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

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11 June 2025

Private & Confidential

Lydia Brown
Senior Coroner for West London
25 Bagleys Lane
Fulham
London
SW6 2QA
United Kingdom

Our internal Reference: Incident Number [redacted]

Dear Ms Brown,

Re: Regulation 28 Report to Prevent Future Deaths – Jonathan Mark George Hamer

I am writing in response to the Regulation 28: Report to Prevent Future Deaths, dated 10 April 2025, concerning the very sad death of Mr Jonathan Mark George Hamer.

South West London and St George's Mental Health NHS Trust (SWLStG) acknowledges the matters of concern raised in your report and takes them extremely seriously. To ensure a comprehensive response, the issues outlined have been reviewed with the clinical leadership team involved in Mr Hamer's care and will be shared with our Trust Board Quality Committee and in our Public Board meeting in July 2025.

Below is our response to each of the identified concerns:

Communication

The MATTERS OF CONCERN are as follows:

1. *'There were communication difficulties experienced by Jonathan's family and his supported housing with the community mental health trust responsible for his ongoing healthcare during the early part of 2024. Telephone calls and text messages were unanswered and there was no communication to confirm that in*

fact the care co-ordinator had a period of annual leave followed by an unplanned period of sick leave. It was unclear at inquest if service users and their support network had been provided with details of any service changes and current up to date contact details. This meant that important information was not being received by the community mental health team.

2. *The community mental health team actively encouraged communication by text message and emails but had no system in place to intervene when the care co-ordinator was not at work and had left no "out of office" message. There was no system to return or redirect incoming calls or messages so these remained unread and unanswered. Those initiating the communication were unaware that the information was not being received or actioned by the Trust.'*

We fully acknowledge and regret the communication failures identified in this case. The lack of appropriate cover arrangements and failure to redirect important messages during the care coordinator's absence represented a serious lapse in service continuity and risk management.

The Trust has procured a digital communication system, called Envoy which enhances communication and engagement with patients. Envoy enables centralised, monitored messaging across SMS from the Trust to patients regarding appointments and provides some ability for patients to provide a SMS through to Envoy around appointments.

While this system improves our communication with patients, there remains some limitations and therefore is supported with the following.

- A new Standard Operating Procedure (SOP) for using Envoy, including cover arrangements during periods of planned and unplanned leave.
- Training for all administration staff, with phased expansion to other clinical staff within community teams.
- A revised process for case list management when unplanned leave occurs, to ensure continuity of care.

In addition, we have reinforced the following protocols across all community teams:

- Text messaging is now limited to routine communication, such as appointment reminders, and must only be used with patient consent. Staff have been instructed not to share clinically sensitive or identifiable information via SMS.
- We have asked community teams to add specifically created email footers to their personal NHS emails to advise recipients that the mailbox may not be monitored and to provide alternative team contact details and crisis service links.

- Teams have been reminded not to rely solely on individual work communication channels and to ensure team mailboxes and phone lines are promoted and accessible.
- Teams have also asked to ensure they always set voice message to inform people who they can contact in their absence, typically either the team base or crisis services.
- We have updated our 'how to make contact with the trust' and care team page on our website to reflect our approach.

While we considered prohibiting SMS messaging entirely, our clinicians advised that text-based communication can be a helpful and preferred means of engagement for many service users. As such, we have sought to adopt a more risk balanced position to help preserving flexibility and accessibility while we continue to implement the use of Envoy. We have asked all care co-ordinators to ensure that they are clear that SMS is not for urgent communication. We have also updated our guidance about how to make contact with the trust and care team on the website to reflect that SMS is not for urgent or important communications and to use the team contact details for such matters.

The Envoy system has already been implemented in some of our clinical therapy teams, and we are now progressing plans to roll it out more widely across all community teams. We are currently working with the community team involved in Mr Hamer's care to ensure they are among the first to benefit.

The revised SOP reinforces the requirement for staff to set 'out of office' replies and voicemail messages on their mobile phones. These should include an alternative contact number as part of the standard message—for example: *"If your call is urgent or important, please contact [alternative number]."* Importantly, the Envoy system will support the administration team in notifying and engaging with patients when a staff member is unexpectedly unwell and absent from work.

The Trust is investing in a new digital solution centred around the NHS App and an integrated central patient portal. This initiative aims to significantly enhance communication between patients and clinicians, thereby reducing associated safety risks. A key requirement of the project is the provision of secure messaging functionality, enabling timely, confidential communication and supporting alerting and escalation processes for patients who may be approaching crisis. The project is currently in development, with tendering underway to support NHS App integration. Completion is anticipated during 2026.

Zoning

The MATTERS OF CONCERN are as follows:

'Jonathan's case was not "zoned" that is, given a priority coding on the case management system. Therefore, there was no expected period for case review or regularity of expected contact. The multi-disciplinary meetings and supervision meetings when Jonathan's case was discussed failed to recognise and address this issue. Appropriate zoning and regular reviews are a fundamental part of mental health care and should be embedded and prioritised as part of each patient's care planning.'

We accept the concern raised and recognise that appropriate zoning and regular review are essential components of safe, coordinated mental health care.

In response, the Trust has reviewed and strengthened its zoning and case prioritisation processes across all relevant community mental health teams.

The following measures have now been implemented:

- **Unzoned Patients:** Any patient not currently assigned a zone is flagged and updated by the Team Manager and Consultant Psychiatrist, with oversight maintained via daily huddle discussions to ensure appropriate zoning is agreed and recorded. Senior Managers also complete regular reviews across the Community Service Line on teams with unzoned patients to ensure action is taken immediately.

- **Daily Huddle Reviews:** All patients identified within the red or amber zones or who have not been zoned are now discussed daily at multidisciplinary team huddles. This includes a review of risks, current concerns, and plans for care delivery, especially during periods when the allocated healthcare professional is unavailable.

- **Zoning Meetings:** Our teams are being reviewed to ensure that they are holding a minimum of two zoning meetings per week in line with our current policy.

- **Enhanced Oversight:** The Enhanced Response Practitioner and Team Manager jointly review red and amber zoned patients daily. In addition, patients requiring enhanced support (regardless of zoning) are flagged and reviewed to ensure timely interventions.

- **Green Zone Monitoring and Escalation**: Patients categorised as green are reviewed during regular clinical supervision. Where there are any signs of deterioration, concerns are raised during the daily huddle, prompting a patient review meeting. This meeting may result in a re-zoning decision and updated intervention plan based on assessed risk and support needs.

To help embed this process consistently, we have also taken the opportunity to review and revise our team huddle agendas. A standardised huddle directive has been

introduced across all community teams, with clear expectations regarding zoning discussion, escalation procedures, and risk review. This standardised approach took effect from 1 June 2025 and clear training and implementation support in place to ensure this becomes embedded in practice and this will be audited against in 6 months' time.

These steps aim to ensure that zoning is not only applied consistently but also actively used to guide care planning, prioritisation, and review frequency in line with best practice.

We extend our sincerest condolences to Mr Hamer's family and support network. The Trust is committed to learning from this tragic event and ensuring that the issues identified do not recur. We are also grateful to all those involved in the inquest process, whose contributions support our continued efforts to improve patient safety and care.

Yours faithfully

[redacted]

[redacted]
Chief Executive