Birmingham and Solihull Mental Health
NHS Foundation Trust

Mrs Emma Brown
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5 September 2019

Dear Ms Brown

Re: Regulation 28 report, prevention of future death pertaining to Mr David Jukes, deceased

May I open this letter by reiterating on behalf of Birmingham and Solihull Mental Health NHS Foundation Trust our most sincere condolences to Mrs Jukes following the sad death of her husband Mr David Jukes whilst he was under the care of our Trust. We would also like to extend our thanks to Mrs Jukes for her participation in our serious incident investigation at a time that must have been extremely distressing for her and take this opportunity to extend an apology to Mrs Jukes once again for any failings that occurred whilst David was within our care.

On 15 October 2018 you commenced an investigation into the death of David Jonothan Jukes. The investigation concluded at the end of an inquest on 11th July 2019. The conclusion of the inquest was Mr. Jukes' death was a result of suicide. Despite being open to a Home Treatment Team ('HTT') and the Complex Treatment Service ('CTS') within Birmingham and Solihull Mental Health Trust ('BSMHT') Mr. Jukes had not undergone an adequate assessment of his mental health by the time of his death as a result of the following:

1. At the time of attendance by the Liaison and Diversion practitioner at Oldbury custody suite on the 28th September 2018, the practitioner did not have full details of the events during the evening of the 27th into 28th from West Midlands Police nor access to records pertaining to his mental health held by his GP, the West Midlands Transition, Intervention and Liaison Service and BSMHT. With access to this information, she would have requested a Mental Health Act Assessment.

2. A Psychiatrist did not attend to assess Mr. Jukes whilst he was in custody on 28th September 2019 contrary to normal HTT practice.
3. Clinicians within HTT did not make adequate attempts to locate and engage with Mr. Jukes after being made aware of the events of the 27th and 28th September 2018 and after it was reported that he was threatening harm to others and to himself in a conversation with a psychologist on the 2nd October 2018.
4. Clinicians within HTT did not make adequate attempts to locate and engage with Mr. Jukes after he failed to attend for medical review on the 4th October 2018;
5. Clinicians within HTT did not offer Mr. Jukes' an urgent medical review when they spoke to him on the morning of the 9th October 2018.

Following a post mortem the medical cause of death was determined to be: 1a) Hanging

During the course of the inquest the evidence revealed matters giving rise to concern in such a way that there is a risk that future deaths will occur unless action is taken. The matters of concern are as follows. –

1. The psychiatric liaison and diversion practitioner employed by BCPFT who attended to review Mr. Jukes in Oldbury custody suite on the 28th September 2018 did not have sufficient information about the history of arrest to inform her decision making on assessment in custody. She was provided with a print out of the first two pages of the custody record which included the statutory arrest reason and the circumstances of arrest but nothing that indicated that he had barricaded himself in the loft, threated suicide and harm to others and not come out in

   We understand that the Black Country Partnership NHS Foundation Trust are responding to you on this matter of concern.

2. The above psychiatric liaison and diversion practitioner gave evidence that she contacted either the duty bed manager for BSMHT or the BSMHT liaison and diversion team based at Perry Barr custody suite and was informed that Mr. Jukes was not known to the service. She stated that if she had been aware that he was open to the HTT she would have sought information about his involvement and would have made the team aware that he was in custody and the events of the previous evening. It was not established during the inquest and has not been established in BSMHT RCA investigation how this breakdown in communication occurred. Evidence was heard that the introduction of the Merit Vanguard system would not give a BCPFT employee in a custody suite access to some information and would mitigate against such circumstances arising again but it doesn't explain why the nurse was left with the impression that he was not known to services. It is not unusual that clinicians from different mental health trusts will need to discuss patients and as full records are not available through the Merit Vanguard this will continue to arise. If reliable information is not being passed there is a risk to life from ill-informed decision making.

   It is difficult for us to comment on this particular finding of the PFD as the liaison nurse remains unclear of who she spoke to or which service she contacted. Nor is there any documented record of this contact within the Liaison and Diversion Service. Within our bed management service we have an arrangement for the identification for patients under our care. We do however recognise that if it were bed management that the nurse contacted, the existing arrangement failed to identify Mr Jukes. We are therefore implementing a

documented and recognised system within our bed management team for all such calls which includes phonetic spelling and other controls to ensure a consistent approach to this matter.

