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NHS Foundation Trust

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

Dear Madam

Prevention of future deaths report - Jonathan Meaney

I write further to your Regulation 28 Prevention of Future Deaths report dated 24 August 2017 in which you highlighted concerns about the care provided to Mr Meaney.

You have brought to our attention a number of concerns which I will address below.

The urgency around securing a bed for Mr Meaney
Following the decision to admit Mr Meaney to hospital in the early hours of 14 March 2017, there was no bed available. Mr Meaney spent 40 hours in the Royal Free's emergency department waiting for a bed at which point he expressed a wish to leave. You are concerned that there seemed to be no urgency about the need for a bed for such a seriously ill man.

Unfortunately, the demand for beds at the time of Mr Meaney's presentation was particularly high. At that time, the Trust was experiencing extreme and unusual pressure in terms of requests for psychiatric beds. Specifically, on the 14 and 15 of March 2017, there were 28 referrals for beds for mental health patients pending.

The allocation of a bed is a centralised task, undertaken by the bed management team, managed by Camden and Islington NHS Foundation Trust. The bed management team received the referral from psychiatric liaison psychiatry, requesting a psychiatric bed for Mr Meaney at 04.46am on 14 March. Patients are prioritised according to both their clinical need, and the assessment of risk, for example, whether the patient is in a safe place. Patients who are not in places of safety i.e. at home or in police custody would take priority for acute beds. The referrals list is something that can change rapidly depending on the priority of new referrals and whether the risk of an existing referral has changed. Senior staff meet daily to review all pending referrals and to estimate when a bed will become available.

From the clinical information relayed to the bed management team about Mr Meaney's presentation, he was considered to be suicidal, and at significant risk of harm to self. This risk was balanced against the fact that he was in a safe place; he was given a bed in a single bay within the Clinical Decisions Unit (a small, short stay ward, designed to accommodate patients who are awaiting outcomes to be decided); he was asleep for 12 hours; and had a mental health nurse with him at all times.

The manager of the psychiatric liaison team has informed me that his team telephones the bed management team to obtain updates about bed availability. They would also provide the bed management team with any updates on the clinical situation of each patient, and whether anything has changed in terms of clinical need and risk. Telephone calls to the bed management team were made on 14 March at 10.05 and 20.54. A further telephone call was made on 15 March at 10.00. Unfortunately, the position remained that there were no beds available.

We are undertaking a serious incident review of this case. Part of its scope is to undertake an in-depth analysis to ascertain in further detail exactly what steps were taken as a Trust to secure Mr Meaney a bed. We will forward you our serious incident review on its completion. We are aiming to complete our review in November.

The assessment undertaken by the mental health nurse before Mr Meaney was discharged on 15 March

Your concerns are as follows:

- When the mental health nurse assessed Mr Meaney before discharge, he did not question Mr Meaney's assertion that he had not intended to take an overdose two days before. This was despite the fact that Mr Meaney had told the assessing doctor that he had been trying to kill himself and he had written notes of intent;

- The mental health nurse assessed Mr Meaney as rational and having good insight despite that fact that he raised a physical problem for which no organic cause had been found; and
- The mental health nurse did not consult any other member of the team before clearing Mr Meaney as fit for discharge from a mental health point of view.

We fully accept that the mental state assessment undertaken by the mental health nurse was insufficiently comprehensive and lacked the depth that we would expect. We agree that the nurse did not properly explore or challenge Mr Meaney's new assertion that his overdose was not in fact to take his life, and that it was a misjudgment that Mr Meaney had good insight into his symptoms. As the nurse acknowledged at the inquest, in view of the complexities of Mr Meaney's presenting symptoms; his suicide attempt of the previous day and notes of intent; and the doctor's decision that he needed to be admitted to hospital, he should have consulted with a member of the team before allowing Mr Meaney to go home.

As a result of this case, we have put the following measures in place:

- As referred to above, we are currently undertaking a serious incident review of this case so we can explore in further detail the sequence of events and contributory factors that led to this incident. The learning from the review will be shared within the relevant clinical team by the clinical director and lead investigator in our divisional quality forum where we discuss the learning arising from individual cases.

- The nurse in question was an agency professional, employed by NHS Professionals. (NHSP). In light of this case, he has been suspended from working at this level of expertise until the serious incident review has been completed. We have also shared your report with the HR department of NHSP and they are currently in contact with our liaison service manager who will keep them up to date with the findings of our serious incident review investigation;

- Any decision taken by agency or bank staff to change the original decision made by another full time clinician whereby they are de-escalating the outcome, must be discussed and agreed with a senior member of the team and this must be clearly recorded in the patients notes;

- All agency or bank staff who work regularly with the team will receive regular formal clinical supervision from the team manager in line with Trust employees. This will ensure the same level of professional accountability and clinical support that all full time employees receive; and

- Any agency professional working as settled members of the team will have the same access to Trust training as Trust staff.

Referral letters to the GP
You raised your concern that the mental health nurse sent the GP a discharge summary, but he did not provide an accompanying note to alert the GP that he had referred Mr Meaney for counselling, and the GP would need to action this.

Going forwards, if there is any specific action that we need a GP to carry out, the mental health liaison team will now write an accompanying note to alert the GP to the specific action and what they are required to do.

To conclude, we agree fully that there are significant lessons arising from this case. I hope that the information in this letter assures you as to how seriously we are taking the issues arising from this case, and our ongoing determination, drive and commitment to ensure that our decision making process is comprehensive and robust. As I said earlier, we will forward you our serious incident review as soon as it is completed.

Yours sincerely

Angela McNab
Chief Executive