Camden and Islington
NHS Foundation Trust

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24th June 2021

Private and Confidential
Senior Coroner ME Hassell
Inner North London
St Pancras Coroner's Court
Camley Street
N1C 4PP

Dear Coroner Hassell

Re: Inquest into the death of Benjamin O'Hara – Prevention of Future Deaths report

I am writing further to the inquest for Benjamin O'Hara which was heard on 11th March 2021. Following the inquest you issued a Prevention of Future Deaths report and subsequently kindly granted the Trust an extension to allow for completion of our Serious Incident (SI) investigation report prior to responding. As explained at the inquest, our commissioners had authorised a 'clock stop' on this investigation due to pressures on services in light of the Covid 19 pandemic, and at the time of the inquest the investigation was in its early stages. Despite this, it is noted that the issues set out within the matters of concern had already been identified within the investigation at the time of the inquest, and evidence was given by the investigator around this. They were subsequently included within the terms of reference and I will address them in this response in turn. A copy of the full SI investigation report is enclosed; it provides full context around these issues and will of course also be shared with the family of Mr O'Hara.

1. **None of the healthcare professionals who assessed or treated Mr. O'Hara in the period leading up to his death asked if he would give permission for his family to be contacted. If she had been told of his deterioration, his mother would have returned from abroad and stayed with him.**

Our investigation considered the issue of contact with family across the number of teams that were involved in Mr O'Hara's care from 2018 onwards, as well as in the period immediately leading up to his death. It found that there was a lack of consistency around

this, complicated by the fact that at times Mr O'Hara reported a difficult relationship with his family, with fluctuating views about whether he wanted them to be involved. It appears that this may have led to assumptions being made around his future wishes in this regard, with the topic not being re-explored with him on occasions when this may have been helpful. It is acknowledged that this was potentially a missed opportunity, given that Mr O'Hara's mother was his main social contact and support outside mental health services.

It is also noted at this point that whilst in the period from September 2020 onwards there did appear to have been an escalation in Mr O'Hara's presentation, in the month prior to his death and the 2 contacts with CSPA that took place during that time, a deterioration in Mr O'Hara's condition was not identified. At this time he described problems sleeping but denied suicidal thoughts, and he appeared satisfied with the discussions that took place with the clinicians on duty.

The Trust recognises the vital role that carers have in supporting their loved ones/our service users and is committed to working in partnership with carers. In order to address the issues around contact with next of kin in this case, the report has recommended that the Crisis Teams review carers policy and benchmark quality standards for carer/family/social engagement against the national Triangle of Care self-assessment. An action plan, including a training package, will be agreed following this self-assessment. This should be completed by August 2021.

In addition, all teams within the acute division of Trust services have been reminded at team business meetings of the importance of family engagement.

2. **There was an alert on Mr. O'Hara's medical record, saying that admission to hospital was unhelpful to him. However, this had been placed on the record 18 months before his death and had not been reviewed since. If it had been brought up to date, it could have affected the decision not to detain him on 3 October**.

   An alert on Mr. O'Hara's Carenotes states '17/04/2018: Information Sharing special requirements - If Mr. O'Hara presents to crisis services, please consult Duty worker at the Personality Disorder Service. Hospital admission is not helpful or suitable for him'.

   If clinicians accessed the risk tab on Carenotes to review the alert the following information was available 'Mr O'Hara is at low risk of self-harm and suicide. He will often present that he wants to kill himself however he has not attempted this in the past. He benefits from space to let out his frustration and talk about his current difficulties. With support and validation, he can then reflect that he can manage this safely at home with support from the community team. He responds well to feeling empowered with life decisions.'

   The alert was raised at a time when Mr O'Hara was presenting to emergency services. The alert was there to ensure the Personality Disorder Service (the team working with Mr O'Hara at the time) were contacted to avoid Mr O'Hara being admitted, if there was a less restrictive option available. The use of the phase 'not helpful or suitable for him' was stated

as the author of the note identified that Mr O'Hara associated his previous hospital admission with feeling looked after rather than an intervention aimed at improving his mental state. At the time the alert was created it was discussed with Mr O'Hara, who agreed with the plan.

