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NHS Foundation Trust

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26th March 2021

Private and Confidential
Coroner Graeme Irvine
Inner North London
Poplar Coroner's Court
127 Poplar High Street
London E14 0AE

Dear Coroner Irvine

Re: Inquest into the death of Thiago Araujo – Prevention of Future Deaths report

I am writing further to the inquest for Thiago Araujo which was heard on 4th – 6th January 2021 and concluded on Thursday 28th January. Following the inquest you issued a Prevention of Future Deaths report to a number of organisations including the Trust. I will address the matters of concern raised in this report in turn.

1. *On 24th January 2020 Mr Araujo had discharged himself from psychiatric inpatient care; he was to be supervised by the Camden and Islington NHS Foundation Trust crisis team. Mr Araujo failed to engage with the crisis team and following a meeting on 30 January 2020 the crisis team closed Mr Araujo's referral. In the course of this closure no arrangements were made to address the risks presented by Mr Araujo.*

Following the initial 3 days of this inquest the Trust wrote to you to provide some additional assurance around the Serious Incident (SI) investigation report and the recommendations made, which were updated and strengthened in light of the issues raised at the hearing. One of the additional recommendations concerned this matter and is as follows

Additional Recommendation: Any service user of the Crisis Team who is being considered for discharge because of non-engagement must be discussed in the Crisis Service Multi-Disciplinary Meeting with senior overview of the decision to discharge. The decision and rationale to discharge because of non-engagement must be clearly communicated to the

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community team and carers and this must be clearly documented in the clinical notes. When a service user is discharged because of non-engagement the Community Team must update the Crisis and Contingency Plans to ensure the service user and carers are aware of the support available following discharge.

This action was due to be completed by the end of February and I can confirm that this practice is now in place.

2. *Following Mr Araujo's death it has become clear that the closure of his case by the crisis team was not permanent, and had Mr Araujo or his family approached the crisis team to reopen his case, steps could have been taken to reinstate crisis team support. Mr Araujo's family were unaware of this facility.*

   On discharge it is the crisis team's standard practice to advise service users that they may re-refer themselves, or be re-referred, should the need arise. We can only sincerely apologise to Mr Araujo's family if this was not made clear to them in this case. All crisis team staff have been reminded of the need to ensure that this information plus relevant contact details is passed on. This is also covered by the recommendation at point 1, where the updating of crisis and contingency plans is required.

3. *Families and carers of patients diagnosed with emotionally unstable personality disorder do not receive support or education upon management of this diagnosis from Camden and Islington NHS Foundation Trust, unless the patient has been received for treatment by the personality disorder service.*

   The Trust has a duty to assess carers need for support as part of its responsibilities under the Section 75 Agreement with the Local Authority. When the Personality Disorder Service identify a carer who may be in need of support, either at the point of referral, assessment or during the treatment of a patient, a Carers Assessment at the service is offered. A Carers Lead is employed to fulfil this role. When the Personality Disorder Service is not directly involved carers are directed to Local Authority services - Support for carers | Camden & Islington Carers Hub | Supporting unpaid carers in Islington. Carers assessments are also carried out by other community teams within the Trust, including the community rehab team, who can support carers to access appropriate support. The Trust recognised that a key theme in the report was that carers had lost confidence in the teams working with the deceased and did not feel their views were taken on board. As a result of this feedback the Trust has revised the action plan with an additional recommendation relevant to carers involvement. To provide assurance that this is consistently happening, the strengthened action plan includes a requirement for community teams to carry out 6 monthly audits, checking that carers are routinely offered an assessment and support plan, and that information, support and psychoeducation are available. Plans will be developed to address any gaps identified as a result of these audits which are now underway within the teams.

4. *By 4 February 2020 the Camden and Islington Recovery Team identified an acute risk of suicide in Mr Araujo, faced with his noncompliance with community treatment they considered an admission into inpatient care. No actions were taken to affect this plan.*

   In evidence the community recovery team indicated that a factor in their inaction was the knowledge that arranging a section 135 Mental Health Act 1983 warrant and assessment would take two weeks. Such an assessment requires actions from an approved mental health practitioner from the local authority, two section 12 Mental Health Act approved doctors, the assistance of the Metropolitan police and the local magistrates court to secure a warrant. A delay of 14 days in securing a Mental Health Act assessment is in my view unacceptable.

   The AMHP service, which coordinates and carries out assessments under the Mental Health Act, is a local authority service, although physically based on Trust premises. The Trust has liaised with our local authority partners in regard to this important issue and we can report as follows:

   The average wait for a community assessment at the moment is around 14 days. In February 2020 when the incident took place the average wait time was closer to 18 days, so we are seeing some improvement but acknowledge further is required. This issue is part of our CQC action plan and ongoing monitoring is in place as part of this via our Mental Health Law Committee.

   Reducing average time
   There have been a number of actions by the AMHP service and the police to reduce wait time over the last year. Very often delays have been due to police availability/capacity in regard to providing a time slot when they are able to attend in support of an assessment. The police now have a permanent team in their mental health department and the size of this team has been maintained. They also have a more robust management structure so we have a clear reporting mechanism if we have concerns. This has enabled the team to continue to support us throughout the year.

   The AMHP team is responsive to the challenges of the Covid 19 pandemic, including the management of staff absence, to ensure all resources across the boroughs are used to maximum effectiveness and response to service user needs.

   In mid-2020 both boroughs made additional investment in their staffing.

   Prioritisation
   Although the average wait time for a community assessment is 14 days, response is managed with individual risk assessment and prioritised response. At the point of referral for a Mental Health Act assessment the referral is discussed with the referrer and an understanding of the risks and urgency of the assessment are established. Any assessments

with significant risks are flagged to the duty manager and service manager and an early conversation is had with the police. It is established practice to communicate with the referrer so that the AMHP team are aware of and can respond to changes in the service user's level of assessed risk.

The inquest has highlighted the need to ensure Trust services are aware of the AMHP service's capacity to prioritise waiting times and the AMHP service's commitment to ongoing information sharing with referrers.

5. *In the days leading to Mr Araujo's death his family became aware that he had made an online purchase of sodium nitrite which was to be delivered to his father's home. Despite raising these issues with Camden and Islington NHS Trust, the Metropolitan police and employees of the Post Office there appeared to be no process available to the family to escalate their concerns to prevent delivery of this package.*

   It was apparent from the evidence given at the inquest that at the time of this incident Trust staff were unsure how to respond to this situation and what actions if any were available to them. The Trust has since sought advice from its legal team and guidance to staff on this issue, as well as reiteration of previous advice around access to means to self-harm generally, has been circulated across the organisation.

   The legal advice we have received is that the Royal Mail do potentially have powers to intercept and destroy packages containing items which are either prohibited or restricted from being sent in the mail. Therefore, as part of the response to concerns of this nature, teams should consider reporting any concerns about potentially dangerous packages to the Royal Mail (via the local sorting office) and also to the police and must ensure that discussions and actions taken are documented in the clinical records.

   It would be very helpful in informing our actions going forward, if we can be provided with a copy of the Royal Mail's response to the PFD as we are keen to work with them in regard to these challenging situations.

I hope that my response clarifies the position and provides you with the necessary reassurance. If you need any further information, please do not hesitate to contact me.

Yours sincerely

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Chief Executive