NHS
West Hertfordshire
Teaching Hospitals
NHS Trust

1 May 2024

Chief Executive's Office

Watford General Hospital
Willow House
Vicarage Road
Watford
Hertfordshire
WD1 8HB

[redacted]

North London Coroner's Service
Barnet, Brent, Enfield, Haringey and Harrow, Barnet Coroner's Court
29 Wood Street
London
EN5 4BE

Dear Mr Murphy

Re: Regulation 28 report to prevent future deaths

I am writing to you in my capacity as Chief Executive of West Hertfordshire Teaching Hospitals NHS Trust (WHTNH) in response to the concerns you raised following the investigation into the death of Mr Paz Ogbe-Millar, which prompted your Regulation 28 report dated 5 February 2024.

The concerns brought to our attention include:

a) There was confusion among Emergency Department staff at WHTNH regarding the appropriate level of observation for mental health patients awaiting assessment by the Mental Health Liaison Team operated by HPUNFT. This confusion stemmed from inconsistencies between WHTNH's Standing Operating Procedure titled "Management of Mental Health Patients in the Emergency Department (ED) at Watford General Hospital (WGH): Standard Operating Procedure ('SOP'), Issue date August 2021" and WHTNH's Emergency Department Adult Mental Health Proforma" Version 3, which lacked a clear guidance on observation levels.

b) The SOP mentions the need for close observation of patients at moderate or high risk of self-harm, with continuous documentation, while the EDP suggests only a 15-minute observation for patients at a medium risk level.

c) Noting the discrepancy, it is evident that mental health patients at medium risk may not be receiving the appropriate level of observation required for their safety.

We have collaborated with the Royal Free London NHS Foundation Trust to refine our assessment tools for patients with mental health needs, ensuring accurate identification of the appropriate level of observation. Consequently, the previously used proforma has been replaced by an electronic assessment which aligns with the current SOP, eliminating any inconsistencies between the two documents.

We are committed to enhancing the care provided to patients with mental health needs awaiting assessment in the Emergency Department. The actions we are undertaking are aimed at improving patient safety and ensuring that incidents like this do not recur. These include the following:

- The Patient Safety Incident Response Plan (PSIRP) and PSIRF Policy have been approved for implementation, focusing on key themes including mental health, which will be reflected in our Quality Account Priorities. (Completed Jan 2024)

- Implementation of an electronic patient record system to improve access to patient information and refine assessment tools for mental health patients. (Completed Nov 2021)

- Recruitment of a Matron for Mental Health to elevate the quality of care. (due to be completed by the end of April 2024).

- Collaboration with Mental Health partnership teams to implement a Suicide Prevention Pathway Pilot is underway.

- Policy updates and a planned mental health awareness week (May 2024) to set expectations for staff.

We would once again like to pass on our deepest condolences to Mr Ogbe-Millar's family for their loss.

As a Trust, we have a deep commitment to patient safety and keep our policies and processes under regular review, The action we have taken reflects our culture of continuous improvement and of learning in order to further enhance patient care.

Please feel free to get in touch if you require further clarification.

Yours sincerely,

[redacted]
Chief Executive