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NHS Foundation Trust

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Mr G Irvine
HM Coroner
East London Coroners Service
124 Queens Road
Walthamstow
London
E17 8QP

Paul Calaminus
Chief Executive Officer
Trust Head Office
West Wing
CEME Centre
Rainham
Essex
RM13 8GQ

14th June 2024

By email only to:
[redacted]

Your ref: 20364757
Trust ref: 1425

Dear Sir,

Re: Inquest touching upon the death of Olayemi Oluwarotimi Kodjo Kehinde

I refer to your Regulation 28 report, dated 24 April 2024, detailing your concerns about the risk of future deaths in light of the findings of this Inquest.

I should like to extend my sincere condolences to the family of Mr Olayemi Kehinde. This must have been an extremely difficult time and I hope that my response provides them, and you, with assurances that the North East London NHS Foundation Trust (NELFT) is taking action to address the issues set out in your report.

I note that your concerns relate to:

1. The ability of staff authorised to supervise S.17 leave at identifying serious incidents that require meaningful intervention.

2. The ability of the Trust to identify matters that require a full governance investigation.

NELFT acknowledges your concerns and wishes to advise that prior to, and post, the sad passing of Mr Olayemi Kehinde, has implemented a number of changes, which are set out below:

The ability of staff authorised to supervise S.17 leave at identifying serious incidents that require meaningful intervention.

1. To ensure that staff who escort a patient on supervised leave under section 17 of the Mental Health Act 1983 ('s. 17 leave'), are able to do so safely and are able to identify serious incidents that require meaningful intervention, and to provide appropriate and timely intervention, new guidance for leave from inpatient wards for mental health patients has been prepared. This guidance (attached) sets out in detail the process to be undertaken before, during, and after escorting a patient on s. 17 leave, and also covers actions to be taken if the patient intends what may be an ill-advised or reckless decision, and/or absconds or attempts to do so. The first page of this guidance contains on a single page an 'At a glance guidance for escorted leave for mental health patients' as a flowchart, to enable effective learning for staff involved in s. 17 leave, and as an aide memoire for the nurse-in-charge to print and hand to the escort to take with them whilst on escorting duty. Please also find attached the relevant policies referred to in the guidance, namely the Mental Health Act Overarching Policy, Clinical Risk Assessment and Management Policy, and Absent Without Leave (AWOL) including Missing Patients Policy, as well as the electronic pre section17 leave of absence risk assessment form for patients who are on section 17 leave.

2. This guidance will go live across the Trust in June 2024 and will be communicated to all staff via the Trust electronic weekly newsletter and a copy of this guidance will be placed on the Trust's intranet. It will also feature in regular Mental Health Act (MHA) introductory and refresher training, and through wider learning at Trust-wide Learning & Development events. This guidance will also be circulated to the Integrated Care Directors, Directors of Nursing, Associate Directors of Nursing, the Directors, the Associate Medical Directors, and the matrons, some of whom were involved in the preparation of the guidance and disseminated through managers' and matrons huddles, as well as in staff supervision. Electronic dip-sample audits will be performed on a two-monthly basis, against the guidance, and the outcome of the audit will be reviewed by the relevant directorates to support any required improvements in this area.

The ability of the Trust to identify matters that require a full governance investigation.

The Trust takes the identification of incidents and the importance of learning very seriously, and has a number of processes in place to support this. A number of these are new, and I have set these out below:

1. The Trust holds a weekly Incident Review Group (IRG) to review incidents that have occurred across the organisation. The Associate Directors of Nursing (ADoNs) for each directorate attend that meeting to provide oversight on their own incidents. This ensures that incidents are seen centrally before being disseminated across their relevant directorates for local management processes.

2. Each directorate holds a regular incident review meeting, at which incidents requiring further oversight (such as unexpected harms) are reviewed.

3. In 2023 the reporting and management of investigations changed with the implementation of the nationally mandated Patient Safety Incident Response Framework (PSIRF). PSIRF supports the development of an effective patient safety incident response system, that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff), and

enables the organisation to respond to incidents and safety issues in a way that maximises learning and improvement.

4. With the implementation of PSIRF, the Trust initiated a weekly Patient Safety Incident Group (PSIG) forum chaired by the Executive Chief Nursing Officer to oversee incidents that have met the threshold for a PSIRF learning response. There are several learning responses to incidents. Decisions about the type of investigation to undertake are decided at the weekly PSIG forum, and a learning response is decided, based on the local PSIRF plan, national PSIRF recommendations via NHS England (NHSE), and following presentations from clinical staff who share immediate learning outcomes.

5. In 2024, the Trust transitioned from one incident reporting and management system (Datix), to another (InPhase). This is, in part, to satisfy the NHSE requirement for LFPSE (Learning From Patient Safety Events).

6. Once the Trust is made aware of an incident that is historic, it reviews the historic incident utilising the current process in place, which consists of reporting it as an incident on InPhase, discussion of the incident at the IRG meeting, and following further directorate oversight, and where deemed necessary, preparation of a 72-hour report for presentation at the PSIG forum. This provides a robust decision-making mechanism, ensuring that the investigation of an historic incident is treated with the same care and attention as all incidents.

If I can be of any further assistance or if you would like a further update on the progress made to address your concerns, I would be happy to provide a further update.

Yours sincerely

[redacted]

Chief Executive Officer