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

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29 July 2024

Private & Confidential

Priya Malhotra
Assistant Coroner for Inner West London
Inner West London Coroner's Court
33 Tachbrook Street
London
SW1V 2JR

Our internal Reference: [redacted]

Dear Madam

Re: Regulation 28 Report to Prevent Future Deaths – Mr Juan David Martin

I am writing to you following receipt of the Regulation 28: Report to Prevent Future Deaths dated 11 June 2024 (received on 13 June 2024), regarding the sad death of Mr Juan David Martin.

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.

In order to examine all of the concerns raised, the Prevention of Future Death Report was shared with the clinical leadership team responsible for Mr Martin's care and treatment and our Trust board quality committee to help the Trust respond to the points of concern you have raised.

I have provided a response to each of your concerns and direction as they were raised in your correspondence:

Fire safety / evacuation

The MATTERS OF CONCERN are as follows:

(1) There was no policy in place at the time to evacuate those liable for detention and/or at risk of absconding in the fire evacuation policy at the time Juan Martin absconded on 12 April 2022. Witnesses confirmed that the local operational policy was updated on 14 April 2022. The fire evacuation policy was updated in February or March 2024. Notwithstanding the now updated fire evacuation policy, a Health Care Assistant who still works in the Lotus Assessment Unit, confirmed he had not seen the evacuation plans, which form part of the policy.

Based on the evidence heard, my principal concern is that there is a lack of knowledge around the fire evacuation policy on the Lotus Assessment Suite. Whilst some action may have been taken by the Trust to update the policy belatedly and deliver training locally by clinicians; the Health Care Assistant was not familiar with the evacuation plans. It follows there is a genuine risk of future deaths directly connected to a lack of training on the fire evacuation policy and embedded learning and familiarisation around it.

(2) The Fire Safety Advisor in evidence confirmed the findings of the Trust's Root Cause Analysis (RCA) report were not shared with him, despite the RCA being completed on 18 July 2022. Further the nurse in charge was not made aware of the findings of the report that "it would have been best practice for Lotus staff to consider removing valuable items i.e. bank card and any cash from the patient particularly after he met the criteria for detention". It is surprising findings from the Trust's own RCA report were not shared with key staff members, namely the Fire Safety Advisor and the Nurse in Charge on the day Juan Martin absconded from the unit.

As captured during the Inquest, both the Lotus operational policy and fire evacuation procedures had been updated with clear guidance for the variance in procedure of the evacuation of sectioned/detained patients. While this should this have been done sooner, it is now clear that such detained patients should follow the section 136 evacuation procedure and route to ensure they are not able to leave the unit.

Since the Inquest, we have:

- Updated the fire training provided as part of the Trust's corporate induction (for all new staff) to include the consideration to the risk of patients potentially absconding during a fire alarm activation and the importance of consideration of detention status and risk status.
- Likewise, the local/team induction information and a focus on the revised evacuation procedures has been established for all inpatient areas and Lotus
- Specifically with Lotus, to provide additional assurance, all staff have confirmed they are aware and understand the evacuation procedures and how to legally hold someone under the Mental Health Capacity Act/Common Law. This includes those individuals awaiting a Mental Health Act (MHA) Assessment, or those liable to be detained under the MHA, where staff have material safety concerns considering risk of possible imminent absconding. All Lotus staff (apart from those on leave) have confirmed and signed a local induction sheet to confirm their understanding of the different evacuation procedures. There are plans in place to ensure all staff who are on leave and all new joiners do the same.
- Fire warden training has also been updated to cover the same information.

- A real time fire evacuation drill has taken place on Lotus and the Fire Safety Officer confirmed this was very successful and staff were aware of the different evacuation procedures. The Fire Safety Officer produced a written summary of the drill. Further drills will take place and be designed into the routine arrangements for fire drills that will focus on the specific variations to evacuation.
- The learning from this situation will be shared and published via our internal Monthly Learning Bulletin (MLB) by September 2024.

Investigation learning

The MATTERS OF CONCERN are as follows:

Based on the evidence heard, my principal concern is that critical learnings from the RCA have not been shared with key individuals. Whilst some action may have been taken by the Fire Safety Advisor following a request for evidence during my investigation, such as updating the fire evacuation policy earlier this year, it is insufficient to resolve the problem of failing to share learning. It follows there is a genuine risk of future deaths directly connected to a failure to share learning from the RCA unless further action is taken.

