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Oxleas NHS Foundation Trust

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Pinewood House
Pinewood Place
Dartford
Kent
DA2 7WG

Tel: 01322 625700
Fax: 01322 625727

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Private & Confidential

Ms Jacqueline Devonish
Assistant Coroner
South London Coroner's Office

Dear Madam,

Regulation 28 response to Prevent Future Deaths Report following the inquest touching the death of Mr Billy Jenkins

Thank you for your correspondence of 21 February 2020 containing a regulation 28 Report to Prevent Future Deaths (PFD), following the inquest into the death of Mr Billy Jenkins which concluded on the 20 February 2020. This response is made on behalf of Oxleas NHS Foundation Trust in regard to the issues of concern outlined below;

1. The findings of the internal investigation by Oxleas NHS were that the assessment undertaken by the Community Mental Health Nurse did not elicit sufficient information to enable the multidisciplinary (MDT) team to properly review Mr Jenkins mental health. Despite this the MDT proceeded with a review and decided that he did not have a mental health condition without seeking further assessment.
2. The Community Mental Health Nurse did not document her formulation or impression. The plan moving forward was not robust and did not explore protective factors or minimise harm and there was an over reliance on alcohol and drug use as the cause of is suicidal ideation. There appeared to be no proforma of questions to ask.
3. As a direct consequence of the limited information gathering Mr Jenkins was not properly assessed and it was not known whether he had a mental health diagnosis which required treatment.
4. It was not known whether as a result of this death there had been any lessons learned by the teams involved in care and treatment of him, or whether there had been any training or support requirements identified for the community mental health nurse.

My response provides further context regarding the expectations of the Trust regarding the assessment process. As outlined in the Trust Root Cause Analysis (RCA) investigation the assessments conducted did not meet the expected standards of the organisation.

The nurse referred to in your concerns, who conducted the assessment, is an agency member of staff who has worked with various teams within the Bexley community mental health service for over two years. Whilst we endeavour to recruit permanent members of the Team we invariably utilise agency staff as vacancies arise and due to the individual's knowledge of the service she has been utilised in different teams during those two years as vacancies arose.

Due to her on-going work she has been treated as a permanent member of the Team receiving supervision and training regarding the expectations of the role as well as clinical cases reviews and discussions. Her work had always been deemed to be of a high standard by differing Team managers she had come into contact with. Despite this however, the quality of the assessment process did not meet the Trusts expectations and standards in the case of Mr Jenkins. This has been followed up in detail with the nurse in question who has been very distressed by the death of Mr Jenkins and noted gaps in her practice. A plan has been put in place to carefully monitor and evaluate her work to ensure that she has understood the expectations of the role and demonstrates an improvement in her practice whilst she remains working in the Trust. The operational manager of the community mental health service is responsible for ensuring this is achieved.

Following this incident we have taken further measures to ensure the assessment of patients within the community mental health team are robustly managed in order to ensure that the MDT has sufficient information to review an assessment and to ensure that where there is any disparity in diagnosis that a further face to face assessment is conducted. The operational team manager is monitoring this practice through discussions in Team meetings, supervisions and MDT case discussions.

I will set out in more detail below the changes we have made in relation to all four issues you have outlined.

As a result of the incident the community mental team core induction tool was sent to all CMHT managers to go through with all the new starters and other established colleagues to reinforce the expectations of their roles and the assessment process. This was shared with all staff in supervision and an email has also been sent to all members of staff. Reflective practice sessions have also been conducted focusing on documentation and record keeping, particularly assessment (needs and risk) and formulation. The impact of this is being monitored in Team meetings and in reflective practice meetings. This will be reviewed again after the current unusual working practices in relation to Covid 19.

In addition to the above, the quality of the assessments being carried out is monitored within team meetings and in 1:1 supervision. Monthly care plan audits is an additional system to monitor quality and standards of practice, it also dictates that we are reviewing the quality of assessments conducted. The operational team manager is responsible for reviewing and actioning areas of improvement arising from this.

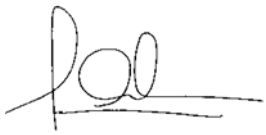
In order to further support staff we have instigated a Trust wide rolling programme of training for mental health community teams. This consists of STORM, a two day suicide prevention programme which offers skills based training in risk assessment and safety planning. Also we have rolled out DICES an evidence based approach to assess and manage risks. The checklist provided during this training support the formulation of risk in the risk assessment utilised by the Team. The training supports staff to notice and assess any risks present, manage the risk

take action to minimise the possibility of the risk happening and demonstrate that you have assessed and managed the risk as well as it is possible to do so and thus supporting timely and effective treatment. The operational manager of the community mental health team is monitoring to ensure all new and existing staff have attended the training and sessions will be on-going following the current Covid 19 situation. We are also exploring online versions of training in the meantime. Other individual training needs are being picked up in Supervisions to ensure practice meets the required standards. Although the community mental health nurse is an agency worker as she has worked across a number of the teams that form the community mental health service she will also access the training and supervision outlined.

Since the death of Mr Jenkins the RCA report has been shared with the team and across the Trust so that similar Teams can reflect on the lessons learnt. The actions arising from the investigation have also been implemented including areas addressed above. Additional learning reflects the need to ensure that all service users who are receiving care and treatment from Oxleas mental health services and also use drugs and or alcohol have equal access to all strands of treatment available to those who are not using substances. Only if there is clear evidence that the use of substances will impact on the ability to clinically benefit from any treatment would a decision be made to withhold treatment and in these instances this would be reviewed regularly with the service user and the team.

I hope my response has adequately addressed your concerns.

Yours sincerely



Dr Ify Okocha
Acting Chief Executive

cc [redacted] Service Director
[redacted] Clinical Director
[redacted] Associate Director