Camden and Islington NHS
NHS Foundation Trust

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11 January 2016

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

Dear Senior Coroner Hassell,

Re: Matthew Groom (deceased) Regulation 28 Prevention of Future Deaths report

We are writing to respond to your Regulation 28 Prevention of Future Deaths report of 12th November 2015 regarding the late Mr Matthew Mark Groom. We are writing jointly on behalf of our two NHS Trusts.

We have worked jointly to make improvements to address the matters of concern that you raised. This work has been led by the Clinical Director for the Acute division Ian Griffiths on behalf of this Trust and Executive Medical Director Dr Richard Jennings on behalf of the Whittington.

Where appropriate in this letter we make it clear which improvements are to be led by which Trust.

1. **Matter of concern** - *Matt Groom waited four hours in the emergency unit before he saw a mental healthcare professional for the first time. I heard that, at the time in these circumstances, it was not possible for a triage nurse to arrange for immediate mental health assessment.*

Improvements in response to concern

We recognise that it is important for us to improve our joint service so that avoidable delays in mental health assessment are minimised as much as possible.

The improvements that we have made to address this issue are:

a) We have strengthened the direct mental health referral protocol from Whittington Emergency Department (ED) triage to the Camden and Islington Mental Health Liaison Team Service, so that patients attending Whittington Emergency who need to see a mental health professional can be immediately and directly referred. This mental health referral protocol was in place before your inquest into Mr Groom's death, but has since been significantly strengthened in that the patient themselves can now trigger a prompt and direct referral to the Mental Health Liaison Team simply by requesting this.

b) The mental health referral protocol has also been strengthened by creating a new referral flow-chart for frontline staff, which has been disseminated and embedded. The protocol is attached to this letter.

2. Matter of concern - *Diazepam was prescribed but never administered.*

Improvements in response to concern
We recognise that it is essential to minimise the chance that prescribed medication is inadvertently omitted.

The improvements that we have made to address this issue are:

a) We have refreshed and embedded a Whittington ED departmental protocol that clearly defines the responsibility of prescribers to inform the assigned nurse once a prescription has been issued. It also directs the nurses to regularly check patient's drug charts to check for any medications prescribed. In circumstances such as Mr Grooms, where the patient is not in a defined cubicle with an assigned nurse, prescribers should highlight the prescription to the nurse-in-charge of the area.

b) This protocol will be monitored through regular audit, which has been adapted to incorporate checking for medication administration.

c) We have strengthened handover of patient information between Whittington ED and Camden and Islington Mental Health Liaison Team so that this now involves explicit checking between the teams as to whether:
- medications have been prescribed and administered
- medications have been prescribed and refused
- there are any outstanding medications that have been prescribed but have yet to be administered

The staff were also reminded of the importance of checking the written records thoroughly and making specific notes of any prescribed medications written by the ED colleagues before or during their assessment of the patient, and to record their findings clearly in the patient's record.

d) We are making arrangements to reduce the risk of psychiatric or anxiolytic medication being inadvertently omitted, we are making arrangements to ensure that Camden and Islington Mental Health Liaison Team prescribers can prescribe in Whittington ED. The Camden and Islington liaison psychiatry consultant is providing the details of Mental Health Liaison Team prescribers who will then be issued with honorary Whittington contracts in order that they can then prescribe medication in Whittington ED.

3. Matter of concern

The mental health nurse who then saw him did not consider what action to take if he should suddenly decide to leave, most particularly given that she felt unable to conclude the assessment without waiting for a doctor to come in from home to assist.

Improvement in response to Concern

The question of what action may be appropriate in the event of someone leaving the ED before an assessment or during an assessment is complex both from a clinical and legal perspective.

Individuals who have attended the ED voluntarily are informal patients and are not subject to any form of legal detention such as the Mental Health Act. For informal patients staff may try and persuade patients not too leave, but cannot in any manner prevent them leaving. A general duty of care can be applied in circumstances where someone is actively violent or is actively trying to hurt themselves or others, and then a physical intervention can be applied by NHS staff. This was not the case for Mr Groom.

The Mental Health Act enables appropriately trained staff to deprive someone of their liberty and enforce treatment; rightly this assessment requires a high threshold to be met. Alongside this the assessors have to consider the persons capacity to make this decision. Camden and Islington NHS Foundation Trust is satisfied that Mr Groom did not display behaviour that was sufficiently concerning that it required Mr Groom to be immediately detained under the Mental Health Act or any other Act.

