NHS
Central and
North West London
NHS Foundation Trust

Executive Office

2 April 2024

Professor Fiona Wilcox
HM Senior Coroner for Westminster
The Coroner's Court
65 Horseferry Road
London
SW1P 2ED

Dear Madam Coroner,

Regulation 28 Report to prevent future deaths in relation to Roberto Bottello

I am responding to the Regulation 28 Report issued on 16 February 2024 following the inquest into the death of Mr. Roberto Bottello commencing on 16 September 2020. The inquest concluded on 1 February 2024.

Central and North West London NHS Foundation Trust (CNWL) deeply regrets the death of Mr. Bottello and the distress that this has caused his family.

We accept the findings of the jury and have evaluated our response to the tragic death of Mr. Bottello in light of the findings.

Following the death of Mr. Bottello, we made a number of changes to the provision of care and services across the Trust. 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. There are matters of practice and procedure identified where the need for improvement has been recognised. I will respond to the matters of concern, setting out what we have already done, what we are doing now, and what we intend to do in the future.

Matters of Concern

1. That CNWL failed in its duty of candour in relation to provision of evidence in this case.

2. That the evidence given by the SPA witnesses was at times not credible.

3. That SPA call handlers were not sufficiently trained in how to identify patients by using computer searches and by not seeking information appropriately for example by using the international phonetic alphabet and using the word for the month in a person's date of birth.

4. That police officers may need reminding to use the phonetic alphabet and using the word for the month in a person's date of birth.

5. That CNWL were and may still be unaware that CNWL staff operate outside policy.

6. That the psychiatric liaison nurses and psychiatric liaison doctors should have regard to and specifically consider diagnoses made by other doctors for example those who see such patients repeatedly in A&E as in this case.

7. That most section 136 usage is out of hours when there is less resource to respond from psychiatric services.

8. That other areas in England could learn from how section 136 suite access has been restructured in London.

9. That the use of film over glass in areas where patients are at increased risk of smashing windows should be more widespread in the NHSE estate.

10. That there are continued shortages in psychiatric care provision.

I have addressed these concerns where they relate to CNWL below:

Duty of Candour

- CNWL takes the concerns which you have raised very seriously. We have discussed the findings of the inquest and matters of concern identified by you during the course of the inquest hearing with our staff.

- CNWL is very sorry that the Learned Coroner considers that CNWL did not provide evidence in accordance with its duty of candour. The Trust has always taken its duty of candour very seriously.

- It is always our approach to work with coroners and their officers collaboratively and to respond to inquiries and directions in a candid and swift manner. We provided evidence from our witnesses to the coronial investigation and cannot locate any requests from your office or from other Interested Persons or their legal representatives for clarification or further evidence, and having attended the pre-inquest hearings, we proceeded on the basis that no further evidence in relation to the issues was required.

- This was an unusual situation whereby whilst there was involvement with CNWL services the incident occurred whilst Mr Bottello was under the care and responsibility of St Mary's Hospital. The Serious Incident Investigation was undertaken and directed by Imperial College Healthcare NHS Trust. CNWL contributed to and collaborated with the investigation as is usual in cases where a lead investigation organisation is assigned. The collaboration was primarily through engagement with the CNWL Psychiatric Team Leader at St Mary's Hospital and with one of our Senior Nurses who participated in

the investigation throughout and was actively involved in collaborating with the investigating team and agreeing actions to be embedded in the subsequent report and action plan. CNWL did not undertake a separate full serious incident investigation into the circumstances of the incident and this was in accordance with the Serious Incident Framework as published by NHS England. The focus of the Serious Incident Investigation on this occasion was on the events which took place at St Mary's Hospital.

- As part of our learning from this incident we will remind our services that where another organisation is leading on a serious incident investigation, in addition to working collaboratively with that organisation, there should be ongoing and robust consideration of CNWL's involvement with the patient even if certain events do not form part of the remit of the serious incident investigation. This will assist as to whether further internal investigation is required.

Witness Credibility

- We have spoken to the witnesses about your concern and are confident that they understand the importance of being open and transparent when giving evidence. We will reinforce this message as part of the support provided to all witnesses who attend court to give evidence.

