

1 February 2024

**Private & Confidential**

**Ian Potter**

Assistant Coroner

Coroner area of Inner North London

Poplar Coroner's Court

127 Poplar High Street

London

E14 0AE

Pinewood House

Pinewood Place

Dartford

Kent

DA2 7WG

Dear Mr Potter,

**Re: Response to Prevent Future Deaths Report touching the death of Mr Luke Mervyn Whitelaw  
(Date of Death: 17 March 2023)**

This response is made on behalf of Oxleas NHS Foundation Trust in response to the Regulation 28 Report to Prevent Future Deaths following the inquest touching the death in custody of Mr Luke Whitelaw who died on 17 March 2023, with the matter of concern outlined below;

- ***Mr Whitelaw's re-admission to hospital was indicated as early as 2 February 2023; however, he was not re-admitted to hospital, informally or otherwise.***
- ***A verbal referral was made for Mr Whitelaw to be urgently reviewed by a psychiatrist following the appointment on 2 February 2023, but not acted on.***
- ***The Oxleas NHS Foundation Trust's Serious Incident Investigation Report, dated 8 September 2023, identified numerous matters and learning points, including, but not limited to the following:***
  - ***There had been a lack of "professional curiosity" in the assessment and planning of Mr Whitelaw's care and treatment***
  - ***Discussions and assessments of risk should be clearly documented***
  - ***Risk formulations should consider both current and historic/contextual risks and incorporate ratings of mood to ensure that these are not used in isolation and are linked with appropriate interventions***
  - ***There were "missed opportunities identified in relation to LW's self-reported deterioration following his discharge from hospital which do not appear to have been fully explored."***

Having reviewed the concerns below is a summary of actions we have taken to improve practice in the areas highlighted.

Oxleas Acute Mental Health Patient Flow and Bed Management policy (updated in December 2023) provides guidance on the purpose of an inpatient admission; and actions to be taken when Crisis Resolution and Home Treatment Team (CRHTT) identify that someone's clinical needs indicate that

an inpatient bed is required. The CRHTT policy and training for staff includes guidance on assessing and managing risk, and changes to the risks and clinical presentation.

We have discussed with the team members of CRHTT the need to precisely document discussions about medication or medical review in future (i.e. to outline date and time of discussion, who was involved in the discussion, and the outcome that was agreed). Since this time, significant discussion and training has taken place with all clinicians in this team to document key discussions and decisions – including when the clinical needs changes to the point that inpatient care is indicated. Training and discussion has also taken place during 2023 and into 2024 with the consultant psychiatrists, managers and clinical staff about meaningful discussion and documentation of same, and consideration of written notes.

In 2023 an improvement plan was put in place for this clinical team to address gaps which were identified during the investigation and gaps which were identified as a result of day-to-day oversight. This plan is monitored by the service director and the clinical director for the Acute & Crisis Directorate and will continue until such time that we are satisfied that the care provided is to the standard needed, and for at least until July 2024.

The improvement plan is broad and incorporates the following:

- assurance on the quality of clinical care by the embedding of clinical standards
- risk assessment and documentation. Embedding a culture of risk assessment and management that is based on holistic assessment, clinical formulation, and full descriptions of the risks considering historical and dynamic factors. In 2023 we have directed clinicians not to rely on ratings such as “low, medium high” in the context of risk
- Embedding a meaningful reflective practice culture
- The head of nursing, Head of psychology, Clinical Director and operational managers have worked closely with the clinical leads and managers to create an ongoing support structure to continue improve on the Clinical Standards of care and Treatment.

As part of the reflective discussion with senior clinical leads on 9th November 2023, specific attention was given to making sure that the team understand their responsibilities around maintaining robust clinical standards and risk assessment. This discussion included, for example:

- Changes in clinical presentation and risk; and consideration of the clinical threshold for moving from treatment at home to inpatient admission
- Professional curiosity on exploring the individual’s clinical presentation and the relationship to their support network and social circumstances.
- Application of the DICES training in day-to-day practice. The DICES training provides clinicians with the skills, confidence, and competence to engage in an open dialogue with individuals and their social network.
- Reinforcement of the standards around articulating and narrating risk narrative risk formulation based on the 4 key factors: static factors, dynamic factors, future factors and strengths and protective factors.

