NHS
Central and
North West London
NHS Foundation Trust

Executive Office

2 May 2024

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

Dear Professor Wilcox,

Regulation 28: Report to prevent future deaths in relation to Adrian James

Thank you for your Regulation 28 report dated 7 March 2024 following the inquest into the death of Adrian James. I am writing to provide Central and North West London NHS Foundation Trust (CNWL)'s response to the concerns that you raised in that report.

We deeply regret the death of Mr James and the distress this has caused his family to whom we would like to extend our sincere condolences.

We have listed your concerns in bold, followed by the Trust's response:

1. That Adrian, despite being a complex patient with multiple psychiatric diagnoses and at high risk of impulsive behaviour and suicide was not seen nor assessed by a consultant either prior to starting psychological therapy or when he deteriorated.

We are issuing additional guidance around managing risk of suicide in those with a diagnosis of Personality Disorder (or more commonly now known as Complex Emotional Needs) reminding staff to consider the need for assessment by a Consultant Psychiatrist.

The team operates as a multidisciplinary unit. Senior clinical support and decision-making are facilitated through weekly Multidisciplinary Team (MDT) meetings, direct oversight from a Consultant Psychiatrist, and participation in the daily meetings, which are regularly attended by the team's Consultant Psychiatrist. In the event of concerns raised during the meetings, there is an opportunity to schedule an appointment with the Team Consultant Psychiatrist for further discussion. However, access to support for service users with complex emotional needs does not require an initial appointment with a psychiatrist.

2. That No pro-active care was considered for Adrian whilst he was in obvious mental health crisis in the last 17 days of his life.

We have shared learning on this with the team and are updating our policies accordingly.

3. That Insufficient consideration appeared to have been given to the risk of impulsive suicide with instead assessment focussing on his denial of increased active suicidal intent.

This is an ongoing area of focus. We are part of interagency Suicide Prevention group for Kensington, Chelsea and Westminster. In addition, we recently held a Learning session entitled - Suicide Prevention Part 1: Understanding Suicide. We are also piloting a new way of caring for service users in South Westminster ("Open Dialogue") with the overall goal to enter into discussion and communication with different sources to ensure increased participation in the safety and treatment of the service user.

4. That no follow up call or assessment was made to Adrian when his treatment session was interrupted by police attendance, and the treatment call was cut off.

We are reviewing our guidance on this and will ensure staff are clear on action to be taken.

5. That there were inadequate communications between the PCN MDT and those providing the psychological treatment.

We are reminding staff of the need for consistent and adequate communication amongst professionals involved in treatment. The team members in both of the teams above attend weekly meetings where the importance of this is constantly emphasised.

Thank you for raising these concerns. I hope that this response provides sufficient assurance that CNWL has taken them seriously, has acted following the death of Mr James and has accepted the points raised and continues to work to improve the service we provide.

Should you have any further questions, please do not hesitate to contact me.

Yours sincerely,

[redacted]

[redacted]
Chief Executive