- From the feedback we have received from witnesses in this and other inquests, the response of the witness is often related to the situation in which they are being questioned rather than the subject matter of the questioning. It is a unique experience that typically arouses strong emotions. The ability of a witness to withstand questioning in these circumstances can be variable. Both of the witnesses were extremely nervous and anxious about giving evidence which of course is not unusual and neither had attended Coroner's court before and found the experience daunting particularly because this was a jury inquest.

Communications

- A weekly meeting between the acute hospital clinicians at St Marys and CNWL now occurs. A joint venture between the two organisations for mental health patients attending the emergency department in the form of an assessment centre for mental health patients (The Lighthouse), at St Marys Hospital opened in the autumn of 2023 and has seen improved communication and partnership working.

- We appreciate there is a need to ensure that Psychiatric Liaison nurses and Liaison doctors have regard to and consider diagnoses made by other doctors who see a patient repeatedly in A&E. CNWL will ensure that the established channels of communications are strengthened through improved consultation and collaboration of patient care and a feedback mechanism is used where A&E doctors provide input on the effectiveness of psychiatric diagnoses and interventions at the weekly meeting referred to above,

Training

- SPA staff attend SystmOne (CNWL electronic record keeping system) training as part of their induction.

- SPA has evolved considerably since this incident and various improvements have been implemented.

- SPA has developed an induction pack, which specifically includes guidance on various ways of searching or identifying patient vis system one/SPINE. All SPA staff now use phonetic alphabet when clarifying patients or callers' details. On each desk within SPA there is a list of the phonetic alphabet, to support and prompt staff to ensure they have the correct spelling. SPA also has a checklist for call handlers, which prompts them to ask certain questions as a minimum, so information is not missed during calls.

- There have been changes in process and systems regarding police contact and as an aid to effective communication we will remind the police that during telephone calls we require the use of the phonetic alphabet to avoid miscommunication.

- By way of assurance to the Learned Coroner, I can confirm that all CNWL policies and procedures are available and communicated to staff through training sessions, staff handbooks and regular updates on the CNWL Trust intranet.

- We operate a comprehensive internal training programme and ensures that all new starters to the organisation have a wide-ranging induction to familiarise staff with policy relevant to their area of work.

- We use established protocols for monitoring staff adherence to policy such as regular audits, supervision and performance reviews.

- We strive for continuous improvement and conducts regular reviews and updates of policies and procedures to ensure they remain relevant and fit for purpose.

S136 (HBPOS) suites

- Recent changes as of November 2023 mean that the Police now have a generic 0300 number, through which they can access immediate support from mental health services. Police can call for advice, or to inform the new 136 hubs, that they have detained a patient under a Section 136 (MHA). London has two s136 hubs, one in the north and one in the south of London. Depending on where the Police are calling from, they will be directed to one of these hubs.

- SPA no longer manages calls from the Police or support with locating Health Based Place of Safety (HBPOS) suites. The s136 hubs have access to all

HBPOS suites across London, for which they check capacity through using a SMART Tool.

- All HBPOS suites across London update the SMART Tool in real time, as and when patients arrive or are discharged from HBPOS suites. In addition, the 136 hubs call to confirm availability, before sending patients to a suite.

- Police can call the 136 hubs whilst with a patient in the emergency department or in the community with a patient. This has helped Police, as they no longer need to liaise with several different mental health trusts across London. This has contributed to a reduction in Police attending emergency departments unnecessarily, due to lack of HBPOS capacity.

Staffing and recruitment

- Whilst there is a national challenge to recruit and retain Registered Mental Health Nurses (RMN's), CNWL has maintained safer staffing levels and provided a full liaison psychiatry staff complement at all times at the St Marys Hospital site.

- CNWL currently has a trust vacancy level of 5.9%, and a 12.7% vacancy rate for qualified nurses which is well below the national average.

- At CNWL, we recognise the fluid nature of this situation and affirm our dedication to consistently recruiting and retaining our valuable staff. We are committed to continuously monitoring recruitment and vacancies, as well as implementing supportive initiatives.

Thank you for raising these concerns. I hope that the content of this letter provides sufficient assurance that CNWL takes the concerns raised seriously and has taken action following the death of Mr Bottello. CNWL continues to work to improve the service we provide. Should you have any further questions, please do not hesitate to contact me directly.

Yours sincerely,

[redacted]

[redacted]
Chief Executive