South London and Maudsley NHS
NHS Foundation Trust

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Case Ref: 03102-2011

1st September 2015

Dr Andrew Harris
Senior Coroner
Southwark County Court
1 Tennis Street
London
SE1 1YD

Dear Dr Harris

Re: Michael George, who died on the 7th December 2011

I write in response to the Regulation 28 Report to Prevent Future Death in the case of Michael George.

Expert evidence was heard that:

1) *The management spokesperson on the Action Plan at the inquest was unaware the Trust had received these two court Regulation 28 reports, suggesting that senior management attached insufficient importance to them and the issue of physical health care of mentally ill patients.*

2) *Although there was now systematic recording of urine and blood glucose of patients on anti-psychotics on the wards, the audit conducted and presented in court showed a number of patients who had refused these tests, but not demonstrated whether in subsequent weeks testing was conducted or whether these same patients, like Mr George, never had their glucose measured, noting that urine measurement was non-invasive, and had an appropriate care plan to address these risks.*

3) *The Trust responses to 2654-11 in September 2014 was that a research bid was being mounted and discussions held with commissioners and Kings College Hospital (KCH). Progress on this was not provided to the court and there had apparently not been action to reduce risks of deaths by ensuring there was domiciliary visits from consultant physicians at KCH (which is across the road from the Maudsley) to mental health wards, as reported to the Trust in 2014. The need to implement such a service was again reiterated by a different expert in this inquest. It is inferred from the expert opinion that*

failure to do so would mean that patients in SLAM in-patient units would be more at risk that those mental health patients in a district general hospital.

4) *Whilst there had been individual learning and changes in training and note keeping and recording, it was unclear whether, in the absence of consultant physician advice, that the serious untoward incident investigation conclusion on urgent transfer would be heeded. It advised that there should have been immediate action to call an ambulance to effect transfer, despite lack of escort, when the blood results were known.*

The Trust has paid particular attention to the physical health care of our patients and those with diabetes in particular. There are a number of initiatives which we hope will help prevent future deaths from the complication of diabetes on our wards:

1. The Trust has established a Physical Health Committee chaired by two consultant psychiatrists, [redacted] and [redacted]. The committee has been working closely with [redacted], Consultant Diabetologist in improving the management of Diabetes Mellitus on our wards.

2. [redacted] has done work with the Maudsley in the past to help provide a framework for the management of non-urgent diabetes as a Maudsley inpatient. She is in the process of revising this older protocol.

3. The MEWs (Modified Early Warning scores, soon to change to NEWS, National Early Warning scores) have been rolled out and are improving the ability of mental health nurses to pick up deteriorating patients.

4. [redacted] Core Trainee 3 (CT3), SLaM linked with [redacted], Consultant Diabetologist, Kings College Hospital (KCH) last year to produce the attached protocol for the management of hyperglycaemia on our wards. (Appendix I)

5. In relation to the previous recommendation of Inreach medicine into the system, the Trust collaborated with KCH to put in a bid for a Medical Liaison Team to consult on the medical management of our inpatients. After repeated revisions, this was turned down. This was unfortunate as we had clearly demonstrated the need as evidenced in Appendix II, where we show that over 10% of our admissions are medically unstable enough to require a night in a general hospital as part of their SLAM inpatient stay. However, to my knowledge, no Mental Health Trusts have Inreach medical care on their general psychiatry wards, although many forensic units have GPs who visit (in keeping with the long length of stay). We plan tp continue to lobby for resources to establish such a service.

6. We have linked with KCH to continue to improve access to care and demonstrated in a pilot study how this affects length of stay in the acute hospital – an indirect indicator of medical need. (Appendix III) I also attach the pathway for rapid access to medical care from the Maudsley site. (Appendix IV)

7. This is a keen area of interest for the Trust to develop, nationally as well as locally. Dr [redacted] and [redacted]n from the Trust are members of a National Confidential Enquiry into Patient Outcome and Death group (NCEPOD) looking at the care of people with significant mental illness in the acute hospital. This derives from the Trust work with Kings, in that the chair and proposer of the topic is [redacted], Acute Medical Consultant in KCH, whom we have worked with closely on this problem.

8. The lack of appreciation of the urgency of the high glucose is important, but not surprising, given the minimal medical exposure in current nursing training. We believe there is a need for more general nursing as part of the RMN course, that would be potentially very constructive.

9. The psychosis physical Health Strategy (Appendix V) does suggest monthly full blood fasting blood glucose (FBG) or random blood glucose (RBG) plus glycolated haemoglobin HBA1c for the first 3 months on clozapine and olanzapine and we are in the process of develop protocols for this. This is a local target and not in the 2014 NICE guidelines. (Appendix VI)

10. CQUINS (commissioning for quality and innovation) have optimised the requesting of tests on the wards but the management of patients refusing tests is very difficult. It is possible to take glucose under restraint under the MHA. The MCA may be used but, restraint for bloods is technically difficult and if someone has a treatment responsive illness, in the absence of an acute deterioration, people often wait for their mental health to settle and try again once, they regain capacity. If someone is refusing bloods, it is rare for them to agree to urine testing – urine is usually more difficult to get than blood. However with respect to sugar, a BM Stix under restraint is feasible – though not pleasant.

11. The Trust is considering adding the Glasgow Anti-psychotic Side-effects Scale (GASS) to our electronic patient record. We have also adapted the use of the GASS for use with clozapine (which we have shown to have a high rate of diabetes). This looks specifically for symptoms suggestive of rising blood glucose. (Appendix VII)

12. SLaM is investing a considerable amount of effort to this area and is liaising widely to generate solutions, which we disseminate locally and internationally. (Appendix VIII)

13. We are as an organisation hugely aware of the need for joint approaches to solve these problems. With this in mind, our CEO, Dr Mathew Patrick, has set up a working group as part of the London Strategic Clinical Network, which he co-chairs, to promote the generation of cross-system solutions.

I hope this letter and its attachments are a testament to the issues which were raised and our continued efforts to improving our services.

Kind regards

[redacted]
Medical Director

Enc. [redacted]