Both Trusts have committed to improving staff awareness of their legal duties, what the options are associated with the various circumstances and clinical contingency planning in line with legal options. These are detailed under point 4.

In Mr Groom's case, following the mental health nurse's initial assessment, she did not reach the conclusion that Mr Groom was acutely suicidal and in urgent need of restraining should

he leave the assessment setting. At the point at which the nurse stopped her assessment to speak with the on call SpR doctor for advice, she did not consider it appropriate to document a contingency plan about what action to take were Mr Groom to leave. This was based on the fact that Mr Groom was not considered to pose an immediate risk of absconding or a risk to himself or others. In this respect Mr Groom did not qualify for detention under the Mental Health Act (or the Mental Capacity Act) and therefore there would have been no legal powers to prevent him from leaving. (Although the assessment was incomplete, this in itself would not have been grounds for preventing him from leaving either.) The Trust did not establish that there were any significant clinical competency concerns in relation to the mental health nurse's clinical judgment.

4. Matter of concern - *When Matt did leave the department, the assessing doctor asked the nurse to call the Police, but neither doctor nor nurse considered seeking urgent assistance from hospital security, given that they were by now both of the view that he would probably now have to be detained under section of the Mental Health Act.*

Improvement in response to Concern

To improve the reliability of assessments made by the Whittington and Camden and Islington frontline staff to consider and plan what action to take should a patient suddenly decide to leave, both organisations are jointly preparing a joint framework and reference document that will be used in the ED to outline and further reinforce clear steps with regard to:

1. Early Assessment/determination of risk.
2. Determining capacity and whether restraint under the MCA is a proportionate response.
3. Proactive instructions to security staff if potential restraint is considered justified.
4. Reinforcing existing practice in terms of formal observations by an assigned nurse in the clinical area.
5. Clear documentation of the risk management steps taken (or of no specific plan if risk considered low.)
6. Communication between to the two services.
7.

This will be completed by March 2016. This will assist staff working in the ED but also security staff to determine when it is appropriate to lawfully detain someone against their will.

Following the inquest we have reviewed the case and we are satisfied that our clinicians did everything within their power to prevent him from leaving the Whittington ED on the night in question.

5. Matter of concern - *The nurse who then contacted the Police did not then convey this to them, but requested a welfare check that would be satisfied by knowing he was with a family member.*

Improvement in response to concern

For the reasons described above (in response to concern 3) Camden and Islington NHS Foundation Trust is satisfied that Mr Groom did not display behaviour that indicated that he was at immediate risk of harm to himself or others to require that the police perform an active search for him. Had this been the case then the Trusts practice is to convey this information to the police. Camden & Islington NHS FT already has joint protocols with the Police, concerning people who leave Trust premises and / or go missing.
As I understand it the police were alerted that if they were to see Mr Groom, they should consider bringing him back to hospital if the family members he left with were concerned. As we understand it, this would also normally entail the police's consideration of the use of section 136 legislation if thought appropriate. The police were provided with his last known address.

We recognise that it is important to continuously improve joint working between clinicians and the Police.

The improvements we have made to facilitate this are:

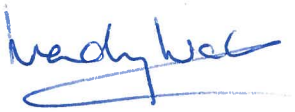
a) We have a new black phone in Whittington Health ED specifically for the police to pre-alert us to patients who are being brought to WH ED under Section 136 of the Mental Health Act, and to communicate any other urgent information.

b) We have a new Standard Operating Procedure for patients brought to the Whittington ED under Section 136 of the Mental Health Act.

c) The Trusts regular meetings with the police have been supplemented by an additional monthly meeting between Whittington, Camden and Islington and a named inspector from Islington Police to agree further actions to improve joint working.

We hope that this response to your Prevention of Future Deaths report reassures you that our two trusts have jointly made significant improvements to reduce the likelihood of any further tragedy like that of Mr Groom's death occurring again. Please do not hesitate to contact us if you would like to discuss anything that we have written here or if there is any other information that we can usefully provide.

Yours sincerely



Wendy Wallace
Chief Executive

Copied to: Dr Richard Jennings - Executive Medical Director on behalf of The Whittington Hospital NHS Trust