3. Despite not being informed by the BCPFT liaison and diversion nurse that Mr Jukes was in custody the HTT were made aware by his wife that he was in custody on the 28th September 2018. She also gave some information about the circumstances of his arrest, further information about the incident and police involvement had been reported to Street Triage during the night and was noted in the RIO notes. Despite this, no psychiatrist visited or attempted to visit Mr. Jukes in custody which it was stated in evidence was the usual practice of the team. It is not known why this was. Not having a robust and effective system to carry out necessary assessments whilst a patient is detained in police custody puts lives at risk.

   We are grateful to you for raising this matter with us as it has identified the need for a joint operating protocol to be developed between BSHMFT and the Liaison and Diversion Service in Sandwell. We have been in liaison with this team and are scheduled to meet and develop this protocol in late September 2019.

4. Following his release from custody on the 28th September 2018 and evidence from a psychologist that he was threating suicide and harm to others, on the 2nd October 2018 the HTT's only recorded attempt to contact Mr. Jukes before the 9th October 2018 was a single call (which probably mistakenly went to his wife's phone) on the 4th October 2018. Despite the fact that his location was unknown and he had not attended a planned medical review on the 4th October 2018 there was no email communication to Mr. Jukes (although he had communicated this way with the team before and provided them with his email address) nor a call to his wife to ask her for assistance. There was evidence at inquest from the RCA Author that there should have been more effort to contact him at least from the 4th onwards if not before. Failure to utilise all means of locating a patient whose whereabouts are unknown, who requires assessment and who is not making contact with the team puts lives at risk.

   We sincerely apologise for this matter. The matter of communication preferences is being addressed by the Trust in that we now have a communication preference field within the clinical record RIO.

5. It was planned that Mr. Jukes would be discussed at a team meeting on the 3rd October 2018 after the psychologist raised concerns on the 2nd. There is no credible evidence he was discussed or a plan made to locate and assess him. No explanation was provided in evidence nor was evidence given of a strategy to guard against this occurring in future. Therefore there continues to be a risk that plans to discuss patients in meetings will not be followed through which puts lives at risk.

   As you state, it is vitally important that clinical records are documented to evidence the care and treatment plans for patients that are discussed between clinicians. We have identified that when our Multi-Disciplinary Team meetings take place there is evidence of some inconsistency in the recording of discussions and outcomes in some areas. In direct response to this finding we have increased administrative resources within our Home Treatment Teams to enable consistent administrative support to our Multi-Disciplinary Team meetings which in turn will ensure that outcomes are clearly recorded. In addition, we have commenced a Quality Improvement Project to develop clear standards for Multi-

Disciplinary Team meetings and recording requirements. We apologise sincerely for this failing in our clinical record keeping for Mr Jukes.

6. On the 9th October 2018 a HTT clinician talked to Mr. Jukes on the phone at which time he sounded intoxicated, was calm and polite, gave his location and agreed to attend an appointment for a medical review on the 12th October 2018 if a bus pass were provided to his location for him to attend. No arrangements were made in an attempt to assess Mr Jukes before the 12th October 2018. By this time there was reason to suspect Mr. Jukes was at risk of harm to self or others, was under the influence of substances, had not had a full assessment by the team, had recently not been engaging with services and his location had been unknown for over a week. This evidence indicates that those making the decision to ask Mr. Jukes to attend on the 12th underestimated his risk and were not pro-active in making contact. The staff involved maintained in evidence that they acted appropriately, evidence was given that this was not the finding of the Root Cause Analysis investigation review panel. In these circumstances to fail to attempt to assess as soon as reasonably practicable a patient who has come back into contact with the team as soon as reasonably practicable puts lives at risk. No evidence was given of specific action to address the decisions that were made on the 9th October 2018 with the individuals involved or the team generally and therefore the risk continues.

   In direct response to this matter of concern we are now reviewing our Home Treatment Team Operating Protocol to strengthen the requirement for nurse led triage and assessment screening and appropriate clinical escalation to a Consultant Psychiatrist. Consultant Psychiatrist overview and scrutiny of each case would either be through direct clinical assessment or review or through input and direction within the multi-disciplinary team or through formal or informal supervision of doctors and other home treatment staff. We note the view of the team that they felt they acted appropriately and are therefore also using this very sad incident as a Case Study in our new Clinical Risk Assessment and Management Training so that staff are fully alert to accumulative risk factors. This training is mandatory for all clinical staff in the Trust irrelevant of clinical profession or team. The first pilot of the new training model which also incorporates suicide prevention training is due to launch at the end of September 2019.

