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Ms Sonia Hayes
Assistant Coroner
Coroner for South London Area
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Care Quality Commission
Our Reference: MRR1-5003472374

Dear Sonia Hayes

Regulation 28: report to prevent future deaths following the inquest of Julia Jane MacPherson

Following the inquest into the death of Julia Jane MacPherson, the Care Quality Commission (the 'CQC') received a copy of the Regulation 28 report from the coroner with a letter dated the 14 February 2018.

We note our legal responsibility to submit a written response to you, however some of the matters of concern relate to the very specific circumstances of Julia MacPherson's individual care and treatment, so we are unable as a regulator to comment on this.

Since Julia Jane MacPherson's death in May 2016, we have inspected Oxleas NHS Foundation Trust once. This was a follow up inspection of the acute wards in the Trust, including Norman Ward, in February 2017 to see if some specific improvements had taken place since the comprehensive inspection in April 2016. We also carried out regular visits by our Mental Health Act reviewers, and the last one took place on Norman Ward in March 2017.

Matters of concern:

Timeliness of medical reviews and assessment of capacity:

At our inspection of the acute wards, including Norman Ward in April 2016, we found that there were adequate numbers of medical staff and we do not specifically mention any difficulties with the timeliness of medical reviews. We noted that patients had access to a multi-disciplinary team.

We also found that staff were trained and able to apply the Mental Capacity Act 2005. However, at the Mental Health Act review visit in March 2017, it was found that two patients had been prescribed high dose anti-psychotics. For one of the two patients, the use of high dose antipsychotics was discussed but no capacity assessment was found.

Staff not regularly reading clinical entries in patient records:

Our report following the inspection in April 2016 does not specifically mention staff regularly reading clinical entries in patient records. It does, however, note the regular handover meetings for core staff to share information about the patients.

Patient records not including a record of discussions when medication is used outside of its licenced indication:

Our report following the inspection in April 2016 said that 70 patient records were inspected. The report does not specifically mention the absence of recorded discussions or decisions in individual patient records for the use of medicines outside of its licenced indication.

Prescribing not in line with NICE guidance:

The inspection in April 2016 looked at 105 medicine administration records and concluded that NICE guidance was being followed when prescribing medicines. We did record that three patients were being prescribed medicines outside of the usual levels, but do not raise any concerns about how that was being managed.

Recording consent to medication for informal patients:

Our report following the inspection in April 2016 does not specifically mention how consent to treatment was recorded for informal patients. It does however say that informal patients were given a leaflet explaining their rights.

We will be returning to inspect Oxleas NHS Foundation Trust later in the year. We intend to follow through some of the areas of concern in more detail. This will be to ensure the trust has learnt from this and made the necessary improvements.

If you require any further information please do contact the Inspection Manager Judith Edwards who can be reached through our main switchboard number 03000 616161 or by email at judith.edwards@cqc.org.uk.

Yours sincerely

Head of Hospital Inspections (Mental Health)