Since the Inquest, we have:

- Provided briefings to the central investigation team to review the process for sharing investigation reports and their key findings and actions at the various stages of the investigation.
- Updated our Patient Safety Incident Response Plan (PSIRP) document, adding a new specific section on 'sharing learning'. This includes the process and guiding principles around engaging and sharing learning with both staff, patients and families. This also recognises that such engagement, following what are often traumatic events can be very upsetting for staff involved, hence the need for a tailored approach (via the key principles) to ensure that the most suitable person engages with the staff involved and best able to provide the necessary pastoral support.
- Reviewed the patient safety investigation template to make actions more thoughtful and meaningful. For example, we now include the focus on *'What does the action intend to achieve'* and *'How will it be implemented / delivered'.* In addition to a firmer focus on assurance and monitoring.
- Strengthened the process for capturing actions from investigations into our incident management system, to enable better allocation of actions.
- Added more focus on the formal issuing of the final report to the relevant service line with better clarity on the expectations that they properly review within their governance and business meetings to assurance themselves learning is shared and embedded.
- Due to national NHS changes that require 'draft' investigation reports to be shared with patients and families (as part of meaningful engagement around patient safety), we are reviewing our internal review and sign-off processes which includes the key roles of specific groups and committees. In turn, this will help ensure we have the right learning, with a focus on sharing and improvement.

Absent without leave (AWOL) and missing persons

The MATTERS OF CONCERN are as follows:

(3) The absent without leave (AWOL) and missing person policy.

(a) The policy in force at the time of Juan Martin's death and currently in force, confirm the necessity for the engagement of the Security team following a patient absconding and that the hospital and grounds should be searched. This did not happen on 12 April 2022. The Nurse in Charge who still works for the Trust, accepted she did not contact security, nor was there a search. Juan Martin was a high-risk patient.

(b) Furthermore, Trust policy dictates that the police should be called immediately. Despite being in possession of a radio during the fire evacuation, the Nurse in Charge nor any other staff member present telephoned nor asked for the police to be contacted until 11 mins after Juan Martin absconded. CCTV confirmed he was in the vicinity of the hospital grounds for up to 8 mins after absconding.

(c) The London Mental Health Trusts Joint policy dated November 2023 concerning patients who are AWOL or abscond is not in line with the Trust's current policy dated 22 March 2023, nor does the pan-London policy contain a flow chart for dealing with patients who are high-risk.

Based on the evidence heard, my concerns are that (i) there is a lack of understanding of the AWOL and missing person policy by senior staff; (ii) the pan-London and local policies do not align. Whilst some action may be taken by the Trust to better align the policies and improve knowledge and compliance amongst clinicians of their duties under the policy; this has not yet been undertaken, nor has a clear proposal been provided, such that in my view it is sufficient to resolve the problem. It follows there is a genuine risk of future deaths unless further action is taken, directly connected to (i) a lack of knowledge of procedures following a patient absconding or AWOL and (ii) inconsistency between policy documents.

Prior to the Inquest (and what was then covered during the Inquest proceedings), the Trust had both policies in circulation, although the intention was to have a single policy in place, being the London Mental Health Trust Joint Policy Pan London ('pan London'). Inevitably this led to a lack of consistency and a lack of alignment, and this was reflective of what was relayed to the Inquest.

The Trust had since removed our internal AWOL policy, replacing with the joint pan-London policy, however the Inquest helped the Trust to identify that there was also key information within our old policy around procedures for missing / AWOL service users that was not reflected in the pan-London policy document.

Since the inquest, we have:

- Reviewed both polices to check what may need to be added into an updated pan-London policy.
- As aforementioned, this included adding the flow chart regarding the missing / AWOL procedure to the pan-London policy as an appendix.
- Liaised with the pan-London policy owners on the changes we have made, with a view of working together during the formal revision period (July 2024), as other trusts may wish to include a version of what we have since added.
- Published the revised policy for all staff to be aware.
- Issued the revised policy to the clinical service lines and specifically Lotus service and sought assurance that management to ensure staff are aware and understand the policy requirements and procedures.
- Walk-through AWOL drills have been undertaken in Lotus to ensure that staff are aware of the procedure which has resulting in a reassuring understanding and response.
- In addition, we will be creating a short scenario video on AWOL and fire, to boaster the awareness and this will be incorporated into both local and corporate induction over the autumn period.
- The learning from this situation will be shared and published via our internal Monthly Learning Bulletin (MLB) by September 2024.

A separate letter will follow from the Integrated Care Board (ICB) and myself in connection to the other PFD related to this sad case.

We thank you for your consideration and commitment to the prevention of future deaths and helping us to learn, and I would like to express our deep sympathy to the family and friends of Mr Martin for their loss. While we seek to make significant efforts to ensure that we prevent any similar deaths in the future, 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 the Inquest.

Yours faithfully

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[redacted]
Chief Executive