#### Training & development of staff

The Greenwich CRHTT has received DICES training, delivered by Association of Psychological Therapies. DICES Risk Assessment and Management System helps a practitioner assess risk using a system of checklist whereby all the risks that a client in crisis may be susceptible to are asked and explored by the practitioner.

The outcome of this checklist will help to formulate a risk management plan using the DICES acronym, Describe the risk, identify options to keep the client safe. Choose the preferred option, explain the chosen option and share the risk management plan with members of the MDT. One of the key benefits of DICES is to help the team move away from the stratification of risk of high, medium, low which does not provide a narrative of what actions will be taken to keep the patient safe.

- Over 50 staff from all CRHTT's have attended the 2-day course. To date 11 of the Greenwich Home Treatment Team been trained and accredited since the training was introduced in March 2023
- More training is planned in early 2024 for further staff.
- The Greenwich Home treatment managers are also trained in DICES to provide leadership oversight of its implementation in the team.
- In addition, the Practice Development Nurse and Quality Improvement lead have been supporting the Greenwich HTT to apply the learning into day-to-day practice
- The "Heads Together" CRHTT skills and development programme to improve skills competencies is ongoing with the Greenwich Home Treatment with a focus on assessments, risk assessments and robust formulations.
- Similar to the approach we used in similar clinical teams, the practice development nurses will now begin a process to demonstrate clinical competency of individual clinicians- identifying general gaps in skills and training.

#### **Assurance that improvements are occurring:**

- The practice development nurses, and the Head of Psychology have been supporting the teams with risk assessment and formulation of complex case discussions on clients on the case load who present with significant concerning risks.
- The team managers, with the support of the Practice Development nurses, audit the quality of risk assessments and to ensure that practitioners are not stratifying risks as low, medium or high.

We have already judged that the team are improving in confidence in the use of DICES risk assessments and formulation to support a sophisticated appraisal and communication of clinical risk.

The most recent audit carried by the Crisis services Manager on 16th January 2024 demonstrated that out of 34 cases reviewed, 28 of the risks assessment were of expected standards. 1 of the 34 cases had risks ratification documented but there was good parallel documentation on the risk narrative for that case.

## Clinical Leadership

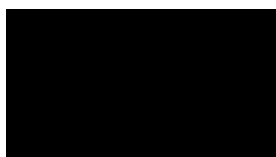
The Clinical Lead and the local managers attend the daily MDT to provide senior clinical leadership and guidance on clinical discussions. In addition, the team have access to the Head of psychology also provides direct clinical input and consultation to the team from August 2023. The team have regular reflective practice to have a protective space to share any learning and best practice to continue to foster an environment for continuous learning and improvement for clinical practice.

We have also had intensive engagement with clinicians and the transformation team to co- design a single crisis assessment form that allows to capture a person journey /story in one single document on the patient recording system. This would prompt clinicians to add to assessment that was carried out previously which reduce the risks of clinicians not considering the full documentation on what has been happening in that person care. The form has recently gone live on the Patient clinical record as of 22 January 2024 and is on testing phase for which we are collecting feedback.

In terms of **process and documentation**, the standards have been reinforced with the managers and clinicians, including for example:

- ALL MDT discussions to be documented and content of the discussions to be recorded clearly in the clinical notes, including the plan and rationale.
- Protected time ringfenced for the team to prioritise discussion of complex cases.
- A weekly session facilitated (in the interim until there is a team psychologist in post) by the Head of Psychology to support the multi-disciplinary team to carry out clinical formulation and risk assessment.
- On a trust wide basis, work is underway to review the Trust Risk assessment template on the electronic patient record. This will support the embedding of the fresh approach to risk assessment, formulation, communication and recording.

Yours sincerely



Chief Executive