Alerts should be reviewed regularly to ensure the information remains relevant. If the information in the alert suggests contacting a secondary care team, the secondary care team should review the alert accordingly on discharge to incorporate this change. In this instance the alert was not reviewed on discharge. Alerts should also provide important information and should refrain from being opinion orientated. On interview, numerous staff assessing Mr. O'Hara indicated that the alert on Carenotes influenced their review.

The report has recommended that the process of using alerts on Carenotes be reviewed and updated, ensuring it is conducted in accordance with when risk assessments are reviewed. Protocols for using alerts, including wording, are to be agreed as part of the risk assessment and suicide prevention strategy. A task and finish group is already in place and managing this work which is expected to be completed by August 2021.

3. **The review undertaken on 3 October was with a S12 approved doctor and an approved mental health professional, but was not a formal mental health act assessment. If the crisis team had been aware of this, they may have sought a formal mental health assessment when Mr. O'Hara disengaged from their care on the 4 October.**

This appears to have been a clerical error in the progress note entered by the clinician, where the progress note was titled Mental Health Act Assessment, but in fact it was a review by a section 12 approved doctor and Approved Mental Health Professional (AMHP), with no second opinion doctor.

By holding interviews with clinicians, the investigation found that this would have limited impact on the decision made on the day of the assessment. If the section 12 approved doctor or duty AMHP had further concerns and felt admission was necessary, they could have completed a first recommendation and requested a second opinion doctor. However, it does appear that it impacted Islington crisis team (ICRT) views on their available courses of action. ICRT were under the impression that a formal Mental Health Act Assessment (MHAA) had been completed, and when Mr. O'Hara disengaged from ICRT almost immediately after being discharged, they felt they had no grounds to request another MHAA as nothing had changed in his presentation, and therefore opted for discharge.

Despite ICRT feeling like the option of MHAA was closed to them, they did not explore this further with the duty team who advised on these matters. The report has made a recommendation to improve communication between the crisis teams and other teams in the Trust, so that in future the crisis team ensure they discuss further any decisions by other teams which are of concern to them. Progress against this action will be reviewed in August 2021.

4. **Mr. O'Hara did not have a care coordinator or other member of the community mental health team in overall charge of his care. This person would have been able to note his deterioration and the increasing frequency of his contacts with the mental health services in 2020.**

After being discharged from the Personality Disorder Service in June 2019, Mr O'Hara was only in contact with acute services. Interviews found that the Islington crisis team recognised the increased frequency of presentation to acute services, and attempted to liaise with the Personality Disorder Service, but did not make a formal referral.

Given Mr O'Hara's frequent disengagement from services, which was his right to do, it is unclear if he would have been able to engage with the Personality Disorder Service, and if this would have provided the consistency, as previously he had found it highly challenging. However, it would have provided a single point of access for reviewing his care which may have made a difference in noticing the pattern of escalation earlier.

Since Mr O'Hara's death the Trust has developed a new post for a Senior Crisis Liaison Nurse to work between Personality Disorder and crisis services. This is intended to provide good support for individuals with a diagnosis of Personality Disorder to receive more consistent community acute care. This post was appointed to in June 2021 and the impact of this new position will be kept under review. This role is in addition to the two Senior Crisis Specialist Nurses already appointed who work at the interface between Personality Disorder and inpatient services. The overall aim of all 3 roles is to improve communication between teams including formal referral processes. Crisis teams have also been reminded that they may bring complex cases to the complex case panel/risk panel for discussion and support.

I hope that my response clarifies the position and provides you with the necessary reassurance. If you need any further information, please do not hesitate to contact me.

Yours sincerely

Chief Executive
Camden and Islington NHS Foundation Trust