing on the engagement of families/carers and liaison with primary care. In addition to this, the Head of Nursing for the service is organising a learning event so that each of the actions identified in the plan can be shared with the team, with the event providing an opportunity for reflection and learning. As referred to earlier the trust is also committed to the triangle of care principles and is just about to undertake the next round of self-assessments.

Enclosed with this letter is a plan detailing the actions taken already or the proposed actions to be taken along with a timetable for action.

Our deepest sympathies are extended to the family and friends of Mrs O'Keefe. The conclusion that we have reached indicates that there is more work to be done with our teams regarding communication with families/carers and the inclusion of key stakeholders with regard to decisions around discharge.

Yours sincerely

David Bradley
Chief Executive