NHS
Central and
North West London
NHS Foundation Trust

Executive Office

12 December 2022

Mr Christopher Williams
Assistant Coroner, for the Coroner Area of Inner London South
Southwark Coroners Court
1 Tennis Street
London
SE1 1YD

Dear Mr Williams,

Regulation 28 Report to prevent future deaths in relation to Daniel O'Sullivan

I am responding to the Regulation 28 Report issued on 21 October 2022 following the inquest into the death of Mr Daniel O'Sullivan in 2019.

Central and North West London NHS Foundation Trust (CNWL) deeply regret the death of Mr O'Sullivan and the distress this has caused his family.

Following this very sad incident we have made a number of changes to the provision of adult mental health services in Kensington & Chelsea, and these have been adopted across the Trust in other services and divisions where appropriate. For the purpose of this response, we have considered the concerns raised by you and where possible we have grouped together details of assurance measures where these appear to deal with more than one area of concern.

1. (a) ***The decision to rescind detention under s.2 on 25/3/19 was undermined [in an essential respect] [by] a failure to formulate a Care and Treatment Plan identifying core treatment needs. My concern is that failures in the formulation of a Care and Treatment Plan made a significant contribution to the death and this failing was not exposed until the inquest when it could have been identified much earlier by the SII in September 2019.***

The fact that a Care and Treatment plan was not formulated gives me concern that the mistake could be repeated in future and my concern is compounded by the SII failing to investigate and make recommendations arising from this issue'.

The requirement for care planning is an essential component for decisions about appropriate treatment. The process of care planning enables staff to provide

individualised support to patient admitted to mental health services. Care and Treatment Plans are designed to underpin short, medium and long-term interventions that are carried out to support a patient's recovery. Care and Treatment Plans include biopsychosocial interventions for the treatment of the presenting mental health condition along with the assessment of capacity to consent to the Care and Treatment Plan. The Care and Treatment Plan also identifies any physical health interventions that may be required.

The overall responsibility for implementing a Care and Treatment Plan for a person admitted into a Psychiatric Ward lies with the Responsible Clinician (RC). The RC develops a Care and Treatment Plan in conjunction with the wider Multi-Disciplinary Team (MDT) over the course of the patient's admission. This process begins when the patient is admitted on to the ward by the clerking doctor and nurse. The nurse completes the initial care plan document contained within the electronic clinical system. This is completed during the twelve-hour shift of the nurse in which the admission clerking occurs.

Information is sourced and gathered from various sources as the Care and Treatment Plan develops. These sources can include A&E assessments, previous history from community services if known, family feedback (where available) and of course the patient. Nursing staff also develop dynamic care plans that provide day to day support, for example, a patient with a physical health condition may require blood pressure monitoring or if someone is displaying high levels of aggression due to paranoid beliefs then behaviour support might be necessary. A Care and Treatment Plan is created using the templates from our clinical system and these care plans are fluid in nature and change with improvements to the patient's presentation.

The Care and Treatment Plan is reviewed daily in the ward morning "Whiteboard" meeting. This meeting involves a multidisciplinary team ('MDT') which includes the Consultant Psychiatrist and junior doctors, Occupational Therapist, Psychologist, Advanced Clinical Practitioner, and nursing staff. This process of review enables appropriate changes to be made to the Care and Treatment Plan and promotes discussion about treatment options, the least restrictive options, leave and therapy and medication. It is an opportunity to gather information about the progress of the patient on the ward and to discuss risk and planned outcomes.

Care plans developed by nursing staff are reviewed daily by the senior nursing staff on duty and are also reviewed through monthly supervision which interrogates the expected standards for care plans. The care plans are audited by our divisional Governance Team on a weekly basis with the results provided to the Ward Matrons. The Ward Matrons meet with all Ward Managers weekly and discuss any areas that may be of concern.

All staff who work on the inpatient wards are provided with an induction that includes 'How to' and 'Where to' enter a Care and Treatment Plan on the clinical system.

In this case it is recognised that a Care and Treatment Plan was not put in place on admission to St Charles Mental Health Unit for Mr. O'Sullivan and it appears that it

was overlooked throughout the admission with reliance being placed on the dynamic plans contained in the notes with oversight of the RC.

A number of changes have occurred within the Trust and more locally at St Charles Mental Health Unit since the incident in March 2019. The Trust began using SystmOne as its electronic clinical system in February 2019. As staff transitioned to the new electronic clinical record system they were learning about the operation and functionality of the system, and this also involved use of templates within the system and recording of information. It is fair to say that in March 2019 St Charles Mental Health Unit was at the start of the process of using SystmOne. Three and a half years later staff are now proficient in its use. This has been assisted by the use of Quick Reference Guides (QRG) developed to support staff**.**

Approximately 18 months ago St Charles Mental Health Unit saw an increase in qualified staff for each ward at the Unit. This has provided additional opportunity for staff to spend one to one time formulating and negotiating Care and Treatment plans, aimed at reducing any identified risks and promoting patient recovery.

