South West London and
St George's Mental Health
NHS Trust

Chief Executive's Office
South West London and St George's Mental Health NHS Trust
Trinity Building
Springfield University Hospital
15 Springfield Drive
London SW17 0YF
[redacted]

19 December 2023

Private & Confidential

ME Hassell
Senior Coroner for Inner West London
West London Coroner Service
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Our Reference: [redacted]

Dear Madam

Re: Regulation 28 Report to Prevent Future Deaths – Mr Michael Joseph HINDES

I am writing to you following receipt of the Regulation 28: Report to Prevent Future Deaths (PFD) dated 20 October 2023, which was issued to the Trust on 13 December 2023, regarding the sad death of Mr Michael Hindes, who died on 15 May 2023.

You have requested that South West London and St George's Mental Health NHS Trust (SWLStG) respond to the matters of concern that you have detailed in your correspondence.

I have included your Matters of Concern below and our subsequent response.

The **MATTERS OF CONCERN** are as follows:

'When Michael was taken to St George's Hospital, he explained that he had been back and forth from the railway station, each time for the purpose of jumping in front of a train. He was discharged with a plan for follow up by the community mental health team (CMHT). I was told that the local CMHT meets at the beginning of every week, and then there is sometimes a delay before an appointment is made, so it was likely that Michael would have to wait an absolute minimum of a week to be seen.

In the meantime, it was not thought necessary to refer him to the crisis team.

Michael's family knew nothing of his mental ill health. He declined an invitation by the nurse assessing him to contact them. He did not want to worry them. Despite her awareness of the multiple therapeutic benefits of the input of a patient's loved ones, the assessing nurse did not in any way try to persuade Michael to allow her to do this.

The first that Michael's family heard of Michael's mental ill health was when they heard of his death. I am sure that, had they been made aware of it while he was still alive, they would have done everything in their power to support him and to engage with the mental health services.

Families very often complain to me at inquest that mental health services have not done enough to try to bring them in to a patient's care. In spite of the frequency of this occurrence, the lesson does not seem to be being learnt.

When you respond to this letter, I should be grateful to know not just what you have done to address the issue in your own trust, but also what you have done to raise national awareness.'

As you are aware through the Inquest, the clinical risk assessment undertaken at the time by the assessing nurse in the Psychiatric Liaison Team deemed the patient to be of low risk of self-harm and that he was suitable to be discharged home. In addition, with a routine referral to the Community Mental Health Team (CMHT) for ongoing diagnosis/further assessment, as crisis services were not required at that time.

The clinical assessment clearly concluded that the patient had capacity to make decisions and the assessing nurse was of the firm view that he was clear that he did not consent to information being shared with his family around his mental health and struggles.

In these circumstances it would therefore have been unlawful not to respect the patient's decision and there is a delicate balance around applying persuasion and respecting someone's rights and decisions. However, we recognise we should have sought to explore his decision further and to relay the typical benefits of support that can come from positive family engagement and awareness, or explored other support options, such as reaching out to a close friend. We also absolutely recognise that our documentation around this area was not sufficient.

We agree with your general view that challenges remain and there is a need for improvements around how to best ensure positive engagement and sharing of information between the healthcare provider, patients, and their families and carers. We are committed to the national 'Triangle of Care' initiative that champions the bringing together of carers and relatives, service users and professionals. It aims to promote safety, aid recovery, and sustain the wellbeing of people with mental health issues and their carers and families. This remains a key area of focus for the Trust. The Psychiatric Liaison Team continue to reflect on this and will be changing their local

protocols to strengthen the prompts to help remind clinicians how best to approach this subject with patients.

As per your request with the PFD to raise awareness of this area, we will take the opportunity to raise awareness within the Trust via a specific newsletter article issued to Trust staff (known as our Monthly Learning Bulletin) to remind and promote how and when to best ensure there are meaningful conversations with patients around sharing information with families. This will focus on the Triangle of Care approach and provide clarity around the delicate balance between encouraging patients whilst respecting their wishes and ensuring this is clearly documented. This will be developed and issued by March 2024.

We will share this and our response to the PFD with the CQC and our Commissioners (Integrated Care System) as per your wish to help contribute to improving greater awareness of this area.

We thank you for your consideration and commitment to prevention of future deaths and helping us and the wider NHS to learn.

I would like to express our deep sympathy to the family and friends of Mr Michael Hindes for their loss. While we seek to learn from this incident, I recognise that this cannot diminish their pain and anguish.

The Trust remains committed to continuous learning and improvement and we are very grateful for all those involved in this Inquest.

Yours faithfully

[redacted]

[redacted]
Director of Nursing and Quality, on behalf of [redacted], Chief Executive

CC – [redacted], Medical Director, SWLStG