7. Throughout the inquest evidence was given of alleged attempted contact and decision making with respect to Mr. Jukes that was not recorded in his BSMHT RIO notes. Furthermore, his Risk Screen was not updated after information came to HTT's attention that affected his risk assessment. There was some evidence that HTT do not have capacity to fulfil their obligation to keep records but evidence from some witnesses suggested that they did not view record keeping as a necessity. If, for whatever reason, RIO notes are not an accurate reflection of contacts, actions and decision-making clinicians maybe misled or ill-informed creating a risk to life. Evidence was given that there is an e-learning module on the topic of record keeping and a 'Key message' 3 minute video but it is not compulsory for staff to watch the video or feedback on it and staff are not tested or individually audited. Consequently there continues to be a risk that individuals will not comply with their duty to keep proper records and that this noncompliance will go undetected.

We recognise the need for an improvement in clinical record keeping standards and how this is absolutely central to the effective care of our patients. We apologise that this was not evident within the case of Mr Jukes and are sincerely sorry for this failing. The importance of risk identification, formulation and recording forms a central part of our new Clinical Risk Assessment and Management Training which, as stated above, will be piloted from September 2019. In addition to this training, all staff irrelevant of discipline are required to undertaken annual training on information governance where the importance of clinical record keeping standards is also highlighted.

We are conscious that our Home Treatment Teams have been operating within an environment of high demand and acuity and that this may at times compromise their ability to consistently meet the important standards that we expect of staff. We are investing a significant amount of new financial resource into our Home Treatment Team to increase workforce capacity. This includes:

- 5.0 Full time Home Treatment Team Managers – 2 positions have now been recruited to and a further 3 are currently out to advert
- 3 Full time Out of Hours Practitioners – all posts are currently out to advert
- 5.0 Full time Additional Medical Middle Grades
- An additional 0.5WTE Psychologist in every Home treatment Team (currently out to advert)
- 4 full time Administrative posts to support Home Treatment Team activity and recording of MDT discussions

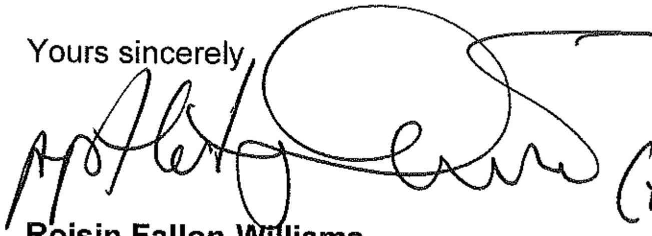
In addition to this, we have launched two critical Quality Improvement Projects – one is to develop and implement core MDT minimum standards for recording of clinical documentation; the second is to improve our care planning and clinical risk assessment processes.

8. Evidence was given at the inquest that the reason HTT may not be maintaining good record keeping was due to insufficient capacity arising from a combination of too few staff arising from under-funding of the service and unnecessary referrals being made to the team. Evidence was given that there is work underway to introduce a systems to prevent inappropriate referrals and that funding has been granted for a further two CPNS for HTTs within BSMHT. However the evidence was that this will not be enough to enable staff to have the time to comply with their obligations to update progress notes and risk assessments. If funding is not sufficient to enable staff to fulfil their professional obligations to their patients, lives are at risk.

Please see the actions that we are taking in relation to an increase in resources to all Home Treatment Teams alongside the Quality Improvement Projects that are being taken forward to ensure that key aspects of record keeping are as effective yet streamlined as possible so that we are able to reduce duplicative entries for staff on the RIO record.

In closing this response, we would like to assure you that we have taken the matters raised in your Regulation 28 report extremely seriously and once again apologise to Mrs Jukes. We hope that the above actions will make a difference to the experience of future patients in our care and thank you for formally raising these with our organisation.

Yours sincerely,



(HILARY GARNETT, Medical Director)

Roisin Fallon-Williams
Chief Executive