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Dr Julian Morris
Assistant Coroner
London Inner South
Southward Coroners Court
1 Tennis Street
London SE1 1YD

Dear Dr Morris

Re: Regulation 28 response to Prevent Future Deaths (PFD) Report following the inquest into the death of Ms. Claire Lilley

Thank you for your correspondence received on 3 March 2021, containing a regulation 28 report to Prevent Future Deaths (PFD) following the conclusion of the inquest into the death of Ms. Claire Lilley on 30 November 2020.

This response is made on behalf of Oxleas NHS Foundation Trust with regard to the concerns you set out in the PFD report. The concerns were:

(1) Individuals who are the subject of detainment under the Mental Health Act are risk assessed at numerous times. For those that are on Section 17 home leave, they are additionally assessed prior to leaving the ward on each occasion. In addition, risks are also reviewed on the regular multi-disciplinary ward rounds.

(2) However, such assessments are not centralised in any one place – there is no central formulation. Reviews by any clinician would have to cover 3 or 4 different entries by way of example: the risk assessment page, the MDT notes, the psychology entries (although they, per se, do not enter risks assessments).

(3) The Court's expert confirmed that such a centralisation/ formulation (supported by the Route Cause Analysis report), would assist in reviewing an individual's risk and allowing ward staff to see the wider input in one place.

(4) Training has been implemented by the Trust to assist staff in formulating risk, a process that was in place at the time of Claire's death. However, there is no central repository/formulation of the outcomes of those assessments. Different teams continue to use different tools; there is no stand-alone document.

(5) Consideration should therefore be given to the creation of a centralised, formulated, risk document to be entered upon by all clinicians irrespective of their own speciality.

We have explored options for the creation of a centralised, formulated, risk document to be entered upon by all clinicians irrespective of the own speciality. We already have an established centralised document that all clinicians are expected to complete on the electronic health record, RiO, before multidisciplinary meetings (MDT). It is known as the MDT template. We also have a Risk Information section on RiO where risk assessments are all recorded in a Risk Assessment document. Two years ago we separated the MDT template and the Risk Assessment document. The rationale for this was so that all professionals could update the MDT template ahead of MDT meetings and that all professionals could take ownership of updating the Risk Assessment document at the point of risks changing. In practice the Risk Assessment tends to be updated predominantly by medics as part of the MDT review (but this is affected by system and organisational factors).

The Risk Assessment document will now be the centralised document for all professionals to document all risks immediately. To support, a new mandatory section will be added to the Risk Assessment document in Rio. This section will be a formulation summary. This summary will then automatically pull through to show on the MDT template and the inpatient care plan.

To further address your concerns we will be focusing on ensuring that the Risk Assessment document is optimised by ward teams and that the MDT template utilisation is improved for wider discussions of the picture of risks for an individual.

We will as a result:

1. Reinforce that all professionals are responsible for taking ownership for updating the Risk Assessment document. This will address an over reliance by multi-professional teams (nurses, psychologists, occupational therapists etc) on Consultants to update the Risk Assessment document. This means that in addition to escalating risks to the Consultant that all professionals must document risks at the time they are identified. It means that all professionals will be constantly thinking about risks and updating the Risk Assessment document when things happen. This will give a much better and clearer picture of risk events rather than that which might be achieved a formulation alone.

2. Reinforce the use of the Multidisciplinary Team (MDT) template where all involved professionals are required to input their feedback ahead of an MDT meeting to include their actions about documented risks that they have identified and added to the Risk Assessment document. However this needs to remain separate to the Risk Assessment document as it is not realistic for the weekly MDT meeting to update, summarise and state what might improve or worsen the risk. Currently the MDT template is not being used as effectively as it could be in a meaningful way, evidenced by internal transfers and this is being addressed with teams to reduce the variation.

3. Emphasis will be put on seeking information and feedback from service users and their families and carers, especially after periods of leave. We will require this to be consistently recorded in the Carer's view in the MDT template following periods of all leave.

4. A decision will be made about the risk at every MDT meeting. The MDT meeting will record as an action, who present at the MDT is going to update the risk assessment for a service user and then ensure that it is done. The allocated clinician will update the RiO Risk Assessment and associate management plan in the care plan for every risk identified after the MDT so it captures what was discussed and agreed.

5. To facilitate this we will remove from the current Risk Management Policy that it is the Responsible Clinician responsibility to ensure that a clinical risk assessment and clinical risk management plan is made before the decision is taken to discharge a person or grant leave. Currently the expectation is that the primary nurse does this but it is not working effectively when the primary nurse is not in the ward round. By making it the responsibility of a professional allocated at the time of the MDT meeting, the expectation that this happens immediately after the MDT meeting will ensue that the Risk Assessment document and associate management plan in the Care Plan is updated contemporaneously.

6. If anything changes in the period between MDTs, as stated, all clinicians will be expected to exercise their individual responsibility to personally update the Risk Assessment.

7. The Clinical Risk Assessment and Management Policy will be updated to reflect these standards.

8. The Medical Director and Director of Nursing will write to all clinicians about these agreed standards. This will be further facilitated through a team approach to risk management led by the Matrons.

To conclude, I am grateful for your report which has ensured that additional measures are instituted so lessons are learned from the death of Ms Lilley.

Yours sincerely,

[redacted]

Chief Executive