Camden and Islington NHS
NHS Foundation Trust

Executive office
4th Floor, East Wing
St Pancras Hospital
4 St Pancras Way
LONDON NW1 0PE
Tel: [redacted]
Fax:
www.candi.nhs.uk

Date: 15th January 2015

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

Dear Coroner Hassell,

Re: Ms Sandra Bodrozic (date of death: 29th June 2014)

I write further to your report on 24th November 2014 in which you highlighted concerns about the care delivered by the Camden & Islington Foundation Trust (the Trust) to Ms Bodrozic. I wish to thank you for bringing your concerns to our attention and I am writing to address the issues you have raised below and give the Trust's assurance that it has reviewed these matters and will continue to do so.

In your report you state that, "during the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you." You outlined your concerns in three areas:

1. Ms Bodrozic agreed on 23rd May to the recommendation of those treating her that she be admitted to hospital on an informal basis. However, no bed was found for her until 30th May, by which time she had changed her mind. There was no exploration of purchasing a bed from the private sector when no NHS bed was available.

2. The Consultant Psychiatrist treating Ms Bodrozic formed the view that on the evening of 18th June that Ms Bodrozic should have a mental health assessment however, however, the psychiatrist was going on holiday the next day and so decided to leave this until her return, rather than asking colleagues.

3. The approved Mental Health Professional (AMHP), a social worker, who visited Ms Bodrozic on Wednesday 24th June 2014 decided she needed a mental health act assessment and

immediately made the appropriate referral. However once the referral was made, it took until the following week for this to be arranged and Ms Bodrozic had killed herself in the meantime, on Sunday 29th June.

Health Care professionals explained in court that Mental Health Act (MHA) assessments are, by their very nature, urgent, but there seemed to be a their general acceptance by the team that they will usually take several days to take place, in this case from a Wednesday until the following Tuesday.

The provision for assessment is open ended, with no apparent sense of urgency, and there is no protocol for the timeframe within which this should take place, nor is a time agreed as appropriate with patient or family

Ms Bodrozic's family were not told that, realistically, they could only obtain and immediate assessment by attending a hospital emergency unit.

The Trust's response to each point:

1. When [redacted] took the decision to admit Ms Bodrozic to hospital on an informal basis on 23rd May 2014 she spoke to the duty nurse at the Highgate Mental Health Centre (the Centre) to make the referral. They discussed the urgency of the referral and although there was no bed available at the Centre it was anticipated that a bed would become available within the next few days. This was appropriate given the clinical urgency of the case at the time. Therefore, a private bed was not considered to be necessary. The family had been advised that they could take Ms Bodrozic to the Accident & Emergency department over the bank holiday weekend if there were any changes in her state of mind or behaviour.

   It was thought that a bed was going to be available on 27th May at 2.00pm, but this turned out to be incorrect. Ms Bodrozic medical notes document that the North Camden Recovery & Rehabilitation Intake Team (the Intake Team), were in contact with the duty nurse as agreed on a daily basis. A bed became available on 29th May and the Intake team made several attempts on that day to contact Ms Bodrozic about the bed. They did not manage to meet or speak to her. Another bed was arranged on 30th May 2014 and Ms Bodrozic's brother was contacted and he spoke to her. He reported back to the Intake Team that Ms Bodrozic was now refusing admission.

   There had been no discussion about finding a private bed rather than a Trust bed because the availability of Trust beds at the Centre was changing daily and there had been an expectation that one would become available within the timescale needed.

   The Serious Incident Report in relation to Ms Bodrozic's death noted that the Trust's bed management policy was not followed correctly. Consequently, the Clinical Director for the Acute Division has clarified and disseminate the Trust's bed management policy to its employees emphasising that, 'any patient requiring a bed will be offered admission regardless of their Mental Health Act status'. This should ensure that private beds are available to informal patients promptly.

2. The Consultant Psychiatrist treating Ms Bodrozic had established a good rapport with her and her family and had made stringent efforts to engage Ms Bodrozic in her care. She felt that it was a reasonable clinical decision to carry out the MHA assessment following her period of leave. Whilst on leave, clinical cover arrangements were in place with another Consultant Psychiatrist, which is the usual procedure in order to continue to provide support to Ms Bodrozic and her family should he need arise. Ms Bodrozic brother contacted the team on 24th June expressing concerns about his sister's mental health and following a home visit by the social worker, a referral for a MHA assessment was made. The social worker advised that the assessment would most likely take place the following week but in the meantime, if more urgent care was required, Ms Bodrozic or her family could contact the Crisis Team or attend the Emergency Department.

3. Although the approved Mental Health Professional (AMHP), decided Ms Bodrozic needed a mental health act assessment, it was not possible, because of the very nature of MHA assessments, to complete these within a specific and agreed timeframe. As part of the process, the AMHP service is required to co-ordinate other agencies such as the police, the ambulance service and Section 12 approved doctors to assist in the process. Arranging the availability of all these services can be prove difficult especially when there are conflicting pressures and priorities. In the future, in order to mitigate against any delays in obtaining a MHA assessment the Trust has put in place the following provisions:

   a) Family members are to be kept informed by community services and the AMHP service as to when an assessment is likely to take place with specific attention paid to the carer and how safe they feel with the person they care for.

   b) The AMHP will also record on the electronic patient record system (RiO) how the risks for any delays will be mitigated.

   c) Delays caused by other agencies being unable to attend will be escalated to senior management and if recurrent put on the Trust risk register.

   d) An alert to delays by the London Ambulance Service to attend MHA assessments have been made to the Joint Commissioner in Camden, and also of the poor attendance of GP's to MHA assessments with the Joint Commissioners in the London Borough of Islington.

I hope that the issues outlined above satisfactorily address the concerns raised.

Yours sincerely,

[redacted]

Wendy Wallace
Chief Executive