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Oxleas NHS
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24 July 2020

Dr Andrew Harris
Senior Coroner
London Inner South
Southwark Coroners court
1 Tennis Street
London SE1 1YD

Dear Dr Harris,

Re: Regulation 28 response to Prevent Future Deaths (PFD) Report following the inquest into the death of Mr. Gary Etherington

Thank you for your correspondence of 30 June 2020 containing a regulation 28 report to Prevent Future Deaths (PFD) following the conclusion of the inquest into the death of Mr. Gary Etherington on 24 June 2020. I note that the medical cause of death was: *1a. Cardiac Arrythmia, 1b Amitriptyline and Nortriptyline overdose. II Coronary Artery Disease and the "conclusion as to the death was Suicide".*

This response is made on behalf of Oxleas NHS Foundation Trust with regard to the concerns you set out in the PFD report. These concerns are:

- The Mental health Act Assessment on April 5 2018 did not involve [redacted] and
- Mr Etherington was discharged from Oxleas' care at the end of July 2018 without consultation with [redacted] and a detailed communication was not provided to Mr. Etherington's general practitioner who referred him back to Oxleas at the beginning of July 2018.

Furthermore, you have asked that I consider whether any further investigation of the failings is required and whether there is a need to review the conduct of our Root Cause Analysis investigations as, in your opinion, this did not recognise or investigate these failings.

My response provides further context regarding the assessments, conduct of Root Cause Analysis investigations in the Trust and changes we have made and will make as a consequence of the PFD report.

I would like to begin by stating that following a review of the Root Cause analysis investigation report and Mr Etherington's clinical records it is clear that the matters of concern you have raised were not addressed in sufficient detail in the report. That said, the report identified key learning and recommendations as:

- Communication and liaison with wider support network in assessment and treatment
- Clinical supervision of cases

The first sought to address the absence of involvement of [redacted] in the assessment and treatment of Mr Etherington and the second recommendation was as a result of the absence of direct supervision of the student who discharged Mr Etherington on 30 July, some four days after a discussion with the team manager during which the discharge plan was agreed.

The involvement of families and carers is a Trust quality priority and the Trust has developed a Support Network Engagement Tool (SNET) to help clinicians identify key support networks and engage them in assessment and treatment. In addition, care plans are audited every month to check for evidence of involvement of each patient's support network especially families and carers and whilst the results of these audits show improvement over the last few years but we recognise there is more to be done.

Regarding your specific concern about the Mental Health Act Assessment, it is important to outline what the Mental Health Act states and the context of the assessment here. The records show that the assessment was conducted close to midnight at Plumstead Police Station on 5 April 2018. The medical assessments were carried out by a senior trainee in psychiatry who was on-call that night and a section 12 approved independent doctor (not an employee of Oxleas NHS Foundation Trust).

There is no requirement under the Mental Health Act for an assessing doctor to obtain any collateral information as part of their assessment. Section 12 of the Act requires that a doctor making a recommendation may only do so if they have *personally examined the patient.* There is no legal duty placed on the doctors to consult each other, or anyone else. The European Courts have held that the medical assessment must be based on the actual state of mental health of the person concerned and not solely on past events (Varbanov v Bulgaria [2000] MHLR 263 para 47).

There is a requirement for the Approved Mental Health Practitioner (AMHP) to notify the Nearest Relative (where practicable) before making an application under section 2. However, in this case the two doctors did not make recommendations, the AMHP was unable to make an application and therefore there was no requirement to notify the nearest relative.

However, the criteria for detention under the Mental Health Act states that a person may be detained with *'a view to the protection of other persons'* and so I take the view that in completing an assessment it may be beneficial (even if it is not required) to obtain collateral information where possible and this may be more relevant where neither doctor has previous acquaintance. This is certainly in line with the Trust goal of engaging families and carers in assessment and treatment and is also supported by the Mental Health Act code of practice which states as follows in in paragraph 14.71:

A medical examination must involve:

- *direct personal examination of the patient and their mental state, and*
- *consideration of all available relevant clinical information, including that in the possession of others, professional or non-professional.*

The Root Cause Analysis investigation concluded that the strained relationship between Mr and [redacted] and the restraining order against Mr Etherington contributed to the failure to engage with [redacted]. To ensure learning from this incident, I will share the PFD report and this response with all doctors, especially trainees in psychiatry, and have asked that this is a topic of discussion at our Oxleas Section 12 and Approved Clinician refresher course for doctors.

Turning to your second concern that Mr Etherington was discharged without adequate consideration of his symptoms and communication to his general practitioner, I have ensured that all our primary care teams (PCP), who are the gateway to our secondary mental health services, write comprehensive letters to general practitioners addressing the specific issues raised by the general practitioner including outlining the outcome of assessments and treatment advice.

Finally, you have asked me to consider whether there is a need to review the conduct of our Root Cause Analysis investigations in the Trust.

The Trust's process of managing incidents is underpinned by the NHS England Serious Incident Framework (2015), which advocates Root Cause Analysis as the method for investigating Serious Incidents. The Trust conducts *"Level 2 comprehensive investigations"* as defined in the Framework: *"suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators"*.

The use of the *"Structured Judgement Review"* was later recommended but has since been abandoned by non-Acute Trusts as the complexity of serious incidents makes it difficult to apply.

In July 2018 the Trust commissioned KPMG to undertake a review of the whole process of managing and investigating Serious Incidents and the final report published in October 2018. One of the recommendations from the review was that a central Serious Incidents Team should be created to deal specifically with oversight of the investigation and monitoring of all Serious Incidents. Prior to this, Serious Incidents were investigated within the Directorates as was the death of Mr Etherington which was investigated over a 3 month period (December 2018 to February 2019).

The central Serious Incidents Team which was established in April 2019 conducts investigations thus offering consistency, robustness and appropriate follow up to ensure actions are completed and learning is shared across the Trust. A systematic approach, adopting Root Cause Analysis, is applied to each investigation. The investigation is carried out with the view to identifying weaknesses in systems and/or processes and to understand what went wrong and why and how any identified problems can be rectified. The Team Lead undertakes the following to sustain this:

i. Maintains a status report on all serious incidents;
ii. Ensures investigations into serious incidents are conducted and completed within 60 working days;
iii. Completes an analysis of incident data to identify and monitor trends/problems and for taking appropriate action.
iv. Shares serious investigation reports and action plans with commissioners and provide relevant supporting information as required;
v. Co-ordinates and oversees the management and investigation of serious incidents;

In addition, the Incident Management Policy and Procedures was updated in April 2019 (subsequently updated April 2020) to reflect the changes within the Serious Incident Team and stipulates that the Terms of Reference for the investigating panel must include:

- The circumstances surrounding the incident;
- The appropriateness and adequacy of care and treatment;
- Additional issues arising;
- Consideration to the involvement of family and/or carers;
- Health and Safety Concerns where the matter involves staff;
- Issues of equality and diversity.

Since the implementation of these changes to the management of Serious Incidents in April 2019, the Trust is confident that investigations are thorough, reliable and identify problems in care, with appropriate action documented to address these.

To conclude, I am grateful for your report which has ensured that additional measures are instituted so lessons are learned from the death of Mr Etherington. I hope that I have addressed all your concerns and from the forgoing, I have reassured you that no further investigation is required and that Root Cause Analysis investigations in the Trust are thorough and comprehensive to ensure problems and failings in care are identified, necessary improvements are made and lessons learned as a result.

Yours sincerely

Dr Ify Okocha
Medical Director and Deputy Chief Executive