NHS
Black Country Partnership
NHS Foundation Trust

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Tuesday 24th September 2019

Mrs Emma Brown
Area Coroner, Birmingham and Solihull
Coroner's Court
50 Newton Street
Birmingham
B4 6NE

Dear Ms Brown

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

Firstly on behalf of Black Country Partnership NHS Foundation Trust may I extend our most sincere condolences to Mrs Jukes following the sad death of her husband Mr David Jukes.

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. In response to you Regulation 28 report to prevent future deaths we have outlined below the actions Black Country Partnership has taken to address the matters of concern that affected our organisation.

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 response to police negotiators. This information was not included in a verbal handover according to the nurse's evidence and there is no record of it being handed over to her. She stated in evidence that if she had been aware of the extent of the events overnight on the 27th into the 28th she would have arranged a Mental Health Act assessment when he did not engage with her. There is a risk to life if assessments of mental health in custody are not informed by material information about circumstances connected with arrest

At present Liaison and Diversion (L&D) nursing staff have read access only to the current electronic custody record (ICIS) and in line with standard operational procedures are instructed to ensure checks are undertaken and all available content on ICIS is reviewed. This is further supported by obtaining a verbal update from the police. To improve

information sharing arrangements with police , senior L&D staff are engaged in the West Midlands wide implementation of the new electronic custody record (CONNECT). Once fully implemented, it will enable staff to access a wider array of information relevant to each case prior to assessment. They will also have read and write access where risk information can be recorded by nursing staff.

L&D leads will raise awareness of the outcome and learning from the regulation 28 PFD report through the Joint Operational Group held with police on a quarterly basis to engage with police colleagues and stress the need for a full handover prior to assessment in each and every case.

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.

Before acting on any referral, L&D staff will do full background checks. This is part of the triage process to establish previous history, risk, current care plans, treatment, compliance and medication for example so staff can make an informed judgement on who needs to be seen and the level of urgency. Local mental health databases are reviewed however when staff don't have immediate access, neighbouring services will be telephoned to attain all relevant information. Across the L&D services we are also rolling out staff access to the Spine to give staff wider access to patient information.

Unfortunately we have yet to ascertain why on this occasion the L&D staff member was advised by BSMHT that the patient was not known to services however meetings with Trust leads from BSMHT are being planned to consider how we can jointly strengthen communication pathways to prevent reoccurrence. Implementation of the MERIT system will further enable staff access to information from mental health Trusts in Birmingham and Coventry. Likewise Birmingham and Coventry staff will be authorised for access to MERIT, for mental health information about those records held on both Oasis systems covering the whole of the Black Country.

Please note that all other concerns raised within the Regulation 28 report affected other NHS bodies and services not provided by BCPFT and therefore we have not commented on these outcomes. We have however approached both BSMHT and CWPT to consider

engaging in a wider learning event to consider all outcomes and where processes can continue to be strengthened.

I hope this provides you with assurance that the Trust has taken the concerns raised in your Regulation 28 response very seriously and will continue to take action to reduce the likelihood of a similar incident from reoccurring. We hope that the actions highlighted above will make a difference and we will review changes made at regular intervals to ensure they are embedded whilst sharing the outcome and lessons learnt with all affected staff across our Liaison and Diversion teams.

Yours sincerely

Lesley Writtle
Chief Executive