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11th December 2017

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 – Sian Witheridge

I write further to your Regulation 28 Prevention of Future Deaths report dated 23 October 2017 in which you highlighted concerns about the care provided to Ms Witheridge.

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

1. **While Ms Witheridge was staying in Highbury Grove Crisis House her mental health records were not available to the OneHousing staff there.**

   We agree that Highbury Grove Crisis House staff should have access to our clinical records. To this end, we have been working with One Housing to enable members of their staff to acquire access to our IT system. We are aiming to have shared access in place in early 2018 following staff completing the relevant training and necessary checks.

2. **You were told that the written risk assessment provided to Highbury Grove Crisis House was not as detailed as it should have been.**

   We have reviewed our risk assessment and I have enclosed a copy for your information. We are satisfied that it contains a comprehensive risk history and that it includes sufficient detail about previous suicide attempts and risk factors.

   This risk assessment would have been provided to Highbury Grove as Highbury Grove does not accept referrals without first reading the risk assessment. As above, going forward, Highbury Grove staff will be able to access our risk assessments and obtain all the relevant information about a patient's previous risk history and current risk factors.

We are also going to move to undertaking joint risk assessments which will be completed by One Housing and C&I staff members. This will ensure that all risk factors as identified by all the staff caring for the patient are taken into account when formulating risk assessments and next steps. In cases where C&I staff conduct the risk assessment themselves, the Operations Manager and Team Manager for the crisis teams have reinforced to the teams the importance of providing detailed feedback to One Housing staff and agreeing a written plan of action for each patient.

We are sorry that we did not bring the medical records to the inquest. We will ensure that we do so in the future.

3. **The Crisis Team Assistant Practitioner who saw Ms Witheridge on 29 May 2017 did not read any further back than the date of her first call to the crisis house i.e. 25 May 2017 despite her very extensive past medical history.**

   The Assistant Practitioner acknowledged at the inquest that she should have read further back in the clinical records than she did. To ensure that the learning from this case is embedded within the teams, the operational manager and team manager of the crisis team have reinforced the importance of undertaking a comprehensive review of the clinical records, including reading the risk assessment, before seeing a patient. The practice of reading the history will be checked in regular supervisions

4. **One of the Crisis Team nurses made a plan for a risk assessment to be carried out before Ms Witheridge took any leave. However, this was unenforceable because Highbury Grove is an open facility. If the crisis team nurse had considered this he might have decided that Ms Witheridge in fact needed an assessment under the Mental Health Act when she sought to self-discharge on 27 May.**

   The nurse in question was unable to attend the inquest to explain his plan. However, he was certainly aware that Highbury Grove is an open facility and that Ms Witheridge could not have forcibly been prevented from leaving the premises. The nurse's intention in asking Highbury Grove staff to check in with Ms Witheridge before she took any leave was for them to obtain an impression of her mental state and to make an assessment as to whether she was safe to leave. If staff considered that Ms Witheridge was at immediate risk of self-harm before leaving the premises then immediate action could have been taken such as trying to persuade Ms Witheridge to stay or calling emergency services. As such, whilst the nurse was aware that Ms Witheridge could not be detained at Highbury Grove, he was ensuring that an additional check was undertaken before she left the premises. This is not dissimilar to the assessment which would take place with an informal patient before they leave a ward. We do not consider that the nurse's action in this instance was inappropriate. A mental health assessment was an option that the crisis team was actively considering. However, they did not consider it was needed when Ms Witheridge sought to self-discharge on 27 May.

5. **There seemed to be a lack of understanding by the staff of the difference between a patient answering positively that they have no suicide plan and a patient simply refusing to answer a question about a suicide plan. False reassurance appeared to have been drawn from the latter. No arrangement was made for the crisis team to meet Ms Witheridge on 30 May.**

   Having spoken with the Assistant Practitioner, we are satisfied that she understands the difference between a patient answering positively that they have no suicide plan and a patient simply refusing to answer a question about a suicide plan. In her evidence at the inquest, the Assistant Practitioner said that she was concerned about Ms Witheridge's mental state and that her response about suicidal ideation was minimal. However, the Assistant Practitioner did not consider that Ms Witheridge was at immediate risk of taking her life. Ms Witheridge was willing to engage in her treatment plan after her meeting with her, she was compliant with her medication, and she was willing to pursue treatment.

   The Assistant Practitioner agreed with Ms Witheridge that she would write down her thoughts on paper and pass this on to Highbury Grove staff as she was struggling to engage verbally with them. When the Assistant Practitioner returned to her team, she verbally fed back her concerns about Ms Witheridge's mental state to senior staff on shift. The plan which was agreed was for a member of staff to review her on 31 May and a referral for a mental health act assessment continued to be an ongoing consideration if Ms Witheridge disengaged from the service and/or if her risk to self-escalated. In hindsight, we consider that a member of the crisis team should have visited on 30 May. However, on 29 May, we did not consider there to be an immediate risk of harm to self because Ms Witheridge was willing to engage in her treatment plan after her meeting with the Assistant Practitioner, she was compliant with her medication, and she was willing to pursue treatment.

6. **The care offered to service users of Highbury Grove Crisis House and the Islington Crisis Team seemed disjointed and not dover tailed between OneHousing and Camden & Islington NHS Trust.**

   We are aware that Highbury Grove has sent you our 'Working Protocol' setting out how our teams work together. As set out earlier, we accept that there have been challenges with information sharing. We are confident however that this has been rectified and Highbury Grove and staff will in the future have ready access to all the relevant clinical information.

We would like to assure you that we have good channels of communication with Highbury Grove, and our senior operational staff meet with the Highbury Grove team regularly to discuss how the service is working, and to identify whether there are problems in particular areas.

Following this inquest we have also agreed to jointly investigate all deaths connected to the Highbury Grove Crisis House to ensure that a holistic approach is taken so that all service delivery problems are identified.

I hope that the information in this letter assures that you we have taken forward the learning from this case, and our ongoing commitment and determination to keep all our patients safe.

Yours sincerely

Angela McNab
Chief Executive

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