North London
NHS Foundation Trust

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Private and Confidential
Mr Ian Potter
HM Assistant Coroner
Inner North London

29th November 2024

Dear Coroner Potter

Re Inquest touching the death of George Kyriacos Petrou

I am writing following the inquest for George Petrou which concluded on 11th October 2024 and following which you issued a Prevention of Future Deaths report to the Trust. The matters of concern raised were as follows:

Evidence from members of staff at the Trust, working in the prison at that time, gave the distinct impression that there were a number of members of the mental health in-reach team that placed significant weight on a prisoner telling them that they did not want to be placed on any form of suicide watch and/or ACCT. This was contrary to the guidance, policy and procedures in place. While not being placed on an ACCT was not a causative factor in Mr. Petrou's case, it nonetheless raises a risk of death in the future. In my view, witnesses from the Trust provided insufficient reassurance that this matter has been addressed.

The Trust acknowledges the concerns raised by the Coroner following the inquest into the death of Mr. Petrou. It is committed to addressing these concerns through a series of actions aimed at preventing future incidents and ensuring the safety of all service users.

The Trust fully recognises the importance and significance of mental health clinicians' competencies and capabilities regarding ACCT decision making – including this matter in particular - ACCT initiation, but also more broadly ACCT continuation and cessation.

The decision in Mr. Petrou's case not to implement an ACCT was made because the assessing clinician believed, factoring in clinical and contextual considerations, that the idea of ACCT implementation contradicted the expressed wishes of Mr. Petrou. Accordingly, ACCT initiation was not believed to be required.

In light of the concerns raised by the Coroner, the Trust will continue to assure training standards around ACCT are sustained, will continue to participate in ACCT reviews in

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accordance with our operational policy, and will implement a learning event for our Unscheduled Care Team workers and clinicians.

The events leading up to the death of Mr. Petrou will be shared and all clinicians reminded of the support mechanisms in place to aid decision making for cases where the implementation of an ACCT process may contradict the expressed wishes of a service user.

The learning event will focus on the message, 'if in doubt, implement an ACCT'. The importance of optimising people's safety through ACCT and our roles and responsibilities, will be included in all future inductions for the Trust's prison healthcare staff.

Leaders in our services will include ACCT dilemma cases on key meeting agendas for review and consideration by senior clinicians.

These actions will be concluded by close of December 2024.

I hope that this response provides the necessary assurance. Please contact me if you have any queries.

Yours sincerely

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Chief Medical Officer