Staff are further supported by the Clinical Risk Assessment, Safety and Crisis Planning Policy for Mental Health Practitioners. This policy was reviewed in April 2021 and includes the 'See, Think Act' framework. "See, Think Act' is a tool which creates a structure and a common language for staff to consider eight different areas, each of which could lead to unnecessary incidents. The framework simplifies each aspect of relational security to help staff to be alert to and understand signals that may signify a potential incident in order that care and treatment can be provided safely.

In addition, St Charles Mental Health Unit has recruited and trained Advanced Clinical Practitioners (ACPs). One of the roles of the ACP is to support the MDT and in particular the nursing team with specific interventions, care planning and risk management. This includes reviewing the Care and Treatment Plan and highlighting any deficiencies.

The St Charles Mental Health Unit site also has a Safeguarding Adult & Mental Capacity Lead Practitioner who provides dedicated support to the unit with training for the assessment of capacity which informs care plans and as part of training will remind staff how this should feed into the Care and Treatment Plan and dynamic plans.

We are satisfied that the process now regarding formulation, monitoring and review of the Care and Treatment Plan is a robust one with appropriate checks and balances to promote the support and interventions our vulnerable patients require. As with all aspects of care and treatment of our patients, our processes are constantly under review, and we will continue to drive towards excellence and to achieve the best possible outcomes for our patients.

(b) The SII commissioned by CNWL, completed on 9/9/2019, did not identify the care plan aspect referred to above and failed to investigate that aspect or make recommendations arising from this issue.

Please see below at 2 (b) (c) and (d).

2. (a) The poor contemporaneous documentation of the grant of unescorted leave from the hospital and the time taken to alert the police when Daniel failed to return on 26/3/19 by 21:00 pm. The delay in reporting the failure to return to the Ward was a factor that contributed to the dangerous situation already created by rescinding s.2. I am nonetheless concerned that, in general, psychiatric patients being tested on voluntary leave are a vulnerable group and as such failures to return should be reported with expedition not only because they may be a danger to themselves, but also due to a risk of being preyed upon by others.

CNWL have a 'Leave for Informal Patients' Policy that supports staff with leave for informal patients from their inpatient wards. The policy is used in conjunction with other Trust policies including a 'Clinical Risk Assessment and Safety Management Policy' and a 'Missing Informal Patient Policy'. The overall purpose of this policy is to provide mental health practitioners with the guidance required in the event that an informal patient either goes missing from an inpatient unit or does not return at the agreed time from leave. The policy reminds practitioners that clinical risk assessments and safety plans must be completed prior to patients commencing a period of leave and highlights the importance of multidisciplinary teams working together to make decisions with patients in relation to developing safe leave plans. Informal leave is an important aspect of a patient's care and recovery and as such must be approached as integral part of the patient's care plan and safety plan.

The Clinical Risk Assessment and Safety Policy was reviewed in April 2021 which includes an e-learning package introduced in October 2020 which is now a mandatory requirement for staff to complete.

The Missing Informal Patient Policy was updated in March 2020. It now requires a checklist to be completed which was not in the previous version. This is a risk assessment checklist that is now used by staff for managing informal leave from the wards. The checklist records the time that the patient leaves the ward and expected time of return (which is agreed in advance with the patient). There is also a risk assessment and an action plan for completion to mitigate against any risk identified. The Missing Informal Patient Policy also now provides a useful flow chart with the steps that are required to be taken in the event of someone not returning at the agreed time. The approach is balanced by the perceived risk.

Each episode of leave is also now recorded on a paper document which is then scanned and uploaded onto the clinical record system each week.

Each patient is allocated a nurse for each shift. The nurse is responsible for completing the leave form for their identified patients and these forms are then uploaded by administration staff to the patient clinical record. The Nurse in Charge of each shift has the responsibility of ensuring that every patient is accounted for hourly. This task is allocated at the beginning of each shift and is recorded hourly, on a separate reporting sheet for every 24-hour period.

The timing of contact with the police if a patient fails to return is not standardised or mandated within the Missing Informal Patient Policy. This should be reviewed as part of planning for leave and incorporated into the plan for leave as agreed with the patient. Assessment of capacity and assessment of risk form part of the overall decision making and will be informed by the views of the multidisciplinary team and the aims and intended outcomes as provided for in the care plan. Although police involvement is sometimes necessary it is not always the default position when a patient fails to return the ward. Failure to return should prompt a discussion between the members of the ward team, involving the RC as necessary. Each patient presents with a unique set of circumstances that has resulted in admission and risk assessment and evaluation of risk and management of the patient by reference to the plans in place and the presentation of the patient will assist in decision making.

In November 2022, an audit of 19 patient records was undertaken to better understand the procedure followed when patients were absent without leave (AWOL) from the wards at St Charles Mental Health Unit. The results of the audit demonstrated that 100% of the patients who went AWOL were reported to the police and this procedure was recorded on SystmOne clinical records under the patients individual Progress Notes. The time taken varied but for those individuals who were deemed to be high-risk patients who went missing from the ward the time taken to make contact with the police was between 2 to 15 minutes.

In response to the audit the following further actions were agreed:

- A review of the Datix incident management system to be initiated to improve the recording of police contact for each AWOL incident recorded on the system. This will enable CNWL to monitor the timeliness of those police reports in comparison to the time of the incident and escalate with the ward teams where there have been unnecessary delays. This is due for completion by the end of January 2023.

- The CNWL Missing Informal Patient Policy is to be updated including clear standards for what information must be recorded in the SystmOne clinical records (under Progress Notes) and within Datix including the time the police were informed about the missing patient. This will be completed by the end of January 2023.

Since March 2019 St Charles Mental Health Unit has forged a greater working partnership with the Metropolitan Police and we now have a dedicated police officer who is on site weekly and works closely with the hospital managers around emerging themes and interface with the police. This provides opportunity for the Metropolitan Police and CNWL to share local and London wide initiatives on interventions for people experiencing mental health difficulties.

We are satisfied that it is recognised by our staff that psychiatric patients on voluntary leave are a vulnerable group and that patient safety is of paramount importance when considering the right course of action if a patient fails to return to the ward after a period of leave.

2.

(b) A leave book with handwritten entries went missing after the death. The missing leave book was not investigated by the SI.

(c) A nurse who called the police, sometime before 00:30 according to the medical records, or at 01:10 according to police records, was not interviewed by the SII.

(d) I found these investigative deficits troubling because the learning of lessons in patient care depends, in part, on an early SII by the hospital concerned so that risks to patient safety can be identified to enable recommendations and improvements long before an inquest conclusion.

Since this incident in 2019, CNWL has introduced several improvement initiatives and enhancements to its serious incident review process.

Royal College of Psychiatrists Serious Incident Review Accreditation Network (SIRAN)

At the beginning of 2020, the Trust sought to incorporate best practice in its management of serious incidents, which would result in improvement and effectiveness of the process and evidenced through Accreditation. Following several months of readiness activity including auditing and self-evaluation, workshops with Divisional representatives, implementation of agreed actions, revision of templates and redrafting of our policy, we succeeded through SIRAN. At the time of the changes, the Trust also introduced a forum to support reviewers/investigators of serious incidents to enhance understanding of the Root Cause Analysis (RCA) process.

On the specific issue of skills and competency to undertake reviews/investigations, 88 members of staff have been trained in RCA methodology in the last 2 years (since 2020). This methodology equips reviewers with the skill to probe and draw out care and service delivery problems and guides them to elicit lessons. In addition, the Division in which the incident occurred now has a dedicated serious incident review post, offering additional skills and support in this process.

In January 2021, the Trust received accreditation for its serious incident review process and was at the time, one of only 2 in the country to receive accreditation of that kind. The process involved quality checking of serious incident reports. This improvement effort continues as we seek to renew our accreditation in 2024, the year that current accreditation is due for renewal.

Internal audit

In August 2021, RSM Risk Assurance Services LLP carried out an audit of the Trust's Serious Incident Review process as part of the Trust's internal audit plan. They recognised the improvements made and gave a reasonable assurance opinion.

Quality Improvement

In the last 18 months, the Trust has completed 2 Quality Improvement (QI) projects relating to serious incidents. A third is in progress. As a result, a standard process has been agreed across all areas of the Trust. There is a new Trust wide 'Learning from Serious incidents Framework 'which has seen the introduction of learning

events and workshops, bulletins and newsletters, and strengthening of processes for review of serious incidents.

Governance

The Trust process for managing serious incidents has strengthened scrutiny of our reports, with quality assurance checks at Borough, Divisional and Executive level. An additional layer of scrutiny is through Commissioners, who review all serious incident reports before final sign off.

Transitioning to the new national framework

In August 2022, NHS England launched the Patient Safety Incident Response Framework (PSIRF), which NHS organisations are expected to implement over the next year. This new framework phases out the RCA methodology, introducing human factors and system-based approaches instead. As rolling out of human factors training had already commenced in the Trust prior to publication of the new framework, the Trust is ahead in its preparations in this regard. A working group is in place and meeting fortnightly to drive implementation of the new process. Education is a significant part of this work and training procured will take learning from this case into account.

We are satisfied that we continue to improve our investigation processes and that we recognise the importance and value of a robust and transparent system of review and that this is an important tool in ensuring the safety of our patients and identifying learning and improvements where appropriate. We have attached some of the documents referred in this letter by way of illustration. Please let me know if you require additional evidence.

Thank you for raising your concerns. We hope that the content of this letter provides sufficient assurance that the Trust has taken the concerns raised seriously, has taken action following the death of Mr O ‘Sullivan and has accepted the points raised and continues to work to improve the service we provide. Should you have any questions or concerns or comments, please do not hesitate to contact me.

Yours sincerely,

Chief Executive